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Ward housekeepers in mental health environments

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Abstract

Purpose – In the year 2000, the UK Government promoted the concept that hospital services be shaped around the needs of the patient to make their stay in hospital as comfortable as possible. In recognition of this, the Government advocated the introduction of a Ward Housekeeper role in at least 50 per cent of hospitals by 2004. This is a ward-based non-clinical role centred on cleaning, food service and maintenance to ensure that the basics of care are right for the patient. Much of the guidance for the ward housekeeper role has focussed on its development and implementation in an acute hospital setting. The aim of this research is to illustrate how the role has been adopted and implemented successfully in mental health environments and the subsequent impact for patient services.

Design/methodology/approach – Four case studies were undertaken in a variety of mental health settings, the principle method of data collection was qualitative semi-structured interviews.

Findings – Common themes were identified from the case studies relating to experiences of developing and implementing the ward housekeeper role. This paper suggests models of best practice which relate to six main areas of: role, recruitment, induction, training, integration and management. It also demonstrates that the role has been successful and is highly valued by nursing staff.

Research limitations/implications – The study was largely qualitative based and therefore the results do not lend themselves to be generalisable across the NHS.

Originality/value – The paper suggests how the ward housekeeper role should be adapted for mental health settings.

Introduction

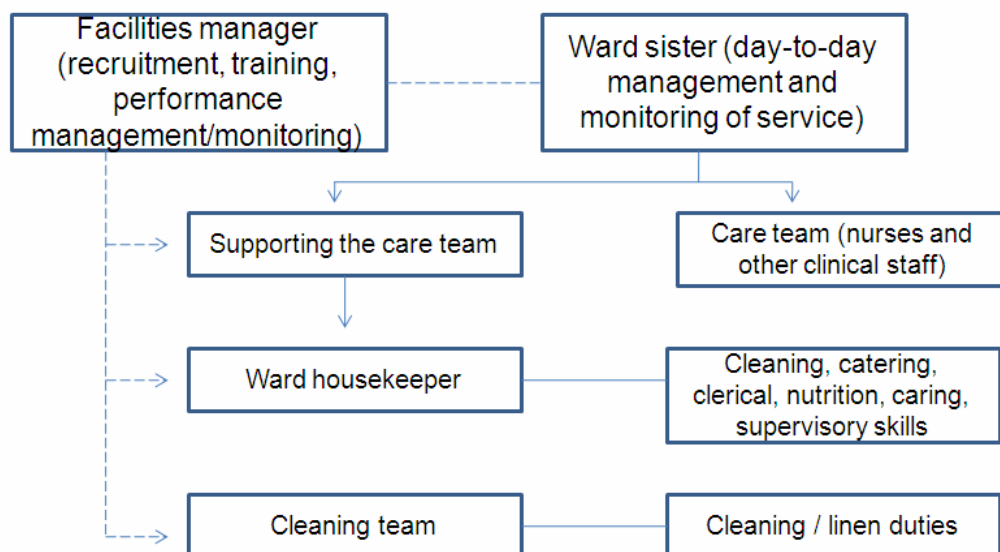
The Facilities Management Graduate Centre (FMGC) at Sheffield Hallam University has been investigating the nature and success of hospitals who have implemented a multi-skilled or generic worker since the mid 1990s (Akhlaghi and Mahony, 1997; Mahony *et al.*, 1997). The concept of the multi-skilled worker was introduced by a handful of pioneering NHS Trusts who realised the value of having a cleaner or domestic perform basic household maintenance duties such as changing light bulbs on the ward.

In 2000, the UK Government promoted the concept that hospital services be shaped around the needs of the patient to make their stay in hospital as comfortable as possible (Department of Health, 2000). The ward environment and services to patients are prime influences on the quality of their stay and in recognition of this, the Government advocated the introduction of ward housekeepers in at least 50 per cent of hospitals by 2004. This is a ward-based non-clinical role centred on cleaning, food service and maintenance to ensure that the basics of the care environment are right for the patient.

In 2001, NHS Estates introduced guidance on developing and implementing the ward housekeeper role for NHS Trusts to use locally. The guidance outlined the fundamental principles of the ward housekeeping service as being:

- Ward sisters will manage the ward environment, supported by the ward housekeeper.
- Ward housekeepers must be ward based, and must be seen as part of the ward sister's/charge nurse's team.
- Ward housekeeping teams must be multi-skilled and flexible in their work practices.
- Patients must be involved in setting up and evaluating the service.
- There must be commitment from Trust management.
- A system of continuous quality improvement must be in place (NHS Estates, 2001).

Within the guidance the possible relationships between the facilities manager, ward sister and ward housekeeper are also suggested. These relationships are illustrated in Figure 1.



source: Adapted from NHS Estates (2001)

Figure 1 Suggested relationships between facilities manager, ward sister and ward housekeeper

At the end of September 2003, 53 per cent (NHS Estates, n.d.) of large hospitals in the UK had introduced a ward housekeeping service, and over 5100 housekeepers were already in place. Although the principles of the role were suggested nationally, the approach, funding and process of implementation were the devolved responsibility of local NHS Trusts.

Much of the national guidance for the ward housekeeper role focussed on its development and implementation in an acute hospital setting. In 2002, the 55 NHS Trusts that form the NHS Facilities Management (FM) Research Forum commissioned FMGC to undertake an evaluation of the various approaches that had been adopted in developing and implementing the ward housekeeper role in mental health environments. They were particularly interested in learning about the role's development, implementation and how it needs to be adapted for mental health services[1].

Four case studies were undertaken in a variety of mental health settings ranging from acute, long-stay wards in hospitals to community extended care units. Table I summarises the type of Trust (or organisation) and the type of unit/ward where the housekeeper was based.

Table I *Summary of case study type and main characteristics of housekeeper*

Case study	Trust / organisation	Ward / unit where housekeeper is based
1	Mental Health and Learning Disabilities Trust	Using housekeepers in acute/long stay in-patients wards and community extended care units.
2	Community and Mental Health Trust	Using ward housekeepers in acute adult inpatient wards and elderly mental illness wards
3	Primary Care Trust	Using a single ward housekeeper on an adult in-patient mental health unit
4	Support Service Organisation supplying FM and estates to a Mental Health Trust	The Trust has a children's and adolescent inpatient unit which has one housekeeper

Methodology

From preliminary investigations it was anticipated that there would only be a handful of Trusts who had implemented the housekeeping model into mental health units/environments. The key selection criterion for identifying case studies was that the Trust had used the guidance model as suggested by NHS Estates. This model recommends that the ward housekeeper is managed on a day-to-day basis by the

ward manager (or equivalent ward based supervisor) and responsible for cleaning, catering and basic maintenance duties. Therefore a purposeful sampling technique was employed, and the Trusts selected as case studies were not representative of the wider NHS ward housekeeping models. Instead, they were chosen to provide illustrative examples of the limited amount of work to date surrounding housekeepers in mental health environments.

During the case studies the principle method of data collection was semi-structured interviewing. Where possible, interviews were conducted with the:

- Director of Facilities (or equivalent representative from the facilities department);
- members of the nursing team (or ward manager); and
- housekeeper (or a number of housekeepers from different wards).

In order to make comparisons with previous housekeeper research in Acute Trusts (May and Smith, 2003), the themes for discussion during the interviews were based on the themes that emerged during the previous study. These were designed to explore the ward housekeeper core role/duties, management of the role (operationally and strategically), recruitment and selection, pay and conditions, funding of the role, training, team integration, problem areas, suggested improvements, evaluation of the role and the value of the role.

Interview questions were also added to reflect the different needs for mental health patients. These additional questions explored specific mental health requirements such as the level of patient interaction and helping to “stimulate senses”. The interviews were designed to probe for further information and provide an in-depth, rich picture of the housekeeping services. Consequently, the account and narrative presented in the case studies reflect the perceptions from the respondents, and are therefore inherently subjective.

A total of 17 interviews were conducted across the four NHS Trusts. The interviews usually lasted approximately 45 minutes to one hour. The interviews were tape-recorded and usually took place in a private meeting room at the hospital/unit.

In order to enrich the case study information and provide a fuller picture of the housekeeper role some documentary evidence and financial data was also requested. This included job descriptions, training programmes and pay rates. Two of the housekeepers provided a “day in the life”; these were descriptive narratives sharing their work experience and helped to enhance the case study data.

The interview tapes were transcribed verbatim. All references to the Trust and the names of those participating were removed to allow anonymity. The transcribed data was analysed using thematic content analysis. The analytical framework allowed the data to be broken down into units of meaning (codes), which were then categorised

and ordered under emerging themes. Using this type of approach to analyse qualitative data there is bias which cannot be assumed to be value or opinion free. This subjectivity is on three levels. First, that of the person or respondent during the interviews describing their “true” account of the situation. Second, that of the person interpreting the account and representing it in the written form of a report. Third, the reader interpreting the written report and meanings presented.

Findings

Case study one

Trust A is a Mental Health and Learning Disabilities Trust that have ward housekeepers in 14 medium/long stay inpatient wards/units.

Role. The role varies according to the nature of the patients on each unit, but the core responsibilities of the ward housekeeper were broken down into:

- *Domestic duties*, including ensuring the ward is clean and tidy in line with the cleaning specification for the ward.
- *Catering duties*, for example making beverages and snacks; preparing and cleaning dining rooms and serving patient meals; ordering patients meals; and the storage and regeneration of cook chill and other food.
- *General duties*, such as maintaining stock levels of consumable goods; assisting with washing and ironing and checking the condition of the linen; making and changing beds; reporting any general maintenance to the Estates department; when required providing a message service by the ward manager.

Before the introduction of the ward housekeeper role, the only non-clinical support given to wards was from domestic staff who were responsible for cleaning. At this time the nursing staff were responsible for making beds, keeping the ward environment tidy, menu collation, table setting, meal regeneration and clearing away. Now that the ward housekeeper has been introduced onto the ward they have taken over all these responsibilities and freed up a large proportion of the nurse's time. The role is valued by the Facilities department as they now have more control over introducing new approaches that aim to improve the patient's experience, for example, appropriate place settings, crockery and condiments. The ward managers also appreciate the work that the housekeeper performs, as one explains:

... all of those jobs have now been taken off us and given us a lot more time to do this, so its integral, it kind of ties together all the bits that we used to do, puts them in a package and gives them to somebody who is appropriate and recruited to do that. It allows the nurses to be freed up to do what they are paid to do.

Differences in mental health service provision. On wards where services are provided for older people, patients generally have organic illnesses and are in a

confused state, so the ward housekeepers provide all the non-clinical services on the ward making the role very similar to the acute setting.

However, the greatest difference is noted on the smaller community extended care units which tend to house younger patients with functional illnesses. In these units the patients are regarded as “residents” in their own home and are encouraged to be as independent as possible as part of their care treatment. In these units the residents often do their own shopping, make several of their own meals, make their own beds, clear their bedrooms, do their own clothes washing and ironing and do their own washing up. The role of the ward housekeeper therefore has to run alongside the residents' activities and be flexible to their needs, although they do still have the same core responsibilities. For example, in this setting the residents will clean their own room which involves making the bed, washing the basin and vacuuming the floor and the ward housekeeper will initially encourage the resident to undertake these activities, provide any help they may need and then undertake a thorough clean once the resident has left. The residents are also encouraged to make their own breakfast and supper; their lunch and evening meal are prepared for them by the ward housekeeper using a cook chill system. The ward housekeepers' catering responsibilities are therefore to order and regenerate two of the residents' meals, but also to ascertain and order supplies for the meals that the residents prepare themselves.

Patient contact. Because of the nature of the illnesses that the patients or residents have, there is much less scope for the ward housekeeper to have “meaningful” contact with them. Nursing staff have requested that the ward housekeepers have little direct contact with the patients, as the relationship may have an adverse effect on their rehabilitation. The contact that they do have with the patients is general chatting, as the ward manager on the Community Extended Care Unit explains:

... like you would be involved talking to somebody in the street and maybe get to know you over a period of time, tell you things. Now the nurses' role is a more therapeutic role at the end of it and has a measurable outcome.

However, he does recognise that, in the smaller community extended care unit, the conversations between the ward housekeeper and residents are:

... part of the therapy, it comes under part of the therapeutic care, there is benefits to come from that, but the role itself isn't a therapeutic one.

The level of interaction that the ward housekeeper has with the resident therefore varies according to the nature of the illness that they are experiencing. This is not included as a formal aspect of the ward housekeeper role, but it is flexible enough to be incorporated if recommended by the nursing staff.

Management. Usually there are three ward housekeepers dedicated to a typical in-patient ward, but this can vary depending on the unit size. They cover the ward from 7.00 a.m.-7.00 p.m. every day of the week. This ensures that all the patient meals are covered so the responsibility does not fall back with the nursing staff. The Trust

found that this approach was more conducive with the needs of the staff and patients on the wards, and more importantly one that was affordable.

Because more staff were trained as ward housekeepers, it was also easier to organise cover for sickness or holidays. This responsibility is undertaken by the Facilities department, as well as the recruitment, training, appraisals and monitoring the quality of their work. Facilities supervisors tend to visit the ward housekeepers every week or fortnight to check if there are any issues or problems, and the ward housekeeper contacts them if they need extra help for staff cover. Day-to-day management of the ward housekeeper is handled by the ward manager, which involves including them in team briefings and dealing with any immediate problems they have. The facilities supervisors and managers then meet with the ward managers or modern matrons once a month to communicate any issues, changes or problems.

Training. Many of the ward housekeepers in the Trust were previously domestic staff following the return of the domestic contract in-house. The training that these staff, and newly-recruited ward housekeepers, receive is a two day induction programme given by the Facilities department. This involves the distribution of uniforms, meeting the supervisor and other team members and shown the locations in which they will be working. Following this there is a specific two-day housekeeping induction programme that includes:

- the purpose of the ward housekeeper;
- the nature of the role that has been developed;
- the importance of the role in the NHS;
- familiarising them with cleaning methods, substances and equipment;
- catering service and standards; and
- the hygiene codes of practice.

New recruits do not receive training that is specific for staff working in a mental health environment. However, it is covered briefly in the Trust induction programme and the ward manager highlights the nature of patients' illnesses on their particular ward.

Integration. With day-to-day management of the ward housekeeper being ward based, they have become fully integrated into the ward team. Housekeepers are actively involved in the ward meetings, briefings, nights out and fund-raising events and the ward manager recognised them as an integral part of the ward team. The housekeepers did view themselves as members of the ward team, however, first and foremost, they viewed themselves as members of the housekeeping team.

Case study two

Trust B is a Community and Mental Health Trust and have ward housekeepers in several of the mental health wards and units across the Trust's 19 hospitals.

Role. The core elements for the ward housekeeping role include:

- regenerating resident meals, which nursing staff then distribute in the dining room;
- general tidiness and order of the ward, including returning belongings to the appropriate location which patients have moved;
- monitoring, ordering and distributing linen;
- bed making;
- monitoring, ordering and distributing stores including breakfast and beverage provisions; and
- identifying repairs and reporting this to the ward/unit secretary, who then reports and chases this with the Estates department.

This service is provided from 9.00 a.m.-5.30 p.m. Monday to Friday. Outside of these times the nursing staff perform any immediate tasks, but normally most other work is left until the ward housekeeper returns.

Linen, domestic, catering, estates and portering services are provided to these units by the local Trust through service level agreements. Prior to the introduction of the ward housekeeper the nursing staff, ward manager and administrator were responsible for putting away linen and stores, regenerating resident meals, reporting and chasing estate issues, and dealing with residents' laundry with an external contractor. Now the ward housekeeper co-ordinates all of these activities and undertakes the residents' laundry duties in-house, so the service is much more consistent and to a higher standard of quality.

Differences in mental health service provision. The core duties of the role are again similar to those found in the acute setting, however there are slight variations to the tasks because of the mental health setting. One of the main differences is dealing with residents' clothing. Allowing the residents to take pride in their appearance and look respectable is an important contribution to the residents' dignity. This aspect of their role involves labelling clothing, compiling an inventory of their belongings, washing, drying, ironing as well as making any repairs and then returning the clothing to the residents' room. The complaints received from residents' relatives regarding their clothing was the main reason why one of ward managers introduced housekeepers.

Some of the residents either prefer, or are encouraged, to do their own laundering, and the ward housekeeper is responsible for facilitating this activity. This sometimes results in the ward housekeeper restricting the use of the washing and ironing equipment, but these activities which keep them independent and active, are regarded as part of their treatment.

This is similarly the case regarding cleaning and tidying the residents' bedrooms. Although this is part of the role of the ward housekeeper, some residents are encouraged to take responsibility for their own bedroom in terms of changing their

bedding, vacuuming, dusting and general tidiness. This is much more time consuming for the ward housekeeper who has the responsibility of checking that the rooms meet the appropriate standard and where necessary make any rectifications.

There are further housekeeping activities that the residents undertake as part of their treatment, but clinical staff assist with these duties rather than the ward housekeeper. To help regain independence and freedom residents can perform gardening activities, cooking and baking, but this is directed by the Trust occupational therapists and not ward housekeepers.

Management. The ward housekeepers in the mental health units at this Trust are funded, employed and managed completely by the ward managers. This includes designing the role, advertising, interviewing and selecting candidates, organising rotas, holidays and sickness cover.

It is likely that this approach has been taken because of the geographic spread of the Trust - it provides mental health services to over 70 different locations including 19 hospitals across a 70 mile area. Subsequently, it would not be appropriate for the Trust to design a single ward housekeeping model, since the units they serve are so different and support would be difficult to provide logistically. All the responsibilities for the role design have therefore been assigned locally to nursing staff as they have a greater awareness of their needs and those of their clients.

Integration. In most cases the ward housekeeper is well integrated into the ward/unit team. The success of the integration seems to be due to the "local" nature of the role and the fact that ward managers have full responsibility for their housekeepers. On one ward, the housekeepers have been employed for over five years and they feel that they are definitely integrated into the ward team. They believe that the nursing staff help them out as much as they can to make their role run smoothly and give the best service to the patients. The ward housekeepers on this ward are invited to attend the ward meetings – although in most cases they are unable to attend.

However, in another unit, where the ward housekeeper has only been employed for six months, they feel much less part of the ward team. They are not involved or invited to any of the ward meetings. The meetings predominantly deal with patients' histories and illnesses so there are issues of confidentiality and appropriateness. Although the ward housekeeper feels they have an amicable relationship with the nursing staff they consider themselves to be more a part of the domestic team than the ward team.

Nurses on this unit recognise the value of the ward housekeeper being seen as separate from the clinical team in the eyes of the residents. As one nurse points out:

... there are some positive aspects to the fact that she's not seen as a nurse and she is sort of seen more of this housekeeper mother figure, and so ...

[residents] do perhaps respond differently to [the ward housekeeper] to how they do to us and maybe it is a good thing that she isn't seen as one of us.

Case study three

Trust C is a PCT that has responsibility for community and inpatient mental health services. The focus for this particular case study is a single ward housekeeper based on an adult inpatient mental health unit. The unit is split into two 16-bedded mixed wards and has had a ward housekeeper in post for nearly a year. The post was initially set up as a pilot scheme to identify any issues or problems but it has quickly developed into a permanent position.

The Trust were fortunate during the implementation of the housekeeper role, as the Director responsible for facilities management was also responsible for mental health and learning disabilities, this helped in getting commitment for the pilot scheme from the Board. The development of the housekeeper role was driven by the increasing number of complaints, received from both patients and carers, surrounding the ward environment. The Community Health Council had numerous complaints about the environment so the ward took the decision to fund the housekeeper by sacrificing a nursing assistant post.

The mental health support services manager justified their funding decision by the amount of time it (the introduction of the ward housekeeper) has freed up for the nursing assistants.

Role. The job summary outlines the key components of the position:

- co-ordination of all patient facilities services in the ward area and ensure a clean, safe and comfortable environment;
- support nursing staff to ensure patients needs are met;
- work with domestic staff to maintain a clean and tidy environment;
- work with the unit administrator to monitor quality standards, report deficiencies and take appropriate action; and
- work as part of the ward team.
-

The patient meals come from the hospital kitchen as cook chill. The housekeeper is responsible for making sure any special dietary requirements for patients are noted and an order placed with the catering department.

During mealtimes it is important for the housekeeper to be present to oversee the meals being served (the meals are served from the trolley by the domestics), make sure there is enough food for all the patients, and check the quality of food.

On top of overseeing mealtimes the housekeeper ensures that there is enough crockery, cutlery and places for all the patients to eat. If there are shortages then the housekeeper will contact the relevant department and arrange for replacements to be sent.

Other general catering work includes monitoring the food and beverage stocks in the pantry. Patients are able to make toast – although the toaster is kept locked away due to the potential fire risk and because patients were using it as a way of self harming – and the housekeeper is responsible for supervising patients who want to use the kitchen. Notices are displayed around the ward which explain that if they need assistance in the kitchen, pantry or laundry room then patients should approach the housekeeper for help.

Among the general duties the housekeeper undertakes is to meet new patients and welcome and guide visitors around the ward. After meeting the patient or receiving information regarding them the housekeeper may feel it is appropriate to pass this on to the domestics, e.g. whether the patient is anxious, aggressive, violent and if it is safe for them to clean the rooms etc.

Patient contact. The housekeeper also plays a vital part in monitoring and maintaining special dietary needs for individual patients. Some patients have care plans involving specific dietary requirements and the housekeeper is available to report back on what they have eaten and drunk. This is important when the nurses are busy on the wards and may not have time to observe during meal times.

The other role the housekeeper plays, in respect to patients' dietary needs, is to help manage portion control. For example for overweight patients the housekeeper makes sure they serve more healthy options rather allowing second helpings of fried or fatty foods.

This illustrates how the housekeeper makes a direct contribution to patients' clinical needs through the non-clinical services they provide. It also gives the housekeeper responsibility for implementing some aspects of the clinical care plans which would otherwise be managed by nurses.

The housekeeper's duties are very much focused on the needs of their patients, which for mental health are different to general acute patients. The unit has tailored the housekeeper role to mirror the needs of their patients and this is reflected in the interaction between the housekeeper and patients. Prior to working as the housekeeper on the ward she was employed as a nursing assistant and is able to compare her relationship with the patients between the two roles. As the housekeeper the patients talk to her more openly and will chat away while she is making beds, however she is clear where the boundaries lie and explains to patients that if they want to talk about their problems then they need to speak to their allocated nurse.

The workload and nature of the role rules out further patient interaction, but sometimes if there is a spare half an hour the housekeeper can sit and play scrabble or cards with the patients.

At times nurses or doctors will approach the housekeeper and ask about specific patients' dietary intakes or what a particular patient has been talking about. The significance of the housekeeper's role as an "information gateway" between patients and doctors is highly valuable, arguably more so in a mental health unit than an acute ward. Examples of this include when they have been observed chatting to a patient who would hardly talk and when they managed to get someone to eat after they had not eaten for three days because the housekeeper knew the patient from a previous stay and remembered what they preferred to eat.

Integration. The way the role was designed, and is currently managed, means the housekeeper is fully integrated, and an integral part of the ward team. The housekeeper attends the weekly communication meeting where the patients meet with a member of staff and any concerns can be raised. Should any of the concerns fall under the responsibility of the housekeeper then they can respond to them appropriately.

As yet no formal evaluation of the role has been conducted, but feedback has shown that staff have noticed a huge difference in the ward environment. The facilities manager reports that the ward nursing staff "could not sing the praises enough". Visitors and patients have also noticed the change since the housekeeper has been employed. Patients who have been re-admitted to the ward have noticed the changes and noticed curtains which the housekeeper has put up and that there are towels and water jugs available. These may seem trivial areas, but they are a result of small changes the housekeeper has made which has impacted directly, and contributed to, improving patient care.

Case study four

The housekeeper studied in case study four works on a children's and adolescent unit which is part of a mental health trust. The unit has had a housekeeper for the past seven years. The main duties revolve around cleaning and housekeeping.

Role. The housekeeper has responsibility for all domestic/cleaning duties in the ward and ordering food supplies for the unit (such as bread, milk etc.) from the Trust kitchen. He also does a weekly shop at a local supermarket to purchase food for patient meals. Parents who stay at the unit cook meals for their children and for unaccompanied children nursing staff will cook their meals. The children are able to go into the kitchen, but are not allowed to make drinks or toast.

The unit has its own laundry room which handles the bedding but towels are sent to the Trust's central laundry unit. All the patient's personal clothing is washed by the nurses or parents.

Patient contact. Within the unit it is very clear where the boundaries and responsibilities for the housekeeper start and finish. The pure nature of the role means the housekeeper does have contact with patients and visitors, but the nursing staff and housekeeper both agree that this is only on a superficial level and not linked to patient clinical needs. The housekeeper deals with any food and cleaning related requests from parents and children. In other case studies the housekeeper acts as an “information gateway” for certain issues between patients and staff[2], but this is not the situation for Trust D. The housekeeper is rarely approached by the patients or parents, however, should this happen the housekeeper knows to direct them to the nursing staff.

During the case study the nurses drew attention to the gender issues that surround the housekeeping role. In general, observational evidence suggests that the majority of housekeepers employed within Trusts are female. A suggested reason for this is the connotation which the name “housekeeper” has with a traditional female role. Some Trusts are aware of this and have deliberately renamed the housekeeper, for example to “Ward co-ordinator”, and have been successful in recruiting a much better balance of male and female staff (NHS Estates, 2003).

The gender issue raised by the nurses highlighted the importance of having a male housekeeper present in what is a predominately female unit. The advantage of balancing the staff gender inequalities for the unit is arguably more heightened for a children's unit than for adult or geriatric one.

Integration. The importance placed on the housekeeper role, particularly from the nursing staff, indicates the level of integration into the ward team. The domestic supervisor provides an example of the value of the role:

... they do miss him very much when he is not there for a week or two because they soon start screaming “ooh can you do this linen” I say sorry I am not a housekeeper ... [by] the time he comes in on a Monday morning everybody is there waiting.

The nursing staff also explain why they value the contribution the housekeeper makes to the ward:

Compared to what I've experienced before this is much better because it takes a lot of pressure off the nurses, things like keeping the kitchen in a reasonable state throughout the day, where I've worked before we just would constantly load the dishwasher and it took time away from what we could do with the kids. So this is much better, somebody that we know is there, who we know can do that.

Conclusions

Research conducted which evaluated the role of the ward housekeeper in acute hospitals (May and Smith, 2003), led to the identification of six common themes (role,

recruitment, induction, training, integration and management). These themes outlined best practice that contributes to the successful implementation of the ward housekeeping role. The findings from the housekeepers in mental health environments research supports these themes.

However, while the four case studies investigated for the research supported the themes, there are a number of variations identified in the role for mental health services. These primarily related to the patients' needs and their environment and are summarised below.

Perception of the environment

The perception (and reality) for some patients in community extended care units and long stay wards is that they are, in essence, the patients' home and therefore should be treated as such.

Mental health patients with predominantly functional illnesses (as opposed to organic illnesses) are encouraged to be as independent as possible to maintain their life skills, and this is an important part of their treatment. Often patients do their own shopping, make several of their own meals, clear and set the table, make their own beds, clear their bedrooms and do their own washing up. The role of the ward housekeeper therefore has to run alongside the patients' activities and be flexible to their needs.

This may mean the housekeeper at times, works in “partnership” with patients. For example, the ward housekeeper may be responsible for making the beds with the patients, encouraging them to tidy their room, ordering supplies for them to prepare their own breakfast and lunches.

Perhaps the most important point related to this is focused on patient independence and dignity. The ward housekeeper needs to respect the patients' needs and adopt flexible working patterns to reflect this.

Patient relationships

Case studies two and three highlighted a slightly different relationship between the ward housekeeper and mental health patients compared to that found with acute patients. It could be argued that they are viewed more as a “mother/father figure”, that patients are happy to chat with and confide in, compared to the more formal arrangements that exist between mental health patients and the nursing staff or doctors.

The informal contact which housekeepers have with patients enables them to be perceived differently. Hence the ward housekeeper acting as an “information gateway” between the patients and doctors is valuable, arguably more so in a mental health unit compared to an acute ward.

Flexibility of the role

The research highlighted several areas in which the actual role in the mental health setting is different to that in the acute setting. However, this supports a finding from the original research, which stated the importance for the ward housekeeper role to be tailored to the needs of the patients on the ward. Mental health patients will have different needs to those in an acute setting, so it follows that the housekeeper role will also differ. Differences found in the case studies included dealing with patient clothing, assisting patients/residents with meal preparation and performing shopping duties.

Consequently, the housekeeper training programme needs to be modified to meet individual ward requirements. This may include providing housekeepers with basic information about what certain drugs do and how they can effect patients' conditions, moods etc. In addition, the basic training should include patient illnesses and how to handle aggressive and challenging behaviour. In some Trusts it was the responsibility of the nurses to provide these clinical training requirements, done on an ad-hoc basis - but in most cases this seems to be an area of weakness.

Notes

1. In the UK, mental health services are provided through the NHS. Care for the majority of people with moderate to severe mental illness is provided by Community Mental Health Teams (CMHT). The CMHT are usually part of a Primary Care Trust or a Mental Health Trust. People with more serious conditions are referred to therapeutic inpatient hospital units, either as part of an Acute Hospital or a specialist Mental Health Trust.
2. An example of this is illustrated in Case Study 3 when at times the housekeeper is asked about patients' eating habits or what they may have said during a conversation.

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