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"More than just cleaning": A qualitative descriptive study of hospital cleaning staff as patient caregivers

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ABSTRACT

Background: Cleaning staff in hospitals can spend an average of 10–20 min per day per patient room. Published literature shows a pattern of interactions between housekeepers and patients, and that they believe themselves to be a part of the patient care team. To date, no study about this phenomenon has been done in the United States or has framed them through the lens of patient care.
Objective: To describe the experiences and perceptions of hospital housekeeping staff in relation to patient care.
Design: Qualitative descriptive.
Setting: A 625-bed tertiary, academic medical center in the United States.
Participants: Eight housekeeping staff participated, ranging from 40 to 62 years old, from diverse cultural and ethnic backgrounds, and worked at the study hospital from 4 months to 20 years. Interviews were conducted between September 2020-October 2020. Participants were recruited through flyers, email, and snowball sampling. Data were collected through semi-structured, in-depth interviews lasting 30 – 60 min. Data were analysed through thematic analysis using a 6-step framework that included data familiarization, generation of initial codes, search for themes, review of data, definition and naming of themes, and generation of a written report. Trustworthiness of the data was established through strategies such as reflective journaling, researcher triangulation and member-checking.
Results: Three themes emerged: 1) "Here to take care of you" 2) Difficulties & Coping: and 3) Perceptions of their role. These three themes provide insight into participants' perceptions of patient interactions and the kind of connections they formed with patients as they went about their duties.
Conclusions: Study findings suggest that there exists among housekeeping staff a respect for the humanity of patients, a duty to protect people from disease, and a longstanding practice of engaging in therapeutic connections with patients. As noted elsewhere, there remains a disparity between the importance of this role and the recognition and dignity afforded it. These results reveal an opportunity to expand our understanding of who we call a caregiver, and to improve how we recognize and support each member of the healthcare team.

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1. Background

In the United States, there are over 300,000 housekeepers employed in hospitals and nursing homes (Bureau of Labor Statistics, 2021). Job duties entail but are not limited to the cleaning of patient and non-patient care areas, including washing floors, disinfecting surfaces, emptying soiled linens and garbage, and restocking cleaning and hygiene supplies. Housekeeping staff can spend more time with patients in certain settings than some clinicians do, with an average of 10–20 min per day per patient room (Jors et al., 2017). Compared to clinical staff in the same hospital, housekeepers have a similar level of occupational stress and are exposed to similar risks for needlestick accidents or musculoskeletal injury (Haytoglu, 2018; Marconato et al., 2017). Housekeepers were found to be at a higher risk for exposure to the SARS CoV-2 virus than nurses in the intensive care unit, potentially due to the number of patient rooms they enter within a shift (Eyre et al., 2020).

The history of housekeeping in hospitals is the history of nursing. When reducing mortality rates within Turkey's Scutari Hospital during the mid-19th century Crimean War (Smith, 2008), Florence Nightingale (1860) demonstrated the link between cleanliness and healing, writing that "the greater part of nursing consists in preserving cleanliness" (p. 121). In early operating theatres, it was the job of the nurse not only to aid with instruments but to clean the floors and furniture with a cloth tied over a brush and dipped in hot water (p. 124). As the growth of hospitals outpaced the number of licensed nurses, what were considered nursing tasks became delegated to unlicensed staff (Wall, 1974).

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 cleanliness was a privilege of the well (pp. 124–125). Nightingale 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 (p. 123). This remains important today, and patient surveys show that people are more likely to trust their healthcare team when the hospital is perceived as clean (Press Ganey, 2016).

Those who work in housekeeping consider themselves a part of the patient's healing process (Mack et al., 2003) and describe an awareness that the job they do is more than the job they were hired for (Ashton and Manthorpe, 2019; Jors et al., 2017; Mack et al., 2003; Schulman-Green et al., 2005). Like clinical staff, they are troubled by patients who die alone (Jors et al., 2017) or by the deaths of young people (Cashavelly et al., 2008; Jors et al., 2017; Mack et al., 2003) and have difficulty moving quickly from one room to another if someone is dying or in distress without sufficient time to process or debrief what they experienced (Schulman-Green et al., 2005). Housekeepers can feel overlooked or devalued by other staff members and often find themselves at the bottom of an imposed institutional hierarchy. Dutton et al. (2016) found that most devaluing actions came from members of the healthcare team, not from patients. In contrast, much of the recognition and validation for the care being given came from patients themselves in the form of praise, acknowledgement, or expressions of gratitude (Dutton et al., 2016; Jors et al., 2017; Mack et al., 2003).

Published literature shows a pattern of interactions between housekeepers and patients, and they believe themselves to be a part of the patient care team (Ashton and Manthorpe, 2019; Cross et al., 2019; Dutton et al., 2016; Jors et al., 2017; Mack et al., 2003; Messing, 1998). To date, no study about this phenomenon has been done in the United States, has framed hospital cleaners as a population providing direct patient care, or has aimed to describe how they view themselves within healthcare settings. Thus, a 625-bed tertiary academic medical center provides an opportunity to learn from staff of diverse cultural backgrounds, working various shifts on different units.

2. Methods

The purpose of this study was to describe the experiences and perceptions of hospital housekeeping staff in relation to patient care. A qualitative descriptive design was employed. This study was deemed exempt by the Institutional Review Board (IRB) at the University of California–Davis.

Participants were recruited through flyers, emails, and snowball sampling. Participants were given a $25 gift card (approved by the IRB) to thank them for their participation. Data were collected between September 2020 and October 2020. Due to social distancing requirements of the coronavirus (COVID-19) pandemic at the time of data collection, interviews were conducted outside of working hours and recorded via Zoom or telephone. Informed consent was obtained before beginning interviews and interview times ranged from 30 to 60 min. Semi-structured, open-ended questions were used for the interviews (see Appendix A). Interviews were conducted by the principal investigator. Demographic questions included age, gender, self-identified race/ethnicity, and length of time working at the study hospital. Each participant self-selected a pseudonym, and identifying details were excluded to ensure confidentiality. Audio-recordings were downloaded to a password-protected laptop, and transcription was done through a professional service. Transcriptions were reviewed against the audio recordings to ensure accuracy.

Interviews were conducted by the primary researcher. Interview data were analysed by the PI and co-PI through thematic analysis using a 6-step framework that included data familiarization, generation of initial codes, search for themes, review of data, definition, and naming of themes, and, in conclusion, generating a written report (Braun and Clarke, 2006). Data were collected until recurrent themes and sentiments were noted. NVivo software was used to facilitate the coding process.

At the time of this study, the principal investigator was employed as a Clinical Resource Nurse in the Pediatric Intensive Care Unit of the study hospital. While the potential institutional, cultural insight, and professional experience likely strengthened this study, the neutralizing of potential bias was also important. Trustworthiness of the data was thus established through several approaches. To ensure rigor and trustworthiness of the data we used Lincoln and Guba, (1986)) trustworthiness criteria [see table below]. Credibility

was established by recording interviews, quickly transcribing them and then comparing the recording and the transcript for accuracy. Credibility was also upheld through investigator triangulation. This approach refers to two or more investigators reviewing data separately and then collaborating on findings to reduce the possibility of bias or idiosyncratic findings (Polit and Beck, 2014). The researchers each analyzed data and reconciled findings through ongoing meetings and discussions. Member checking was also employed to ensure credibility. Member checking is a process where researchers provide emerging themes to study participants to obtain their reactions to the interpretations (Polit and Beck, 2014). The primary investigator reached out to all participants and invited them to review a summary of the themes and subthemes. Of the eight participants four agreed to review the de-identified themes. A response rate of less than 50% is common among studies where response rate was recorded (Birt et al., 2016; Thomas, 2017). All agreed the findings were consistent with what they had communicated, including the sentiment of three participants that the researcher "perfectly captured" what it is like to be them in their role.

The final technique used for credibility was peer-debriefing. This means that during data analysis, the primary investigator also engaged in peer-debriefing with an outside peer-researcher who listened as they processed information and encouraged the PI to evaluate potential assumptions and to consider multiple strategies for ensuring credibility. Dependability was maintained through careful note taking and use of a password protected share drive that allowed both researchers access to the data. To establish and maintain confirmability, researchers engaged in reflective journaling before and after each interview. Transferability is established through rich, in-depth interviews such as those collected for this study.

3. Results

Eight people who worked as housekeepers in the hospital were interviewed. Participants ranged from 40 to 62 years old, were predominantly female, represented a variety of racial and ethnic backgrounds, 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 worked the night shift. Table 2,

Three primary themes emerged from the analysis: (1) "Here to take care of you," (2) Difficulties & coping, and (3) Perceptions of their role. Sub-themes were identified under two of the primary themes.

3.1. "Here to take care of you"

Each participant spoke about interacting with and forming connections with patients and their families as they went about their duties. Some would sing songs with patients, others would bring up topics like the weather or sports, and all but one spoke of not asking how patients were doing. As Abraham said: "it often may open Pandora's Box". For several, these interactions were an important part of their job, and a few spoke about visiting patients on a break, or when they were no longer assigned to their unit. Many of those interviewed, noted that people could be hesitant to ask for help but believed that the care of patients was what they were there for:

> "Because…a lot of them are embarrassed. Sometimes because they spill stuff on the floor, they don't want to make it seem like I'm their servant. They'll say: 'I don't want to bother you. Because I know you're busy and… I had an accident on the floor in the bathroom, and I'm so embarrassed' And I'm like, no… that's what I'm here for. I'm here to take care of you just as well as the nurses are" (Tony).

Table 1
How trustworthiness was sustained.

Criteria	Definition	Action
Credibility	Accuracy, truth, or internal validity of interpreted data.	Interviews recorded, transcribed immediately and transcript checked with recording.
		Researcher notes taken throughout.
		Researcher triangulation
		Member checking with four out of eight participants.
		Peer-debriefing
Dependability	Clear data analysis process or audit trail.	Data, notes, codes, themes documented on a password protected and secure share drive
Confirmability	Verifying the neutrality of the data and interpretation.	Reflective journaling before and during data analysis
		Expert review for plausibility
Transferability	Contextual similarity or the degree to which data could be applicable from one context to another	Rich in-depth interviews of the perspectives of hospital housekeeping staff.

Table 2
Sample characteristics.

Time employed	Number of participating staff
<1 year	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
Race/Ethnicity (self-identified)	**Number of participating staff**
African-American	2
Mexican-American	2
White	2
Pacific Islander	1
West African	1
Gender	**Number of participating staff**
Male	2
Female	6

Table 3
Themes & subthemes.

1) "Here to take care of you"
2) Difficulties & coping
a) "Part of the job"
b) Ways of coping
3) Perceptions of their role
a) "Germ-busters"
b) Not the nurse, not the doctor…but a bridge
c) More than just cleaning…we matter

Participants shared how little time it took to show care or compassion to a patient and how these moments were frequent. Some of them reported needing only five minutes, ten minutes to show someone kindness, restore their dignity or reassure them when they were anxious.

> "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 become a part of your life…And it's not just like a moment, it's the whole event, the whole time that they're there at the hospital. The interaction and…you know, maybe just a soft hand on their foot, tell them, it's gonna be okay… tomorrow is going to be better." (Tammy)

A few spoke of a mindset or approach that they had before interacting with patients and their families. Susie described it as going into patient rooms "with open arms" while several others mentioned not wanting patients or families to feel as though they were too busy to help or to take care of their needs.

Patients recognized them in several ways. Participants told stories of patients wanting to talk to them as soon as they would walk into a room, or how a patient would remember them from the day before and ask when they would be back to visit. A patient remarked to one participant, that whenever he entered his room, it was like the "sun had just dawned". Many of them told stories of recognized in public by a former patient or family member, sometimes years after they met in the hospital and one participant shared that on two occasions, family members had requested that she be at the bedside when their loved one died.

3.2. Difficulties & coping

Participants discussed the experience of working around death and with people who are suffering. Though they viewed it as a part of their job, feelings of distress, discomfort, or sadness were expressed regardless of the unit or shift worked.

3.2.1. Part of the job

Many of those interviewed said that it was difficult to work around dying or critically ill people, with one describing it as traumatizing when a patient would die. The interviews were conducted during the first six months of the COVID-19 pandemic, and several named the pandemic and the risks that came with it as a more recent source of fear and stress with two describing it as traumatic and stressful for housekeepers to enter a hospital when the entire world was afraid of COVID-19.

A few shared stories of watching someone being resuscitated, not knowing what would happen to them.

There was another time when a child, he was probably about 5 years old, 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, um… [paused, collected self before continuing] he was literally on this child's chest trying to do compressions…And so, that one was another one… 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)

Others spoke of the stress felt, having to clean a room soon after the patient in it had died. While saying that it was a part of their job, they expressed discomfort and anxiety. Following the death of a patient in the emergency room, one participant talked about cleaning the resuscitation room so that the patient's family could come in: "And we have to go and clean up around it so the family can come in…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)

3.2.2. Ways of coping

Some used prayer or gardening as a way of coping, while others would talk with co-workers or family members. Most would try and not think about things that happened, opting instead, to leave difficult experiences at work and not bring them home. A few mentioned leaving the room when a resuscitation was occurring with one (Susie) described it feeling: "like a wall up…so I can feel like I can breathe". A common response for most participants was to continue with their day:

> it's kind of hard, but I tend to get used to it by now.... Especially when somebody loses a child, and you know, it's kind of a bummer, you know, but yeah, it's just hard. I just kind of just try to brush it off and just go on about my day. (Tony)

While they described different ways to cope with work, participants also talked about a good feeling they would get from knowing that they were helping people. "…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. You'll be thinking you're doing your job in cleaning the room for another patient to come and get help too. So, it's for the good." (Rosa)

Several participants explained that the reward of seeing people recover helped to balance the weight of what they witnessed.

> "…just seeing the suffering and the pain. And it's hard. But it's always just so great, though, to see them get better, you know? And get to go home. (tearful) That's always just the best part of it all. (wiped tears and paused)" (Tammy)

3.3. Perceptions of their role

Participants described themselves as "germ busters" who help to protect patients and fellow staff from infection and disease. They talked about taking pride in their work and described a belief that they have a unique and crucial role within healthcare.

3.3.1. "Germ busters": communicating through cleanliness

Most participants spoke of cleanliness as a way to communicate to patients and their loved ones that (1) they would be cared for, and (2) they could trust the hospital they were in. Several described a duty to protect patients and staff before the COVID-19 pandemic, but especially during the pandemic. They spoke of themselves as the protection between the patients and germs. Heaven stated:

> You know, I consider myself the germ buster, that's what I am, I'm the germ buster…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.

Many described a responsibility to protect patients, and some discussed not wanting ever to be responsible for harm or death. A clean environment was how they would help people to heal and to feel taken care of. Most talked about how people get a feeling when a space is dirty: that a clean room is not noticed as much, but a dirty room can be felt when you walk into it. Most described feelings of pride when they shared stories of patients or family members telling them how good a clean room made them feel. They believed that a clean space also communicates to people that they can trust they will be taken care of properly. They talked about how a family member might trust a surgeon more, might trust their care team more because the hospital was clean. "…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)

3.3.2. Not the nurse, not the doctor…but a bridge

They also discussed being a unique kind of caregiver and described a quality of listening that they were able to provide. The participants each had one or more stories of patients opening up to them, sometimes unexpectedly. A few participants described being able to act as a bridge between other staff and the patient by advocating for them to speak with their doctor or helping to notify nursing staff when the patient was needing assistance. "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…" He went on to say, "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)

Several participants took pride in being able to communicate with or advocate for patients labelled "difficult" by the healthcare team and a few remarked that it was the patients who seemed the most difficult that needed someone to listen to them. One participant said:

> 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…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…But mainly, they just need to be listened to, that's all. (Tammy)

Some spoke about being a type of cultural broker for some patients, recognizing that healthcare staff's cultural or ethnic backgrounds are sometimes different from those of their patients.

> It's also fun, like being a bridge…from a different part of the community. I know a lot of the people that are nurses and doctors; they haven't been where we've been or experienced what we've experienced. So, the communication isn't going to be the same. Sometimes…they just need somebody that's mutual to come in between and break the ice, and I like to do that....

She went on to share an example:

> I felt like…there may have been a little judgment on them (a patient) 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. (Shyla)

3.4. "More than just cleaning…we matter"

Participants spoke about feeling like they were an important part of the healthcare team. but reported feeling devalued or like they were invisible at times to the staff around them.

> And don't get me wrong, there are some doctors and some nurses who go out of their way to say thank you for the job that you do. There's one particular lady; she does it all the time. And so not all of them don't notice you, but I'll say 80 percent of them don't notice. (Abraham)

Some participants talked about times they felt invisible until they had cleaned a specific area. For example, three shared stories about working in a unit for a length of time, but not being referred to by their name or greeted in any way by physicians until they were assigned to clean their call room or reading room.

Others remarked that it did not matter how people saw them or treated them; what mattered was how they conducted themselves.

> 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 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. (Ruru)

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 discussed mattering and wanting to be treated with respect and dignity and to be treated as though they were all a part of the same team, rather than only noticed when people were unhappy with their work. Those interviewed asked for just a little bit more recognition for themselves and other ancillary staff. They spoke of wanting people to see what their job is like, to see what they go through and to treat them like people. In different ways, several described connecting with patients and providing care as a part of their job, even if others did not recognize it: "You know, maybe they don't see that another part of my job is to connect to that patient, make eye contact and smile…but I can't even imagine doing my job without that being a part of it" (Tammy).

4. Discussion

The responsibility for a clean hospital, a clean patient room, is a progenitor of modern-day nursing (Hegge, 2013). Cleanliness increases patient confidence in the health care team, as people tend to describe the overall cleanliness of a hospital as the most important indicator of the quality of care they will receive there (Press Ganey, 2016). Participants in this study understood this and shared a belief that not only were they keeping people safe, but they were also helping them to feel cared for, and to believe that they could trust the healthcare team. It is worth noting that these observations were recorded during a time when participants were exposed to the higher risks and stressors accompanying the COVID-19 pandemic. While we could not have known at the time how the pandemic would influence the responses of those interviewed, it is also worth noting that the responses of the participants who had been hired after the start of the pandemic, were consistent with those who had worked in hospital cleaning for decades.

The finding that cleaning staff provide mental, emotional, and spiritual, person-centered care that is beyond their job description is consistent in literature (Ashton and Manthorpe, 2019; Jors et al., 2017; Mack et al., 2003; Messing, 1998). 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. Studies that have evaluated the perspectives of ancillary staff including housekeeping, have also found among participants, a shared attitude of being there to look after patients, being an essential part of the healthcare team, and providing care for patients that was beyond their job description (Ashton and Manthorpe, 2019; Jors et al., 2017; Mack et al., 2003). And like those interviewed, participants in Ashton and Manthorpe's (2019) study believed that supporting the humanity of the patient added value to the work of cleaning.

With a unique openness and humility, participants seemed to connect with patients and see them in a way that is different from

other members of the healthcare team. What they offered patients, was the gift of being seen outside of their illness or reason for admission. Most noted that they would never ask how someone was doing, but rather, would focus on positive or uplifting topics and conversation. As Jors et al. (2017) found, patients recognize and remember these moments of brightness and connection and these compassionate interactions can have a profound impact on someone who is sick (Fogarty et al., 1999).

The work of cleaning has been historically undervalued both institutionally and socially in most cultures (Ashton and Manthorpe, 2019; Cross et al., 2019; Dutton et al., 2016). While participants shared moments of recognition from hospital administration and other staff, these moments were overshadowed by a larger sense of invisibility, communicated by being ignored or overlooked (Dutton et al., 2016). To be recognized only after cleaning someone's space, as one participant cleaning a physician call room noted, infers that their personhood and value are linked to the job (Dutton et al., 2016). And as Ashton and Manthorpe (2019) noted, when the recognition that housecleaning staff does receive is based on the tasks of cleaning and not patient care, it infers that patient care is not part of their job. With visibility comes value and dignity (Dutton et al., 2016), a gift that participants were able to give to patients through their listening, connection, and compassion. Study findings suggest that there exists among housekeeping staff, a respect for the humanity of patients, a duty to protect people from disease, and a longstanding practice of engaging in therapeutic connections with patients.

4.1. Limitations

There were limitations worth noting. All participants were over 40 years old and mostly women. It is possible that a younger group of participants with more male representation would have reported a different set of experiences and perspectives. Though the participants were from various cultural backgrounds, this study did not take the context of their diverse backgrounds into consideration.

The interviewer was a nurse at the participating hospital and was known to three of the participants prior to this study. There was a potential for participants who knew the interviewer personally or who knew they were a fellow employee to respond differently than they may have to a different interviewer external to the institution. Also, it is possible that there was a level of trust and acceptance in their presence that meant perspectives were expressed that might not have been otherwise. Multiple people chose not to participate in the study, citing [to the interviewer directly or through other participants] fears of punitive action for talking about patients outside of the hospital or for being seen as talking with patients instead of cleaning.

4.2. Implications

It is shortsighted to discuss housekeeping staff as caregivers without also discussing their historical invisibility as such, and so further research exploring the hierarchies of care within health systems worldwide would be beneficial. Future research with a larger sample would be helpful in confirming the themes and 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 reason, interviews could be conducted by a third party.

The potential for cleaning staff providing care to patients opens multiple possibilities for future research. There is little understanding of this phenomenon from the patient perspective, and of the ways in which environmental services staff can support interprofessional care and collaboration. The retention of experienced staff is vital and so wages which reflect the value of their work must not be overlooked. Their contribution can also be recognized by giving them equal access to the same health benefits and paid sick leave, vacation leave as other staff. As Berg & Frost (2005) found, increased wages alone are not enough to elevate the dignity experienced by cleaning staff in hospitals. It would, therefore, be of value to ensure opportunities for professional expansion and to include representatives in problem-solving meetings for issues that impact their department or staff.

Within each hospital, the resources that are available to caregiving staff could also be made accessible to cleaning and other ancillary staff that are involved in patient care. Assigning cleaning staff to specific units where they can become established and recognized members of each department would provide continuity for staff and patients alike. For new staff who will be encountering patients, it would be of benefit to offer education on professional boundaries, therapeutic communication, and patient confidentiality. Since this is not a new phenomenon, it would be wise for such training to occur with insight and guidance from the housekeeping staff.

5. Conclusion

These results reveal an opportunity to expand our understanding of who we call a caregiver, and to improve how we recognize and support each member of the healthcare team. The irony should not be lost that the honouring and recognition of humanity which participants delighted in providing patients, is often not extended to these members of the care team. As noted elsewhere, there remains a disparity between the importance of this role and the recognition and dignity afforded it (Dutton et al., 2016; Messing, 1998). These findings suggest that the job of cleaning staff in hospitals and healthcare settings is not separate from patient care, but, as Salerno et al. (2012) noted, should be considered among the healing professions.

6. Contribution of the paper

- **What is already known:**
  Hospital cleaning staff in several countries have been shown to have insight into perspectives of patient care, and to be an integral part of patient safety.

- Studies that have evaluated the perspectives of ancillary health staff including housekeeping, have revealed shared themes: they believe they are also there look after patients, they consider themselves to be an essential part of the healthcare team and believe they are providing care that goes beyond their job description.
- **What this paper adds:**
  This is the first study to our knowledge to describe the experiences and perspectives of hospital housekeeping staff solely through the lens of patient care.
- Study findings suggest that there exists among housekeeping staff, a respect for the humanity of patients, a duty to protect patients from disease, and a practice of engaging in therapeutic connections with patients.

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CRediT authorship contribution statement

Nicole Vance: Conceptualization, Investigation, Data curation, Formal analysis, Project administration, Writing – original draft, Writing – review & editing. **Kupiri Ackerman-Barger:** Conceptualization, Project administration, Supervision, Writing – review & editing, Resources, Validation, Methodology. **Jann Murray-García:** Writing – review & editing, Resources, Validation. **Fawn A. Cothran:** Writing – review & editing, Validation.

Declaration of Competing Interest

At the time of the study the principal investigator was also a facilitator for an employee course called "Re-Igniting the Spirit of Caring" at UC Davis Health. The three day workshop is licensed by Creative Health Care Management, and Mary Koloroutis, an author cited in the discussion, is the Vice-President of Creative Health Care Management.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.ijnsa.2022.100097.

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