“A Culture of Caring”: The Intersection of Hospital Housekeeping Staff and Person-Centered Care

By

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THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Nursing Science and Health-Care Leadership

in the

OFFICE OF GRADUATE STUDIES

of the

UNIVERSITY OF CALIFORNIA

DAVIS

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Committee in Charge
2021

Acknowledgements

It was Cliff who first made me feel welcome as part of the team when I was a new-graduate nurse in 2003. For the last 17 years I have watched him and his colleagues in environmental services go above and beyond in caring for patients. From a soft hand on a foot of someone worried, to a listening ear for a tired and anxious parent, they have been a steady presence of comfort and compassion.

Over the years, I have facilitated a course named: "Re-Igniting the Spirit of Caring". In this workshop, we invite guests who were once patients to come and share their stories. At the end of their story, we ask them: what did caring look like? What did it feel like? Time and again, former patients would mention housekeeping. "Don't forget about your housekeepers" one said, "they were there for me when no one else was". It was then I realized there was something unique happening between patients and housekeeping staff. And that who is called part of the "patient care team" was not necessarily who patients considered to be the full care team.

When I began this research journey, I expected to learn about interactions between housekeeping staff and patients in the hospital. What I gained, was an awareness of hierarchies of power and class within healthcare. I also gained insight into the true heart of caring and seeing people in their humanity. I am humbled by the generosity of the participants and the stories they shared with me. It is my hope that their combined wisdom will start deeper conversations and reflection on person-centered care and truly inclusive and equitable teamwork within healthcare.

This project would not have been possible without the wisdom and support from my research chair and committee. Thank you for your generosity and guidance and for believing in this work. This journey would also not have been possible without the love and encouragement of my MS-L 2019 cohort, and of my friends and family.

Abstract

This qualitative descriptive study explores the experiences and perceptions of hospital housekeeping staff, how they interact with patients, and how they perceive their impact on patient care. There is increasing recognition of hospital housekeeping staff as frontline workers. There are anecdotal reports that detail housekeeping staff giving mental, emotional, and spiritual support to patients, yet little is known about this phenomenon. A total of eight housekeeping staff participated in semi-structured interviews ranging from 30–60 minutes. Participants ranged from 40 to 62 years old, were from diverse ethnic backgrounds, and had worked at the participating hospital from 4 months to 20 years. Transcribed interviews were evaluated using a process of thematic analysis and investigator triangulation, while bracketing, reflective journaling, and member-checking were used to enhance validity.

The themes that emerged revealed a widespread culture of caring among housekeeping staff where they build meaningful connections and trust with patients. Recognizing their role as unique, they often act as a bridge between patients and the rest of the healthcare team and provide a listening ear to patients and their families. Witnessing the suffering of patients is viewed as a part of their job, and they are impacted in similar ways as other healthcare staff. Participants were unanimous in describing the importance of cleanliness but believed that their impact is "more than just cleaning." Further research is needed to understand these phenomena from the patients' perspective. Greater recognition is necessary for these members of the health care team, as are policies giving them equitable access to caregiver resources within the health system**.**

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Introduction

In the current healthcare system, housekeeping staff members are a sometimes invisible and under-valued workforce (Mack, Froggatt, & McClinton, 2003). Known in hospitals and clinics as "environmental services" (EVS) staff, cleaners are valuable members of the team. Besides being the frontline staff of a hospital's infection prevention team, EVS staff also spend up to 10–20 minutes with a patient whenever they are cleaning a room (Jors, Tietgen, Xander et al., 2017). The provision of high-quality person-centered care does not belong to one department alone, and more and more, the importance of interprofessional practice and collaboration is being realized. As with other teams considered "ancillary" or "support" staff, cleaners are not considered direct patient care staff. And yet, housekeeping departments are responsible for preventing the spread of infection and creating an environment of quality and safety for staff, patients, and visitors alike. There is a gap between the importance of their housekeeping role and the recognition they are given for it (Messing, 1998).

Background

Population Data

In the United States (U.S.) alone, there are over 400,000 housekeepers employed in hospitals (Bureau of Labor Statistics, 2018). The median wage for EVS staff in the state of California is $13.80 hourly, with a median annual salary of $29,829 nationwide (De Luce, Court, & Hoff, 2020). Job duties include but are not limited to cleaning of patient care and non-patient care areas, cleaning floors, disinfecting surfaces, emptying linens and garbage, and restocking cleaning and hygiene supplies. Employee health benefits and other income supplements vary depending on the workplace (State of California Labor Market Info, 2020).

The hospital is a peculiar working environment with occupational hazards and risks for exposure not found in many other workplaces. Housekeepers in hospitals are responsible for the disinfection and cleanliness of office spaces, clinics, interventional and diagnostic areas, and patient care units. In some institutions, they are assigned to a specific unit; in others, they could be sent to a different area each day. With a high volume of physical work and repetitive tasks, housekeepers are exposed to various injury risks (Alamgir, 2008). A study conducted in Italy found that hospital cleaners had a similar level of occupational stress and were exposed to a similar risk as nursing staff in the same hospital (Marconato, Magnago, Dalmolin et al., 2017). In a recent study, cleaners and transport staff were found to be at a higher risk for exposure to SARS CoV-2 than nurses in the intensive care unit (Eyre, Lumley, O'Donnell et al., 2020).

The cleaning staff are not who people initially think of when they mention "healthcare heroes" or when they talk about their care team at the hospital. Their breakrooms and managerial offices are often found in the basement of hospitals and in many places, hospital cleaning is outsourced to private companies . Yet, few roles in the hospital are more critical for patient and staff safety. The EVS is responsible for keeping the health system running. Their work impacts mortality and morbidity; they spend a lot of time in patient care areas, they are in close proximity to patients, and work alongside healthcare staff all day. They spend more time with patients, according to Jors et al. (2017), than some clinicians in certain settings do.

Nightingale's Theory of Environmental Cleanliness

The history of housekeeping in hospitals is also the history of nursing. It was Florence Nightingale during the mid-19th century Crimean War who made headlines after reducing mortality rates within Turkey's Scutari Hospital using scrub brushes and her theory of environmental cleanliness (Smith, 2008). Nightingale (1860) first made the connection between

a clean environment and healing, and the responsibility of hospital cleanliness soon became a foundation of nursing care. As the growth of hospitals outpaced the number of available licensed nurses, more and more tasks became delegated to unlicensed staff. It is a tenet of nursing practice that cleanliness and healing go hand in hand. Nightingale (1860) wrote that "the greater part of nursing consists in preserving cleanliness" (pg. 121). In early operating theatres, it was the job of the nurse to not only aid with instruments but to clean the floors and furniture with a cloth tied over a brush and dipped in hot water (pg. 124).

It was then and is still believed that the environment and the person who is sick are "inherently linked" (Hegge, 2013). Nightingale (1860) argued that to be healthy is a privilege often taken for granted. To be able to change the environment, to leave the room, and not to be dependent on those around them for the cleanliness of their own space was a privilege of the well (pp. 124-125). She believed that what could be a "trifling inconvenience" to someone who is healthy could also be a source of suffering or discomfort for someone who is sick (Nightingale, 1860, pg. 123). To this end, Nightingale wrote: "Very few people, be they of what class they may, have any idea of the exquisite cleanliness required in the sick-room" (pg. 121). The cleanliness of a hospital is vital in not just creating a safe environment with reduced hospital-acquired infections but in creating comfort for patients and confidence in the health care team and facility. Maintaining cleanliness is a way of doing for them what they are not able to do for themselves.

Caring Moments

Care and compassion are human qualities, not limited only to those with degrees or licenses in healthcare. Studies have shown that even brief moments of compassion can have a profound impact on someone who is sick (Trzeciak, 2019). Thus, healing is best facilitated when

the relational and technical aspects of care are balanced with intention (Trzeciak, 2019) There may be a linear beginning and end to a technical task. But relational care, according to Jean Watson (Watson, 1988), is not limited to a task or a moment. Those moments can take a different form, different shape. Unique to each person and moment, they are woven through and alongside the technical tasks of patient care (Watson, 2009). In a study of physician interactions with patients, it was discovered that a mere 40 seconds was all that was needed to create a moment of perceived compassion that was found to reduce anxiety for the patient (Fogarty, Curbow, Wingard et al. 1999).

Purpose

The potential exists for therapeutic interactions between housekeeping staff and people who are hospitalized. A large, academic medical center provides an opportunity to learn from staff from various shifts who work different units and have diverse cultural backgrounds. This thesis explores the experiences of hospital housekeeping staff—(1) how they interact with patients, and (2) their perceptions of their impact on patient care within the health system.

Literature Review

A review of existing literature from 1980 to 2020 was conducted using Pubmed, Google Scholar, Scopus, CINAHL, and PsychInfo. To identify articles related to the experiences and perceptions held by cleaning staff in hospitals, multiple search terms were used. In the literature, hospital cleaning staff are referred to as: “unlicensed staff,” “support staff,” “domestic staff,” “hospital cleaners,” and “ancillary staff.” Systematic reviews and meta-analyses were excluded, and only English-language articles were selected. Of those, 50 were excluded due to not relating to the topic. After completing the search, five more articles were chosen from a manual search of the reference lists of those selected. A total of twelve articles were selected for review.

Of the twelve selected articles, five were qualitative, five were mixed methods, one study was a quantitative survey, and another was a case study. All but three of the studies were conducted outside of the United States, and two articles also included the views of "porters" or transport staff and EVS managers. Three studies were solely qualitative, consisting of semi-structured interviews with nine to twelve participants (Ashton & Manthorpe, 2019; Mack et al., 2003). Six of the studies were mixed methods, with two of them using baseline interviews and focus groups conducted to create a survey that was then distributed to the rest of the staff (Cashavelly, Donelan, Binda et al., 2008; Jors et al., 2017).

Owing to the lack of literature focused solely on the experiences of and perceptions held by cleaning staff, this review includes studies evaluating "support staff" such as transport staff. Emphasis was given to responses and data from the cleaning staff participants of each study. The review of existing literature uncovered five themes: more than the job description, time spent with patients, feeling invisible, witnessing suffering, and how they cope with the stress of the job.

More Than the Job Description

Participants from multiple studies described an awareness that the job they did was more than the job description they were hired for and that they were an important part of the quality of care despite not being recognized for it at times (Ashton & Manthorpe, 2019; Jors et al., 2017; Mack et al., 2003; Schulman-Green, Harris, Xue et al., 2005). One study found that all 29 participants interviewed believed that their job was "critical" to the hospital running smoothly and vital to patient care (Dutton, Debebe & Wrzesniewski, 2016). Participants from the study by Mack and colleagues (2003) believed that they were a part of the patients' healing process and that they brought value to patients that was more than their role of cleaning. In a study by Ashton

and Manthorpe (2019), participants discussed a sense of accomplishment from the work that they did with patients but said that it was not shared by all of their housekeeping colleagues. One participant remarked: “We are here to look after them; I know some of the others don’t think that way.” Another noted that “It’s the little things we do, it can be the tiniest thing ever that they have waited so long for the nurses to do.” Participants in Ashton and Manthorpe’s (2019) study also believed that supporting the “personhood” of the patient added value to their work of cleaning.

A study conducted by Henderson (1981) described cleaning staff in a nursing home as “indigenous therapists”, trained for an ancillary role but found to be providing psychosocial care to the residents (p. 121). Nurses were seen to be constrained by time and a high load of technical tasks, while the very nature of housekeeping duties allowed cleaning staff to be in the patient’s room for long periods. Those interviewed in other studies believed that they were an essential part of the hospital, a part of patient healing (Jors et al., 2017; Mack et al., 2003), and were often the “eyes and ears” for the patients (Ashton & Manthorpe, 2019). Despite being hired for the job of cleaning, they believed they provided care that was more than their role (Mack et al., 2003) and that the emotional care of patients was “part of the job” (Schulman-Green et al., 2005). In an anthropological look at hospital housekeeping (Messing, 1998), the researcher found that housekeepers viewed themselves as playing an important role in the care of patients, especially those who did not have regular visitors.

In more than one study, participants expressed feeling a duty to cheer patients up and would intentionally steer the conversation away from the patient’s illness or reason for hospitalization (Ashton & Manthorpe, 2019; Jors et al., 2017; Mack et al., 2003; Schulman-Green et al., 2005). One participant mentioned singing with patients as a way to bring them hope,

and another remarked, “If you can make someone happy, I know everyone’s schedule is tight, but to come away thinking I’ve done my best that I could possibly do” (Ashton & Manthorpe, 2019, p. #). Those interviewed believed that the emotional care was a part of their job, with one member of the cleaning staff saying: “I’m not dealing with the patients, but I am [because I’ve] got to make sure their rooms are clean, and talk to them, because some of them are really down, so I cheer them up” (Schulman-Green et al., 2005). This time spent with patients was seen as a valuable part of many participants’ work experience (Mack et al., 2003). In the discussion of their findings, Salerno, Livigni, Magrini et al. (2012) believed that because of the time spent with patients, hospital housekeeping staff should be considered “a cure job” or part of the patient care team.

Interacting with Patients

The majority of participants identified similar caring behaviors. The amount of time spent in patients’ rooms varied according to the hospital (Ashton & Manthorpe, 2019; Cashavelly et al., 2008; Cross, Gon, Morrison et al., 2019; Jors et al., 2017; Mack et al., 2003) and in one study, averaged 10–20 minutes per day with an estimated 1–5 minutes of conversation with patients and families (Jors et al., 2017). The environmental services staff considered themselves part of the patient’s healing (Mack et al., 2003), and many had their own personal philosophies of care (Ashton & Manthorpe, 2019).

The caring actions taken by many of the domestic staff demonstrated a therapeutic relationship by modeling patient-centered care (Ashton & Manthorpe, 2019). They viewed the little things as being important to the patient (Jors et al., 2017), valued seeing them as a person and not a disease (Ashton & Manthorpe, 2019; Jors et al., 2017), and focused on keeping the conversation light and cheerful (Jors et al., 2017). “It’s really fun to be with people. I really

enjoy the work with the patients. The work I don't like so much but working with the patients…" (Jors et al., 2017). According to the study by Schulman-Green et al. (2005), housekeeping staff did not receive any training in communication or interacting with patients. Despite this, listening to patients was a priority because they believed patients felt more comfortable talking to them than to the medical staff (Cashavelly et al., 2008; Jors et al., 2017; Mack et al., 2003). One participant remarked that: "some patients have said that when we come in, it's like the sun just dawned in the room" (Jors et al., 2017) and another that: "we are here to look after them" (Ashton & Manthorpe, 2019; Cashavelly et al., 2008).

"We Don't Exist; We're Invisible For Them"

In the majority of studies reviewed, participants mentioned different aspects of feeling overlooked or devalued by other staff members. Henderson (1981) noted that the American health care system is "organized along business and medical hierarchical schemes." For this reason, cleaning staff often find themselves at the bottom of this imposed hierarchy or an invisible caste system. In a study of what actions and behavior express value or devaluing, Dutton and colleagues (2016) found that most "devaluing" actions came from members of the healthcare team. The lack of value was communicated through "non-recognition" and took many forms. Some reported a theme of their presence being ignored or not noticed, or only hearing their name when someone needed a task completed. Others talked about feeling like "an invisible person that sort of floats around on the outside looking in," only becoming visible when there was a complaint about their cleaning work (Dutton et.al, 2016 p.). As one person said: "Sometimes you get the impression like, you know, they think they are more important than you are. And I mean their job is very important, but you know, cleaning the hospital is very important too" (Dutton et.al, 2016) .

Participants in other studies reported feeling recognized by the patient care team, such as nurses and doctors but felt overlooked by hospital administration (Jors et al., 2017). While there were exceptions to the experience of feeling devalued or invisible, it remained a recurring theme, and many verbalized a desire for more recognition and respect for their work (Cashavelly et al., 2008; Jors et al., 2017; Mack et al., 2003: Messing, 1998). Rather than look to hospital leadership to find value in their work, housekeeping and support staff took their value from being able to help care for the patients (Ashton & Manthorpe, 2019; Cashavelly et al., 2008; Schulman-Green et al., 2005). It is interesting to note that in Dutton and colleague's (2016) study, only one participant (*n*=29) reported feeling devalued by a patient or visitor. According to Dutton et. al, (2016), it was from the patients and family members that many of the participants reported feeling valued and seen.

The work of cleaning is undervalued both institutionally and socially in many cultures (Ashton & Manthorpe, 2019; Cross et al., 2019), and hospital staff are not exempt from this (Ashton & Manthorpe, 2019; Cross et al., 2019; Jors et al., 2017; Mack et al., 2003). The importance of the relationship they can have with patients is not acknowledged, and so they can feel like they are "at the bottom of the pecking order" or "like a nobody on the unit" (Cashavelly et al., 2008). The recognition that they do get is based on how well they complete the tasks assigned to them (Ashton & Manthorpe, 2019), and if they do receive feedback, it is most likely negative (Jors et al., 2017). One participant noted: "I feel so small, like a little mosquito. But still nothing would work without us" (Mack et al., 2003 p.).

Participants in more than one study described being invisible unless their work was being criticized (Clynes, Kilcullen, Lawrence et al., 2010; Jors et al., 2017; Messing, 1998). Messing (1998)(Messing, #107) spent time in two Quebec hospitals to better understand the experiences

of housekeeping staff. In her paper, she wrote about walking alongside a cleaner as she pushed a garbage can when two people walking by tossed trash in the moving garbage can, barely missing the author and the cleaner without a word exchanged. The author herself describes a moment when, after being in an auditorium with a colleague, she realized that there was a woman cleaning the seats who she did not notice after being in the room for ten minutes. Participants in her study talked about having to organize their work so they did not interfere with other people since being invisible was a desirable characteristic for cleaning staff (Messing, 1998). Participants also described the conflict between not wanting to wake a patient up while cleaning their room and not wanting to get in trouble for not cleaning it.

Being devalued can lead to an erosion of trust between environmental services and support staff and the rest of the healthcare team (Jors et al., 2017; Mack et al., 2003). Participants were sometimes not warned if they were entering a room with a dead body or a room with an infectious organism present (Jors, 2017). Participants from two separate studies cited the undervaluing of their work as the reason why they did not trust nurses or doctors to warn them of the hazards of chemotherapy or radiation exposure from patients (Jors et al., 2017; Mack et al., 2003) In light of this, some wished that there was more of an acknowledgement about the emotional toll of their job (Cashavelly et al., 2008).

Witnessing Suffering

Participants from many studies experienced difficulties when working with people who were sick or dying (Jors et al., 2017). Feelings of helplessness, detachment, and moral distress were reported in a majority of the studies (Ashton & Manthorpe, 2019; Cashavelly et al., 2008; Jors et al., 2017; Mack et al., 2003). Housekeeping staff were frequently troubled by patients who died alone (Jors et al., 2017) and had difficulty moving quickly from one room to another if

someone was dying or in distress without time to process or debrief what they had experienced (Schulman-Green et al., 2005). Deaths of young people or people with children were the hardest for many staff to deal with (Cashavelly et al., 2008; Jors et al., 2017; Mack et al., 2003). Feelings of helplessness were reported when working in rooms where it appeared that a patient's life was being prolonged despite considerable suffering (Ashton & Manthorpe, 2019).

In a quantitative study of minor psychiatric disorders experienced by staff, Marconato, Magnago, Dalmolin et al. (2017) made the point that those who work in a hospital are around people who are in some of the more trying moments of their life: "moments of illness and finality." Marconato and colleagues (2017) also found that in their work, hospital housekeeping staff are exposed to similar risks as other healthcare staff and have a slightly greater prevalence of minor psychiatric disorders. Witnessing suffering and being exposed to trauma and patient situations impacted the hospital cleaning staff, and many described various coping methods to deal with the stress (Jors et al., 2017).

Coping Methods

Working alongside human suffering and dealing with the stress of being undervalued or feeling invisible led to various coping measures taken by the cleaning staff. There is no one way to cope with stress, and, similar to medical staff, environmental services staff had many methods. Talking with family and friends about what they were feeling did occur (Cashavelly et al., 2008; Jors et al., 2017), but many preferred co-workers to talk with because they understood what they were feeling (Jors et al., 2017). Others chose detachment as a coping strategy (Ashton & Manthorpe, 2019; Cashavelly et al., 2008; Jors et al., 2017), with one participant saying: "I can't be bothered with it all. I have enough of it at home. I just switch it off" (Ashton & Manthorpe, 2019 p.). Some started their career troubled by what they were seeing but later got used to

dealing with death as time went on (Jors et al., 2017), while others would simply limit the amount of time they spent talking to patients when they were in their room (Jors et al., 2017). Some learned to establish boundaries so they would not feel "so overinvolved" (Cashavelly et al., 2008).

Limitations of the Review

There are few studies that have explored the experience of environmental services staff within hospitals. None were found that had been conducted in the U.S. While many of the studies included individual interviews, none of them addressed the phenomenology of the EVS experience. This is interesting to note because the same themes were identified in each of the articles, regardless of country or sample size. It is important to note that each of the articles reviewed was not focused solely on the experiences of cleaning or support staff, but instead were studying the perceptions of cleaning and support staff within the context of conditions like dementia, chronic pain, cancer care, and death or dying.

While the majority of the articles also included support staff and were not an accurate representative sample of the EVS population, the same themes were identified among support staff as among EVS staff.

Conclusion

As demonstrated, few studies have evaluated the experiences and perceptions held by hospital housekeeping staff. Studies have been done to evaluate their impact on the incidence of hospital-acquired infections and the incidence of mild psychiatric disorders. Research is needed to understand better the experiences and perceptions held by environmental services staff. As an overlooked part of the healthcare team, there is a gap about the impact of their involvement in patient care and their experience of things like moral distress or compassion fatigue. Further

research is needed to explore caregiving from an EVS's perspective. Their impact on hospital cleanliness and infection control has been documented (Cross et al., 2019), but no studies were identified that examined their impact on the patient's care experience. Because the same themes were identified in different countries and with varying types of support staff, research done in the U.S. would add to this rich perspective. The environmental services staff appear to be a marginalized population within the international healthcare workforce, and further understanding is needed regarding the physical, emotional, and psychological impact of their role. Thus, this thesis explores the experiences of and perceptions held by hospital cleaning staff regarding patient care and how they view themselves within the healthcare team.

Methodology

Study Design

A qualitative descriptive design was used for this study. This design was chosen because the goal of a qualitative description is to create a comprehensive summary of the meaning of unique events or experiences from the perspective of the person(s) being interviewed (Lambert & Lambert, 2012). There is room for some interpretive analysis in this design (Sandelowski, 2010), and it is beneficial when time and resources are limited (Bradshaw, Atkinson, & Doody, 2017). As Sandelowski (2010) points out, it is also helpful when data on a phenomenon is limited.

Protection of Human Subjects

This study was deemed exempt by the Institutional Review Board of the participating hospital. All participants were provided written, informed consent forms and were given information on how to access employee counseling resources. Participants were asked to refrain from identifying themselves, and all data was de-identified.

Each participant was given a code, and while demographic information was collected, identifying details were excluded to ensure confidentiality. Due to the coronavirus (COVID-19) social distancing requirements at the time of data collection, interviews were conducted using Zoom or a telephone call (depending on participants' preferences), and an audio-recording was taken of the interview. One interview was conducted over the telephone since the participant expressed discomfort with using video. Audio-recordings were downloaded to a password-protected laptop and destroyed once transcription and data analysis were complete. Transcription occurred through a professional service, and only the principal researcher, the transcriptionist, and the research chair had access to the transcribed files.

Recruitment

Recruitment occurred from September through November of 2020 through the use of flyers and convenience sampling. Interview participants were also recruited through email, inviting them to contact the principal investigator (PI) if they would like to be interviewed. Please see Appendix B for the original survey flyer. An email with the study flyer was sent to all staff employed by the Environmental Services Department. Study flyers were distributed during the pre-shift huddle on four occasions. Participants were also recruited through convenience sampling by talking to people from different shifts during the course of a typical workday. Participants volunteered to participate in the study and were given a $25 VISA gift card to thank them for their time.

Interview Process

The interviews will be semi-structured with open-ended questions that were designed with the input and expertise of the research chair and committee (see Appendix A). Responses to interview questions will be followed up with prompts such as: "Could you tell me more about

that" or: "What do you mean when you say___"? Formal interviews will be conducted via web-based tele-conferencing or telephone. Consent will be reviewed verbally beforehand, and permission requested to audio-record the interview. Interviews will range in time from 30 minutes to an hour.

Trustworthiness

Positionality Statement

The principal investigator is a clinical nurse at the hospital where the study was conducted. She also facilitates a workshop for employees called "Re-Igniting the Spirit of Caring" (designed by Creative Health Care Management), where former patients are invited to come and share their experience of being in the hospital. This study was partly inspired by the personal experience of the PI and also by the repeated mentioning by former patients of the housekeeping staff in the units they were admitted to. Patient guests who shared at these workshops often spoke of housekeeping staff being the ones to show them a caring or therapeutic moment. This experience combined with the PI's own experience as a nurse: watching different housekeeping staff listen to parents talk about their child's cancer diagnosis, bring a warm blanket to someone, welcome new patients to the unit, and check up on patients who had been transferred. These collective moments informed the foundation of this study. The PI is a white woman, was 39 years old at the time of the study, and has worked as a clinical nurse at the participating hospital for the length of her 17 year career. There can be an inherent power dynamic between housekeeping and clinical staff, particularly nursing as discussed by Messing (1998) and Mack et al. (2003). The PI leaned on the expertise of her thesis committee to learn how to conduct interviews and analyze data while acknowledging her unique perspective, implicit biases and an imbalance of power weighted toward her. Because of the connection to the

population being studied and her relationship to the population, the PI also engaged in reflective journaling and bracketing. Perspectives, observations, and concerns that arose were discussed with the research chair throughout the process.

Reflective Journaling and Bracketing

The practice of bracketing, as described by Creswell and Miller (2000), allows the researcher to acknowledge and suspend previously held preconceptions and beliefs about the phenomena being studied. Reflective journaling is another way to incorporate and contextualize the researcher's experiences and perceptions as a part of the data (Johnston, Wallis, Oprescu et al., 2017). The PI will take notes after each interview, journaling about her own experiences and thoughts following the sessions. Observations and experiences during the data collection process and data analysis will be recorded, and notes taken during the interviews.

Investigator Triangulation

To add depth to the analysis of emerging themes found in the data, investigator triangulation will be performed by the PI and the research chair. For this process, two or more researchers review the data and offer their observations or conclusions. The aim of this is to simultaneously add different perspectives while also confirming the initial findings (Denzin, 1978). The original transcripts with the codes and themes identified will then be sent to the research chair for review. After reviewing it, the PI and research chair will meet together to analyze which themes could be folded into each other or broadened to include more of the participants' experiences. This will allow the PI to confirm and expand the findings, giving a different lens through which to see the data.

Member Checking

To further confirm the validity of the findings, member checking will be performed. In this process, the results of the themes and summaries are reviewed by selected participants to obtain their reactions to the findings (Polit & Beck, 2014). While this method of trustworthiness is believed to potentially privilege data that favors either researcher or participant (Polit & Beck, 2014), it also enhances validity. When working with potentially marginalized populations, thoughtful member-checking can address specific power dynamics inherent in the process (Hallett, 2013). According to Hallett (2013), it is the duty of the researcher to protect marginalized populations from further marginalization as a result of the research process. Thus, the opportunity to review the themes and their descriptions will not be offered until interviews are completed and the PI has come to know the participant and what their data contribution would be (Hallett, 2013). Summaries of each of the themes and subthemes will reviewed by three participants and approved as having accurately described their unique experiences and perceptions.

Data Analysis

Data will then be evaluated through thematic analysis using the framework outlined by Braun and Clarke (2006). A six-step process beginning with data familiarization, generating initial codes, looking for themes, reviewing, then defining and naming themes, and concluding with producing the report (Braun & Clarke, 2006). To accomplish this, the PI will listen to each of the interviews after the interview was conducted and write out a page summary of their answers from their perspective, answering the question: "What would __ say the story is?" Notes will then be taken on points or phrases that stood out from the participants' interviews. Recordings will be transcribed either by the PI or a professional transcription service.

Transcriptions will be reviewed against the recording and notes made of any pauses, exclamations, or emphases made by the participants. Coding software, such as Nvivo, will be used to identify and organize codes, themes and subthemes. Investigator triangulation and mind maps will also be used to analyze the data.

Results

Sample

There was a total sample size of eight participants. Inclusion criteria included: employed at the hospital for at least three months, work primarily in patient-care areas, an employee of the participating health system, and English-speaking. Participants ranged from 40 to 62 years old, were predominantly female, and had worked at the participating hospital from 4 months to 20 years (see Table 1). Four participants worked the day shift, two worked the afternoon shift, and two participants worked the night shift.

Table 1

Sample Characteristics

Time Employed in Environmental Services	*Number of Participating Staff*
3 to 6 months	2
5 to 10 years	2
16 years	1
20 years	3
Age (Years)	*Number of Participating Staff*
40 to 50 years old	4
50 to 60 years old	3
>60 years old	1
Ethnicity (self-identified)	*Number of Participating Staff*
African-American	2

Latina	1
Mexican-American	1
White	2
Pacific Islander/Portuguese	1
Ghanaian	1
Gender	*Number of Participating Staff*
Male	2
Female	6

Interviews were conducted using web-based conferencing with the exception of one done via a telephone call due to the participant's request. Lasting thirty to sixty minutes, recordings were transcribed and reviewed according to the methods outlined previously. Initial codes were generated using Nvivo, and a code tree of approximately 25 codes was built. This allowed the data to be organized into groups that held shared meanings. As the coding process continued, the research aims were used to identify codes within the data that addressed the specific aims of the study

Once everything had been coded and organized into groups, the PI began to look for common themes using mind-maps and charts to organize different codes into groups or themes. Early maps were also submitted to the research chair for review. The early analysis yielded five themes and nine sub-themes. At this point, the themes were reviewed with the research chair and evaluated to analyze which ones could be combined or folded into each other. A thematic map was built, and themes were broadened into two main themes with a total of eight sub-themes contained within. Themes were then named and defined using investigator triangulation with

meaningful data points or quotes added to illustrate the theme or subtheme. The final report was then written to tell the complex story from the data.

The aim of the study was to explore the experiences and perceptions of hospital housekeeping staff, how they interact with patients, and how they perceive their impact on patient care. Two main themes were identified according to these aims. The first: "Interactions with Patients," described how participants interacted with and were impacted by patients. The second: "Perceptions of their role and impact on patient care." For each of these themes, the following sub-themes illuminated the essence of the participants' experiences and perceptions.

Table 2

Themes & Subthemes

Theme 1: Interactions with patients
a. Bonding, connection, and trust
b. Seeing suffering: "Part of the job"
c. Making sense of the suffering and ways of coping
Theme 2: Perceptions of their role and impact on patient care
a. "Germ busters": Communicating through cleanliness
b. "More than just cleaning…we matter"
c. Keeping things positive
d. "Not a nurse, not a doctor…but a bridge"
e. A culture of caring

Interactions with Patients

Participants described numerous patient interactions woven throughout the performing of their job. Cleaning was what brought them into each patient's room, but they took opportunities to talk, to brighten someone's day, or to comfort them. They watched as patients got better or watched as they suffered or died. They were affected by what they witnessed, grateful to be able to make a difference, and sometimes impacted by seeing the suffering of other people. When interacting with patients, they formed bonds and connections, and many told stories that revealed a unique trust in them from patients.

Bonding, Connection, and Trust

Building connection, trust, and communicating with patients was a common emerging theme for participants. Each of those interviewed had stories of talking with patients. A positive part of their job, they shared how they were able to cheer people up and how little time was needed. This was not viewed as separate from their job description but was woven in with their daily duties: "There's more that I go on and talk to, too many…there's several of them that I bond with and sit and talk to, and get to know" (Susie). They formed connections during their time talking with patients, and some would continue to check on patients that they had met: "If I have a minute, I'll come in a little bit later and talk to them about anything, or if they need help… I'm just always checking up on them" (Tony). Most participants told stories of patients who asked where they were the day before, of patients who asked when they would be back, or of patients they would check up on. The connection and trust that patients had in them was a fulfilling part of the job:

> "There's a little girl on ____, and I think she's been here for a long time. It's not my business to ask why she's here, but every time she sees me push up the door open, she's

like: ‘Abraham!’ And so I manage to get her to sing songs from the *Little Mermaid* that I taught her. And so she’s become a little friend. She waits to see me; she says: ‘Why don’t you come every day?’ I said, I’m a floater, I go wherever they need me. So practice that song, when I see you next time, we’ll sing it again. And I love that, I love that” (Abraham).

Aware of the value of attention and the importance of having someone to talk to, the participants found that patients often wanted to open up to them: “Yeah, they feel comfortable, they’re alone so like I guess they want to talk to somebody or they’re bored from being there so long they just want to say whatever they’re feeling inside” (Rosa). While most were aware that patients wanted to talk to them, one participant expressed surprise at the extent in one case:

“And so the nurses were like: “That’s the most conversation we’ve heard him have since he came in here. And I said, ‘Well, I don’t know what I said. I just went in there to clean. And he had this obsessive need to chat with me, and of course, I kept him going.’” (Abraham)

When there were times that they would initiate a conversation, it was often because they noticed how a patient was struggling or was lonely and knew that they could make a difference: “I would make the conversation because you don’t have nobody to share what you’ve been through. So being able to have someone just for a little bit of time it feels good to your heart” (Rosa).

Participants wanted patients to know that somebody cared and that they were never “too busy to take care of their needs.” One woman shared a story.

“There was a young man when I worked at _____. I had noticed, I was working during the day, of course, and I was assigned a floor. He had diverticulitis real bad, and they had split him open from his sternum down to his belly, and they were trying to heal him

inside out. But I just didn't go into that. Anyway, I noticed he never had any company. And so, you know me, I'm going in, I'm introducing myself, 'Hey, how you doing? You know, it's good to see you today, blah, blah, blah.' So, we started talking about animals, he's an animal lover, I'm an animal lover. And then one day, I just bought him a card, a get-well card because he had probably at this point had been there a couple of weeks. I had never seen a visitor, I had never seen a get-well card, you know. So, I bought him a card and we just kind of kept talking." (RuRu)

Another participant told a story of a patient who, due to COVID-19 restrictions, was not able to have any visitors.

"I have this patient...and he's been at the hospital off and on now…But, he doesn't have anybody…and he's in isolation right now. And um, he likes to do scratchers...So, he had a stack, okay. 'You need to do me a favor. Okay? Please. Take these lottery tickets, and cash them for me and get me some more scratchers, okay?' And like, oh my gosh, oh my gosh…you know, I shouldn't do this."

Concerned with getting in trouble for redeeming the patient's lottery tickets for them, the staff member wrestled with what to do, knowing how much the patient enjoyed playing the lottery and how they weren't able to have any visitors: "…because this guy, he's sick, he's in pain…and he's in isolation" … "And then also, you know…he loves doing this." (Tammy)

Seeing Suffering: "Part of the Job"

The participating staff spoke of the experience of working around death and dying. What they witnessed depended on the department they were working in, but they were impacted by the loss of patients.

> "When I have seen a person there day after day after day, I cry. Sometimes, I can hide it, sometimes I can't, you know, because I worked in the ICU and the ER in _____ and had developed relationships…some die, you see patients, some of them make it, some of them don't and I just clean." (RuRu)

Though they saw it as "part of the job," they still described the death of patients as difficult: "So it's just… like, it's just traumatizing every time somebody dies." (Shyla)

Multiple participants expressed feeling helpless or sad when people were alone in the hospital: "I think what's really sad is a patient dying alone" (Tammy). A few told stories of watching someone being resuscitated, not knowing what would happen to them.

> "And there was another time when a child, he was probably about 5 years old, he was brought in because he was hit by a drunk driver. And that one was another emotional and hard one for me. Because the doctor, ummm... (paused, collected self before continuing) he was literally on this child's chest trying to do compressions…And so, that one was another one. I was definitely praying my way through it. And I don't always get to know what happens to the patients. It's just, um, it's sad, you know. (long pause before speaking again). So, there's that part of the job..." (Heaven)

One participant spoke of a time that someone's family had requested she be present when their loved one passed: "…you know, I've been in the room by request, you know, when they took their last breath from them and the family": '____ don't leave'… I say, 'I can't stay!' Because I'm just a bucket of water, because I feel." (RuRu)

Three participants shared the discomfort felt when cleaning a room after someone had died.

> "And it did shock me just to see somebody just die and you'll be the person that has to go clean the room where the person died, and I'm like, 'Oh my God, this person just died, I'm going to clean the room and then somebody is going to be there.' It's, what can I say, a little uncomfortable, but you have to do it." (Rosa)

One participant talked about what it was like to clean a room after a patient dies following resuscitation efforts, and of an anxiety felt when trying to finish before family members came in the room to see their loved one.

> "Like, your heart is beating so fast because you don't even want to be there when they come in. So, you're trying to hurry up because you already know it's gonna be a traumatizing thing, so you don't want to take yourself into that whole emotional thing of them coming in here and seeing their loved one like that." (Shyla)

Though the participating staff believed this element of the job was something they "signed up for," they were still impacted in different ways and had diverse ways of coping with various situations.

Making Sense of the Suffering and Ways of Coping

Participants were affected by working around death and dying. Regardless of their unit or shift, they had times of feeling sad or helpless regarding what they saw. Recognizing it as still "part of the job," they would talk about what they witnessed either with co-workers or family. Not everyone had family at home who wanted to talk about it, but those that did would share with spouses or close friends. Some participants spoke of prayer as a way of coping with or processing what they saw.

> "And, I just, it really broke my heart to know that they're gonna go out and tell the family members that he didn't make it. And that was just so sad to me; it was very sad. So, that affected me. But I just kinda prayed my way through it." (Heaven)

Others chose to "try not to think about it" and to leave it at work or "don't bring it home." While they viewed working around death and suffering as a part of the job, they also talked about the impact of it and shared different ways of coping and processing.

> "…for somebody working there, that stuff that you don't see it every day. It's kind of…it's kind of hard, but I tend to get used to it by now. You know, I just sometimes, that's how life is. I mean, it's not fair sometimes. Especially when somebody loses a child, and you know, it's kind of a bummer, you know, but, but yeah, just hard. I just kind of just try to brush it off and just go on about my day." (Tony)

There was also a purpose for some, for why they would try to keep things at work: "But we try to not really take it home like that because it's just too much. And you don't want to think about it like that, it'll consume you." (Shyla)

Participants shared how they were moved in these moments to help patients "feel good." As one woman participant shared.

> "So, you hear how sick they are, how they are struggling. And sometimes they're crying. And it makes you want to feel, like for me… more to help them if I can in any way to make them feel good at least with what I do." (Rosa)

They shared a positive outlook despite what they witnessed on a regular basis. Knowing that the patient was not suffering anymore and was at peace created a better feeling for some: "I'm sad, but then I feel good. I do. Because they're not suffering anymore. They're at peace. And…that's

the way it is" (Tammy). "A lot of my co-workers will tell me, like, 'How do you work up there?' I mean, it's so sad! But I feel like I get more good than I do" (Susie).

To cope with the impact of witnessing suffering, they leaned on family members or friends, prayed, and tried not to "take it home" with them.

> "I come home and play in the dirt and continue to pray and ask God to take care of them on their journey, on their transition, you know. And to keep their family in prayer and in mind, you know, in the loss of their loved ones. And, I like my plants. I come home and play in the dirt, you know, and continue because I know life goes on. You know, that's just the cycle of life. But it hurts." (RuRu)

Some coped by not focusing on things for too long: "I just don't understand, like, it just kills me about how much that happens in there. I mean, I just try to go outside, you know, not deal with it as much" (Shyla). When they would "take it home" and talk about it with family, some had people they could talk to, while others had family members that did not want to know what had happened.

> "No, because my whole life is just so much different and so full of life, you know. Like, I tell my husband more about stuff happening, and he'll be like, 'I don't even want to hear it. I don't want to hear it, don't tell me, because it's just too much, you know.' I guess it is a lot, you know." (Shyla)

Prayer was also important for many participants. A few participants described prayer as a way to get through difficult moments in the hospital, with one participant saying: "I just pray my way through it" (Heaven).

Perceptions of Their Role and Impact on Patient Care

The participating staff in this study believe that they are an important part of patient care. With a focus on "keeping things positive," they uplift spirits and bring encouragement to patients. They are "germ busters" who use cleanliness to communicate to patients and their families that they can trust that they will be cared for. While "not a nurse, not a doctor," the impact they have is unique and crucial to not only the health of the patient but the success and functioning of the entire health system. Those interviewed shared their personal philosophies of care, showing a widespread culture of caring. They believe that their work and the impact they have on patients matters a great deal, whether it is recognized or not.

"Germ Busters": Communicating Through Cleanliness

Participants recognized the importance of cleanliness in keeping patients and fellow employees safe. They also spoke of using cleanliness, or clean spaces, as a way to communicate to patients and their loved ones two things: (1) that they would be cared for, and (2) that they could trust the hospital they were in. Describing a duty to protect patients from "getting sicker," participants spoke of themselves as a "wall of protection" between the patients and from germs: "so no one comes home with anything they don't have to." (Abraham)

> "You know, I consider myself the germ buster, that's what I am, I'm the germ buster. (said with conviction). I go in, and I arrest the germs, and I take them away, you know, we're the wall between the germ and the next patient. We are what keeps the sick from getting sicker and the next patient from getting sick with whatever might have been in there." (Heaven)

They owned the responsibility they had to protect patients, and some talked about not wanting ever to be responsible for harm or death: "We don't want to see **our** patients pass, you

know, especially at our hand because we didn't have it clean enough. And that's what it means if we don't have it clean enough, then we're putting that patient at risk, and I don't want that on my epitaph. I don't" (RuRu). Some mentioned the global coronavirus (COVID-19) pandemic occurring at the time of the interviews as another reminder of the importance of their role.

> "Well now, it's more like okay, whatever; but at first, the housekeepers didn't even want to go into rooms and clean them, you know, like the whole world is shutting down, people aren't going to work, kids aren't going to school, no concerts. But we have to go in and do what we know they're running from. It's almost like a firefighter, the firefighter that runs into the fire when we're all running out, you know, and that's exactly what the housekeepers had to do." (Shyla)

A clean environment "takes away the gloom" and helps people heal. They are there to clean, but nearly everyone talked about what cleanliness communicates not just to patients but to their families as well. A clean room tells someone that people care about them and brings them comfort: "That makes them feel like someone cares and that they're important to somebody. That's what I feel that I leave them with" (RuRu). Besides imparting care, they also communicated support, talking about how a clean space let people know that people would help clean up after them as well. "Because when you're sick, you feel awful and you feel sorry that somebody has to clean your mess that you should be able to do yourself. I bet that's really comforting for the person that is sick." A feeling of disgust, making sounds like "ick" or "ughh" was used to describe the impact of a dirty room on the psyche and emotional state of someone who is already sick. Most everyone talked about a "feeling you get" when a place is dirty and how you "don't notice as much when it's clean, but you can ***feel*** it when it's dirty" (Shyla).

What came up often was the belief that a clean space communicates that they can trust the healthcare team. Participants spoke of this in different ways: "…especially when family comes in, they get a good feel, and a good vibe… that the area is taken care of... they feel comfortable with their family member being there, knowing that everything's okay..." (Tony) "You would notice if it was dirty" came up multiple times and participants shared an understanding that they could reassure patients and family members by how well they cleaned an area. This was confirmed by what one participant heard from parents in a pediatric unit she worked in: "Because when they would look at me and say and feel like their child was being taken care of even better because it's clean, you know? Like, you're not gonna notice it being clean, but you would notice if it was dirty…" (Shyla)

The staff believed that the cleanliness of the hospital was an indication to people that everyone there cares for them, not just the doctors and nurses.

> "So, when people walk into our hospital, I want them to be: 'Is it clean?', not because that's something that we do but because this is my job and I'm proud of where I work. And I want other people, when they walk in, to notice that not just the doctors and nurses care, but we all care as a team. That EVS workers care, and we make sure that it stays clean." (Heaven)

A few participants elaborated more about what a dirty space or room communicates to patients and their family members. If a clean space communicates that someone can trust that they will be well cared for, then a dirty room communicates the opposite.

> "I mean, you go in there, the first thing you do is look around, you know, they start to notice if things are on the floor and stuff like that. You kind of get a different vibe, you're like, wow, you know, they're not even, you know, they're not even picking up around

here, or they're not even doing anything and, you know, my family members in this room and the patient next to them is hollerin' you know, stuff like that…you've just got to make it look presentable…" (Tony)

"You would have a definitely different attitude if you were sick and your room was messy. It would just make you feel like people just didn't care about your well-being there. you know?" (RuRu). For those interviewed, though they were hired as part of the housekeeping team, they realized that their job meant so much more than the act of cleaning.

"More Than Just Cleaning…We Matter"

While the cleaning staff acknowledged being a "part of the team," they also spoke of an awareness of an invisible hierarchy within the hospital that they sometimes found themselves on the bottom of. Despite this, they were clear about the importance of their impact beyond cleaning. All the participants viewed the emotional care they gave to patients as important and a part of their job.

"We come in doing more than just cleaning. We're emotionally involved; we care, you know. We want the patients to be healthy and discharged and home, you know, we just want them to know that it's better than the cleaning job because my whole heart's in it." (Shyla)

While many felt acknowledged and appreciated by many people within the hospital, they also felt devalued or invisible at times to the staff around them. Two participants talked about feeling recognized and appreciated by nursing leadership, naming the CNO of the hospital as someone who appreciates them; one also talked about the nursing staff as "supervisors" for the environmental services staff. Two people talked about not being noticed by physicians until they started cleaning their call rooms or workstations. Others felt that it did not matter how people

saw them or treated them: what mattered was how they conducted themselves. Some participants felt that their department or job as a whole was not appreciated: "Cause, you know, well, I feel like we're looked at as little" (Susie). Nevertheless, this awareness of being devalued by some did not impact how they showed a caring attitude toward patients. One participant (RuRu) expressed this when asked if she believed nurses and doctors saw everything that she did for patients:

> "You know, it goes from zero to 100. You'll see a group of doctors, and I'm one that I'll say hello to everyone. I don't care who you are. I don't care whether you're the president of the United States or a homeless person on the street; everybody is important to me. And I'll pass doctors and nurses and say hello, or walk into a unit and say, 'good evening ladies or good evening gentleman' or whatever. And there are those who will speak and look at you with a smile in their eyes because that's all you can see now is their eyes. And then you'll see the other ones that think: 'Well, why are you speaking to me?' But it's not about them, you know, it's about how I want to be perceived and about how I walk in my light. And I won't let anybody damper it, but yes there are some that look at you as an equal and are glad you're there, and then there are some that look at you like you're beneath them."

When asked further about perceptions of value or recognition of care given to patients, participant responded defiantly: "let us stop doing it…let us stop doing what we do".

The current COVID-19 pandemic during the time of the interviews seemed to draw more attention, not less, to the invisibility or devaluing that they felt. They were aware that they were at an increased risk for exposure to COVID-19, and one participant recognized that it was often not housekeeping that people referred to when they talked about "healthcare heroes":

"So, our role is very important although we aren't really noticed in the public as far as an important role in the, umm, healing field, so to speak, and especially this world that COVID's going on. It's mainly the doctors and the nurses; they're like, yeah, you guys put yourself on the line. And sometimes I find myself going: Hey, hello! Right here! We do too!" (Heaven)

A few spoke of having to speak up for themselves as well when it came to isolation precautions. Some had stories of entering a room and not being aware of the kind of isolation the patient was in because the proper signage had not been displayed outside the room. Some were proactive and would seek out whatever information they could before entering a patient's room, but they did not always trust other staff to keep them aware of the correct isolation.

"Yeah, that's why I talk to the nurses before I enter because sometimes on the phone, they say there's an isolation and you come, and there's no sign. So, I go ahead and communicate with the nurses and the nurse that has that room to find out what happened and what kind of isolation you need before entering. Because it can be risky, it can be risky." (Rosa)

Many believed that some members of the healthcare team knew about their patient interactions. Still, many also believed that hospital leadership and management, in general, did not understand how great their impact was.

"If management, like, really, really knew, I don't think they totally really, really know what I do like that. I mean, they know that I see them, and I talk to them, and I'm nice to them…They probably don't know just how good it makes the patients feel. I don't feel like they have that much, you know, they're not looking in that hard on what we're doing on that end." (Shyla)

The importance of the environmental services work that they do, including the emotional care they provide the patients, was a unanimous theme among those interviewed. When asked: "If you could make everyone understand one thing about your job, about your role in patient care, what would it be?," they spoke of their importance. They spoke of mattering and of wanting to be treated with respect and dignity. They wanted people to "work with us for a day, see what we go through" and to treat them like regular people. One also wanted more communication and more relationships with the staff. In the way that the nurses and doctors were friends with each other, they wanted friendship as well.

> "Because sometimes, it's just…you come there, do your job and you leave. There is no communication, no relationship between the employees as a friend, I mean… that would be nice. To see us like people, regular people, like their own staff too." (Rosa)

Being under-appreciated was "a sore point for a housekeeper…". And each of those interviewed took their job very seriously and wanted to be recognized for it. Because as one participant stated: "There is more of us that care than not." Those interviewed recognized that patients needed only a little bit of time or effort to feel cared for. In the same way, they asked for just a little bit more recognition for themselves and others: "Pay a little more attention to everybody on the team. Be it EVS, be it mental case workers…" (Abraham).

Keeping Things Positive

Whether they had worked in the hospital for a short time or 20 years, the majority of participants spoke of a personal policy to "never ask how the patient was doing" or why they were there and to instead keep the conversation positive: "…and I know not to ask them how are you doing, you know, because it often may open Pandora's Box" (Abraham). They avoided talking about why the patients were there and instead focused on brighter topics. "So, I just

understand at that moment that they need somebody to talk to, somebody to say something positive" (Shyla). They were aware of the patient's need for not only privacy but also a smile and kindness.

> "The main thing is to treat each and every person with dignity and respect, and respect their privacy. I never, ever ask a person what's wrong with them. And, I always say, 'Well, I hope you're feeling better, speedy recovery,' you know, always with a smile and happiness no matter what or where they are." (RuRu)

They keep the conversation light, with a focus on topics from pets at home, sports, family, favorite movies, or the weather.

> "They tell you: 'Yeah…I've had better days. I don't want to be here.' And I said, 'Well, tell you what, let me just spiff up your room, disinfect it, make it smell like a hotel, make it look really nice for you. And I said, but you look out the window. You have a nice view.' Or, I look for something, something that can make the conversation positive and better." (Abraham)

Two participants even had stories of singing songs with patients to cheer them up.

> "I'll sing songs with the patients and stuff like that. And they just, you know, like I said, I'm just trying to make them feel comfortable and happy and have a good stay with us, you know, even if it's a couple of days." (Tony)

Many were aware that patients appreciated this: "You know, because then the next day, if I'm not there, they'll ask for me. You know, they're like, 'Man, I wish you were here yesterday,' and, you know, 'you just brighten up the room'" (Tony).

Sometimes, it was the participant who would start a conversation, and sometimes it was the patient or family member. But regardless of who initiated the conversation, the majority of

participants shared that they never ask the patient how they are doing or what brought them to the hospital.

> "I don't really find myself going in saying what happened. I mean, I don't like going in there and like, 'Oh, what happened? What happened to your baby?' You know what I mean? It's more like, you know, I'll be in there or whatever. Then, they'll open up. But, I don't go in there and question them." (Susie)

Most of the interviewed cleaning staff knew that patients appreciated it as well: "I think they're happy to see me because you know what? Even though they feel like crap, I always get a little smile out of them. I do. And I see it. I see the smile, I see the eyes, I see it" (Tammy).

Not a Nurse, Not a Doctor…But a Bridge

Participants talked about being a unique kind of caregiver: "not a nurse, not a doctor" …but "a bridge." They are as important and a part of the team: "Of course, I'm not the nurse or the doctor, but the nurses need me, the doctors need me, and the patient needs me too, so we're all on the same team…" (Abraham) They acknowledged that patients or families recognized this as well and would remind them of their importance.

> "I just walked in there; I'm just a housekeeper. And I kind of make that introduction, and they say 'Oh no, you're so much more,' and I've had that happen to me several times. You know, you're just as important as a nurse, as the doctors, then, you know, that makes me feel better, you know. Oh no, you're so much more. And you're just as important as everybody else, if not sometimes more important." (Susie)

Aware that their position was different from that of other medical staff, it was no less important. One participant, in particular, talked about being able to leave patients feeling good about themselves and their care.

> "Because there is nothing that I can do about their physical being because that's not my job. Well, it's just there is nothing I can do. I'm not a nurse, so I can't do that. So, I try my best to concentrate on how they… that they're happy when I leave, you know, and they're feeling good about themselves and what they you know the care that they're giving." (RuRu)

This time spent in the room, talking with patients, allowed them to act as a bridge at times between nursing and medical staff and the patient: "And because I'm the custodian and I'm in the room, I guess I've got the opportunity to see what others don't see" (Abraham). Many times, patients would ask them simple requests for things like blankets, pillows, or towels, and they were always happy to help.

> "So, I go in there, and I'll, you know, just try to ask them if there is anything they need to let me know. And sometimes, they'll go, 'Oh, can you get me some water?' And I'll go, 'Oh, you know what, I can get you a nurse.' And then there are some that want to know if I can give them a blanket; they're cold. And I'll go get them a blanket, and, you know, I'll just continue to clean the room as best I can." (Heaven)

One participant talked about times when non-English-speaking patients would ask her to tell the nurse they needed to be cleaned up or "have their diaper changed," while others talked about encouraging patients to share their concerns or frustrations with the doctors and nurses.

> "You know, whether it's: 'Oh, I've called my nurse for 30 minutes, you know, she hasn't come yet'…Well, I'm sure she's on her way because you know she's got a lot of other patients and I try to diffuse any situation that does come up." (RuRu)

Multiple participants talked about being able to connect with and listen to patients who were described as "difficult" by staff.

> "Usually when people are 'difficult', they just want to be listened to. That's all; they just want to be heard. And if I'm the one that needs to stand there and listen to their complaints, you know, and if I know the procedures for the complaint, then I'll say, 'Well, you know, you might want to speak to the charge nurse.' Or, 'you may want to speak to your doctor when he comes in,' you know. 'If you really have a complaint, then you might need to write it down,' you know. But mainly, they just need to be listened to, that's all." (Tammy)

Another participant shared:

> "The FYI patients (patients with violent behavior), they only talk to me. Like, they'll be in there cussing the nurse out, and I'll be like, that's my friend, please don't talk to her like that. And they'll be like, 'Okay, but she's being a bitch, you know,' like all the time it happened." (Shyla)

A few participants spoke about being a sort of cultural broker for some patients, recognizing that the backgrounds of nurses and doctors are sometimes very different from the backgrounds of their patients.

> "And then, it's also fun, like being a bridge, like being from, you know, from a different part of the community. And then I see I know a lot of the people that are nurses and doctors that they haven't been where we've been, and you know, experienced what we've experienced. So, the communication isn't going to be the same. And, you know, sometimes…they just need somebody that's mutual to come in between and break the ice, and I like to do that." (Shyla)

The same participant shared a time when she was able to help a family whose daughter had been shot by acting as a bridge between the family and the staff members:

> "And then, I could just tell that the nurses…don't understand how a baby gets shot in the head. How was this little girl shot in the head... So, I felt like…there may have been a little judgment on them which I didn't understand how either, but then at the same time, I know how accidents like that happen where they live…you know, the street that they lived on, I could totally see it happening. That's why we try to not live in places like that, but sometimes people can't afford it. Sometimes people get stuck in situations, and they need money to move, but it costs a lot to move, especially if you have bad credit, you know. So, it was nice to be able to be a bridge because people were coming in that I knew, that knew them. I didn't know them personally, but I knew people in common. So, I was able to talk to them, and you know…they would come to me for everything. So, it just felt good to make them know that, you know, it was okay." (Shyla)

A Culture of Caring

Woven throughout the interview sessions was a shared culture, a thread of intentional behaviors and beliefs about caring. Each participant had unique and personal tenets of patient care that they brought to their workplace. They viewed patients as people, separate from their illness. In the words of one participant: "They're only people, they only need conversation and love, that's all they need is to know that somebody cares" (Shyla). It was clear that the patients were important to them. They were not invisible, and treating them with dignity and respect was important to everyone interviewed: "Umm…(paused) they're very important to me. (emphasized and nodding) Yeah, I'm, uh, I do not even know how to really describe it…they're human beings (paused, tearful). They have feelings. At one time, they weren't sick, you know, they had a life" (Tammy).

Multiple cleaning staff spoke about personal intentions or a frame of mind that they would enter a patient's room with: "And so, that is what sunlight means to me, you know, smile, smile at patients, it may be the only smile they get. Say something about them. Say something to them." (Abraham) Another participant shared:

> "…I never want a patient or a family member to feel like I'm too busy to listen or to take care of their needs. I'm not looking for nothing. I don't go in there wanting anything, I don't ask for anything, I go in there as a giver: 'How can I help you? How can I love on you a little bit to make you feel special to make your day easier?' They're being poked and prodded and woke up all night long, you know. That's **my** job (emphasized words, placed hand on chest). I want my little light to shine." (RuRu)

The environmental services staff discussed an awareness of being mindful of the emotional or mental state of the patients. "And so, of course, I afford them all the grace and all the respect as well as all the empathy." "I believe love and kindness is a virus also, and it's a virus worth spreading also. And so the reason why I'm big on positivity and or, you're walking down the hallway, you've got to go do something, and you see someone, I say: 'Hi, I see you.'" (Abraham) "So, over the years, I just, like I said, mentally, spiritually and emotionally, that's my goal to leave them happy and feeling good about themselves and about their treatment, having confidence in their doctors and nurses and that I'm going to leave them clean and sanitized" (RuRu).

They worked hard to help patients feel better about being in the hospital and not being embarrassed about needing help. Some made a point to let the patients know it is okay to depend on them.

"Because, you know, a lot of them are embarrassed. Sometimes, because they, they spill stuff on the floor, they don't want to make it seem like I'm their servant, you know… 'I don't want to bother you. Because I know you're busy.' And, you know, 'I had an accident on the floor in the bathroom, and I'm so embarrassed.' And I'm like, 'No, it's, that's what I'm here for. I'm here to take care of you just as well as the nurses are. So anything that you need, spills or whatnot, I'm here to help you clean it up.' And, you know, I'm just trying to make them feel comfortable around, you know, of their state of being there to try to be helpful as well with them, you know?" (Tony)

It was clear that they believed interacting with patients, showing them compassion, and caring for them was considered a part of their daily work. They were impacted by what they saw and had different ways of coping with the stress but viewed it all as part of their responsibility. One participant talked about being unable to separate the task of cleaning from the care she gave to the patients, saying:

"You know, maybe they (people outside the hospital) don't see that other part of my job is to, you know, connect to that patient and eye contact and smile and do it. And, you know, they don't… now that I think about it…Yeah, maybe they don't...but I can't even imagine doing my job without that being a part of it." (Tammy)

This culture of caring was also about bringing hope to the patients and seeing them as people in spite of their illness. Day in, and day out, seeing them through with small gestures and moments of caring:

"You know, it's not like just a moment, you know, it's like every day. Like a connection…you know? You're seeing these people every day. They, you know, become a part of your life, almost like you're seeing them. And it's not just like a moment, it's

just like, the whole event, the whole time that they're there at the hospital. The interaction and just, you know, maybe just a soft hand on their foot, you know, tell them, it's gonna be okay, you know, tomorrow is going to be better, you know." (Tammy)

Each participant, regardless of how long they had been employed, saw the care of patients as an important part of their role in the hospital, whether people around them were aware of it or not.

Discussion

This aim of this study was to explore the kinds of interactions that housekeeping staff have with patients and the perceptions that they have about their impact on patient care. The findings demonstrate that among those interviewed, a connection exists between patients and hospital housekeeping staff that is unique and that goes far beyond a clean surface.

Cleanliness as Caring

Nightingale (1860) believed that cleaning was caring. She defined nursing as: "the act of utilizing the environment of the patient to assist him in his recovery" (Nightingale, 1860). It is a privilege of the well, she argued, to not be dependent on those around you for the cleanliness of your own environment (Nightingale, 1860). This cleanliness also inspires confidence in the health care team. It demonstrates a quality of care that patients and families attribute to the entire hospital. A Press Ganey (2016) survey found a correlation between patients' perception of the cleanliness of a hospital and three important indicators: (1) risk for a hospital-acquired infection (Hussain, Lei, Akram et al., 2018), (2) hospital quality indicators on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and (3) HCAHPS teamwork indicator scores (Press Ganey, 2016). In general, the Press-Ganey survey found that patients tended to describe the overall cleanliness of a hospital as the most important indicator of the quality of the care they would receive at the facility. Those interviewed recognized this, and

saw their work as directly contributing to how much people trusted the hospital and the clinical staff. They knew what Nightingale believed in 1886: that someone who is sick is dependent on their environment (Hegge, 2013) and it is the duty of the caregiver to bring comfort and safety through the environment as well as through clinical practices.

A Unique and Valuable Connection

This phenomenon, of cleaning staff providing mental, emotional and spiritual, person-centered care that is above and beyond the job description, is consistent in the available literature and deserves recognition (Ashton et al., 2019; Jors et al., 2017; Mack et al., 2003; Messing, 1998). Whether their care for patients is recognized or not, they will continue to provide it. Schulman-Green et al. (2005) found the emotional and mental care of patients to be considered "part of the job" by cleaning staff and other unlicensed healthcare staff. They connect with patients and see them in a way that is different from the therapeutic relationship of a nurse or a physician.

This unique connection is more than just listening and presence. As Jors and colleagues (2017) found, they bring a brightness to patients. A therapeutic relationship exists when someone knows that they are viewed as a unique person, when they believe they are being treated with kindness, and when they "perceive they are being treated with dignity" (Koloroutis & Trout, 2012, pg. 47). What they offer patients, is a gift of being seen outside of their illness or reason for admission. Even going as far as to never ask how they are doing, but rather to focus on positive or uplifting topics and conversation.

The interactions described by the participants also illustrate Watson's (1988) definition of a caring moment as a "transpersonal caring relationship" wherein space is created for healing through the connection of the person receiving care and the person caring for them. These

moments of caring, no matter how brief, have psychological and physiological impacts (Fogarty et al., 1999). A mere 40 seconds was all that was needed to communicate compassion in a way that decreased anxiety and lowered heart rate and blood pressure for patients (Fogarty et al., 1999). It is interesting to consider what Salerno et al. (2012) noted: because of the length and quality of time spent with patients, hospital housekeeping should be considered "a cure job" and a part of the health care team.

Trauma Experienced, Ways of Coping & Making Meaning

There is a well-documented impact of witnessing the suffering of others (Jones, Wells, Gao, et al., 2013). Feelings of helplessness, detachment and moral distress are common among housekeeping and other so-called "ancillary" staff (Ashton & Manthorpe, 2019; Cashavelly et al., 2008). These same feelings were endorsed by many participants. Troubled by seeing people die alone, those interviewed shared the same difficulties as participants in studies of housekeeping staff by Jors et al. (2017) and Shulman-Green et al. (2005). They found meaning though, in recognizing that they were making a positive difference for patients. And were aware that patients saw them as a source of positivity, hope and comfort. Making meaning from the good you are able to bring to another, is a form of compassion satisfaction (Cummings et al., 2018). Shown to reduce signs of burnout in clinicians with secondary trauma syndrome, compassion satisfaction is an effective tool for resilience (Cummings et al., 2018) and seemed to be an important part of coping for those interviewed. Coping methods described also mirrored those described in similar studies (Ashton & Manthorpe, 2019; Cashavelly et al., 2008; Jors et al., 2017) revealing a theme that was shared by other health care providers. Though, what was not shared by nurses or physicians, was a widespread feeling of invisibility.

Integral Yet Invisible

Some participants noted moments of recognition from hospital administration and felt that some people did understand the magnitude of the care they gave to patients. These moments, while appreciated, were overshadowed by a larger invisibility. Historically under-valued, the cleaning staff in most spaces are invisible, often recognized only when the job done is not satisfactory (Dutton et al., 2016; Messing, 1998). Within the hospital structure itself, the breakroom or meeting spaces given to cleaning staff are often found in the basement. Messing (1998) found that cleaning staff were not only aware of an invisible hierarchy within the hospital but found themselves at the bottom of it.

This hierarchy is communicated or felt through something Dutton and colleagues (2016) termed "non-recognition," invisibility communicated through being ignored or overlooked. This non-recognition came mostly from doctors, more rarely from nurses, and only once from a patient (Dutton et. al, 2016). The recognition that they do receive is based on the tasks of cleaning and rarely associated with direct patient care (Ashton & Manthorpe, 2019). Yet, the results of this study show that the majority of recognition of the value of their work came from patients. With visibility comes value and dignity, a gift that participants gave to the patients they cared for, despite not always receiving it themselves.

Those interviewed saw themselves as a part of the health care team, whether those around them did or not. Caring for patients, they recognized that only a little bit of time was needed to remind people of their humanity. This care is not separate from their duties, but was woven in as a part of their job. This responsibility for the environment, attuned listening to patients and family members, trusting and caring relationships being formed…all of these things show that

the role of housekeepers in the hospital is not separate from patient care; it is the heart of patient care.

Limitations and Strengths

There were limitations worth noting in this study. Though data saturation was achieved, the participants were all over 40 years old and mostly women, not an accurate demographic representation of the entire department. The PI was a nurse at the participating hospital and was known already to three of the participants. There was a potential for participants who knew the PI personally to respond differently than they may have to a different interviewer. At the same time, it is also possible that there was a level of trust and acceptance in the PI's presence that meant perspectives were expressed that might not have been otherwise. Personal worldviews and perspectives of the PI were a limitation. In order to frame this influence on the data analysis, the PI engaged in reflective journaling during the data collection and analysis process. The study was conducted at one hospital in a region of northern California in the U.S.. Though the results are not generalizable to other areas, they are consistent with findings and themes from the literature review. It is worth noting that the participants from each shift were represented, and they were from a variety of departments, including the "float pool," where they were assigned to a different unit each day.

Future research should consider the power and relationship dynamics between who is deemed to be clinical staff and who is considered support or cleaning staff. For this, interviews could be conducted by a third party. It is possible that the participants were cautious discussing interactions with patients because it could seem like they were neglecting their job. Though the participants were from various cultural backgrounds, this study did not take the context of their diverse backgrounds into consideration. A major strength of the study is the range of years

worked among the participants. Themes remained similar despite different shifts worked, years of service, or working part-time or full-time.

Interviews were conducted via web-based software due to COVID-19 social distancing requirements from the Institutional Review Board of the participating hospital at the time of data collection. There were two participants who expressed unfamiliarity with using video chat to communicate and had a preference for an in-person interview. It is possible that the unfamiliarity of the technology used also created a barrier for some participants.

Implications

Several implications arise from this study. If housekeeping staff are a population of caregivers, then they have a right to access to the same resources and training given to other clinical staff. Their role is unique, and training should be tailored to include the patient interaction component with adequate empowerment and education on communication and professional boundaries. Such training would be best provided with insight and leadership from housekeeping staff themselves. It is the author's belief that there is a risk of "colonizing" the care that is already being given to patients, and it would be wise for anyone designing an educational module or resource to listen to the leadership and guidance of the population first.

Caregiver resources such as employee counseling, peer-support programs, and resources for burn-out should also be made available. The results of this study reveal a lack of inclusion in the healthcare community and recognition for the scope of the care being provided to patients. Greater recognition is needed to acknowledge the care that is being given.

Conclusion

Despite limitations and challenges, the findings of this study illuminate the experiences of people employed as housekeepers in hospitals. Little is documented in the literature about this

phenomenon, and those who participated offered rich data and experiential stories. This study describes the interactions that this population has with patients and visitors and how they perceive their impact on patient care. There exists an established culture of caring that will continue whether it is researched in the future or not. Described by Henderson (1981) as "indigenous agents of psychosocial support", those employed as housekeeping staff have, and will continue to care for people. The person-centered care that occurs is distinct from nursing or medical care and is marked by a unique humility and openness occurring in the context of a relative lack of recognition from fellow hospital employees and traditional health care team members. Study findings suggest that there is much to be done in recognizing the care that is occurring and in supporting the cleaning members of the healthcare team. There is a need for more discussion of the socioeconomic class or caste system present inside our modern health care system. It is short-sighted to discuss housekeeping staff as caregivers without also discussing their historical invisibility as such, despite their position being the very foundation of nursing care. It is my hope that this research will encourage more conversations to be had about whom we consider a caregiver or healthcare worker and the invisible hierarchies that are present within hospitals and healthcare systems.

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Appendix A: Semi-Structured Interview Questions

1. Tell me about your relationship with patients during the course of a typical workday
2. When you have conversations with patients, what do you talk about?
3. How do you view your role in patient care?
4. What is an example of a deeply rewarding experience you had with a patient?
5. What is an example of a stressful or traumatic patient event that you witnessed or were involved with?
6. How do you deal with these events?
7. How do you think doctors and nurses see your role with patients?
8. How do you think management and administration see your role with patients?
9. If you had a magic wand, and could make everyone (doctors, nurses, administration) understand one thing about your job, what would it be?
10. Tell me about something I didn't ask, that you think is important for me to know

Probing follow up questions:

- Could you tell me more about that?
- Could you tell me about a time when_____?
- What do you mean when you say_____?

Appendix B: Survey Flyer

My name is Nicole Vance, and I am doing a study about the experiences of environmental services staff in the health system.

I want to learn about your interactions with patients and how you see your role in patient care.

The survey is anonymous and will take 5-10 minutes

There is an option at the end of the survey to be entered into a drawing for a $50 VISA gift card. If you'd like to enter the drawing but don't want to take the survey, please email me.

Use the camera on your phone to open the survey, or click on the link below

https://ucdavis.co1.qualtrics.com/jfe/preview/SV_9sr3xlNsTEHynlj?Q_SurveyVersionID=current&Q_CHL=preview

Thank you for your time!

-Nicole Vance (please contact me with any questions or if you would like to be interviewed)
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