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Evaluation of the new ward housekeeper role in UK NHS Trusts

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Abstract

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 and 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. In 2002 the Facilities Management Graduate Centre at Sheffield Hallam University completed a series of six case studies looking at the role within different NHS Trusts. These were developed through interviews and observations with the facilities manager, ward housekeepers and nursing staff and also by collecting documentary evidence such as job descriptions, financial details and training information. Common themes were identified, relating to experiences of developing and implementing the ward housekeeper role. This paper suggests models of best practice relating to role, recruitment, induction, training, integration and management.

Introduction

The Facilities Management Graduate Centre (FMGC) at Sheffield Hallam University has been investigating the nature and success of hospitals that 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^[1] 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.

Shortly after the release of the NHS Plan the UK government announced two other key initiatives related to hospital cleaning and hospital food. The *National Standards*

of Cleanliness for the NHS Report (NHS Estates, 2001b) outlined national targets that each NHS hospital was required to meet regardless of whether the service was performed in-house or contracted out.

The better hospital food[2] programme aimed to address the standard of food service in the NHS. During research patients had said:

... that menus were complicated and carried poor descriptions; there were also comments on the time that food was ordered and delivered; on the presentation and temperature of food; and the size of portions.

The programme has also introduced targets relating to the patients' experience of food which all Trusts have to meet.

The performance data for the national Standards of Cleanliness and Better Hospital Food programme are now published and available as league tables which attract high profile political attention.

In 2001, NHS Estates[3] introduced guidance on developing and implementing the ward housekeeper role for NHS Trusts to use locally. The guidance outlines 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; and
- a system of continuous quality improvement must be in place (NHS Estates, 2001a).

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.

As of 1 January 2003 NHS Estates assert that 32 per cent of hospitals in the UK have begun to introduce housekeeping services, with nearly 5,000 ward housekeepers already in post[4].

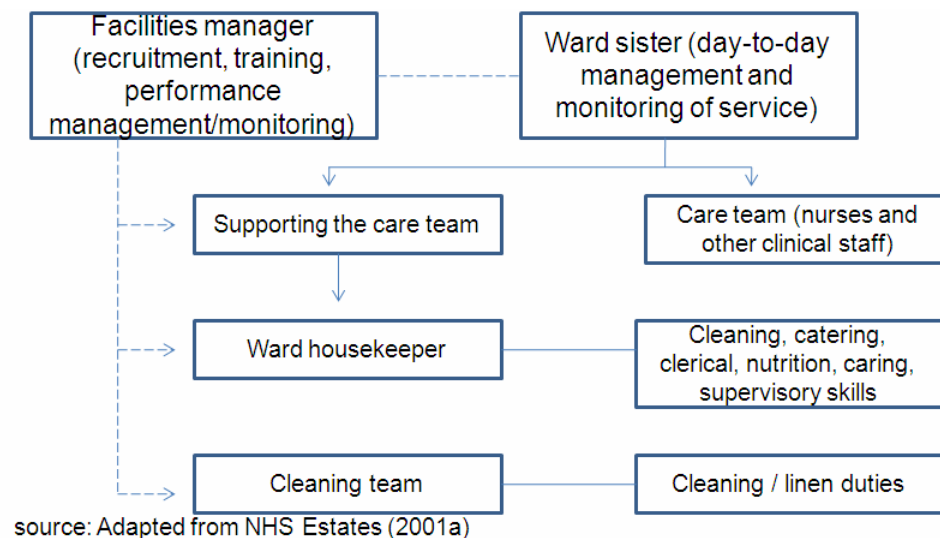


Figure 1 Suggested relationships between facilities manager, ward sister and ward housekeeper

Although the principles of the role were suggested nationally through the guidance, the approach, funding and process of implementation were the devolved responsibility of local NHS Trusts. In 2001, the 55 NHS Trusts that form the NHS Facilities Management (FM) Research Fora commissioned FMGC to undertake an evaluation of the various approaches that had been adopted in developing and implementing the ward housekeeper role. They were particularly interested in learning about the role's development, funding, implementation and its value. A series of six case studies was undertaken, which looked at the role across different NHS Trusts. Table I summarises the type of hospital during each case study and the main characteristics of the housekeeper.

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

Case study	Hospital type	Main characteristics of housekeeper
1	General	Mainly catering related work, but also responsible for the laundry cupboard, replenishing stores and general tidiness
2	Acute	Purely catering work, i.e. ordering and serving patient meals and the clearing of the crockery and cutlery afterwards
3	Acute	Supervisory role, responsible for overseeing all non-clinical work on the ward
4	District	Serving meals, cleaning and tidying the ward, making beds
5	Community	Mainly catering related duties such as ordering and serving patient meals. Some general work such as bed making and checking linen trolleys
6	Acute	Mainly focused on cleaning the ward, however they are responsible for serving hot drinks

Case studies were chosen from the members of the NHS FM Research Fora which FMGC co-ordinates. Selection was based on the nature of the ward housekeepers' role and their lines of management. Since the NHS Estates guidance insists that the ward housekeeper be managed on a day-to-day basis by the ward manager, those who fell into this category were considered of greater value for the research.

During the case studies the principle method of data collection was semi-structured interviews. The interview questions 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.

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 the
- housekeeper (or a number of housekeepers from different wards).

In most instances there were three or four interviews conducted for each case study. The interviews were tape recorded and usually took place in a private meeting room at the hospital.

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.

The interview tapes were transcribed verbatim and then analysed using content analysis, the units of coding being the themes of role, recruitment, induction, training, integration and management.

The objective of the research was to evaluate the ward housekeeper models implemented using the NHS Estates guidance (2001). The ward housekeeper was introduced as a result of a patient consultation exercise and since the research was focused on the role development and how the housekeeper model was implemented locally it was not deemed appropriate to include patient interviews within the case studies.

Findings

Several themes arose from the case studies relating to the Trust's experiences of implementing the ward housekeeping service. The main themes identified related to six areas:

1. (1) role;

2. (2) recruitment;
3. (3) induction;
4. (4) training;
5. (5) integration (into the ward team); and
6. (6) management

Further details of the experiences of Trusts under each of these headings will now be considered followed by a section highlighting areas of best practice in order to help implement a housekeeper post successfully.

Role

The case studies demonstrated that the housekeeper role had been adapted and modified by each Trust to meet their needs and the needs of their patients. For example, at some of the hospitals the ward housekeeper was responsible for the patient meal service in terms of menu completion, ordering the meals, regenerating and serving the food to patients. In other hospitals members of the catering team performed these roles. The historic practices, finance and the availability of time all contributed to influence the aspects of the support service that the housekeeper can perform.

The case studies also showed that the housekeeping service was more effective when wards had a dedicated and permanent housekeeper. This was because they were able to take ownership of the ward, which developed their pride in the service they delivered and helped to nurture trust between them and ward staff. They reported that being dedicated to a ward also allowed more continuity for patients during their stay and allowed the housekeeper to get to know the patients' particular needs (e.g. diets) and to understand the culture and routines of the ward and therefore ultimately provide a better service for the customer.

Only one of the Trusts involved in the research included the ward housekeeper at a supervisory level, as recommended in the NHS Estates guidance. While other Trusts did not view the role at this level, the Trust that chose to take this route felt that it would help raise the profile of the housekeeper and assist in their responsibility of overseeing non-clinical duties in the absence of the ward manager.

Recruitment

Some problems were identified with recruiting housekeepers. The main issues related to the role's unsociable hours, pay levels and for some its temporary nature since the new role was only on trial. Some of the case studies had sufficient funding to position the role at a supervisory level[5] and they experienced fewer problems with recruitment.

One recurring theme relating to recruitment was the importance of involving ward managers and if possible nursing staff in the process. The case studies that did involve the ward managers and nurses, as early as possible, during the recruitment process believed it helped to gain the trust and “buy-in” from ward staff. One example of this was a working group that was set up which included representatives from the hotel services department, ward managers and nurse managers. The working group was responsible for forming a core job description and then tailoring this to meet the specific needs of each ward.

Induction

The case studies identified some interesting examples included in the housekeeper induction programme. One Trust identified a “buddy” from the ward team for the ward housekeeper, who explained the structure and roles of the rest of the ward team and was a point of contact for the housekeeper during their introductory period. Another Trust recommended that their induction training should include visits to other hotel service departments with which the housekeeper may have to liaise, as this would help them understand the physical structure, functions of the organisation and where they fit into the “bigger picture”.

Training

The research indicated that training structures and programmes were pragmatic and aligned to the ward housekeeper role. Included in the programmes were basic food hygiene, cleaning procedures and standards and other ward-based skills required for the housekeeper role.

Training away from the ward introduced the housekeeper to the other services they may encounter in hotel services and the wider Trust including estates, dietician, chaplaincy, security and infection control. Representatives from each department were involved in this training (rather than using the ward managers’ understanding of the services) which provided the ward housekeeper with greater knowledge of the functions they will be dealing with and the wider structure of the organisation.

A number of Trusts had introduced National Vocation Qualifications (NVQs) that the housekeepers could undertake such as in “customer-care” and cleaning and building interiors. Most Trusts were waiting for the introduction of the ward housekeeper NVQ that the UK organisation “skills for health” are currently developing in consultation with hospital managers and professional associations. Other Trusts had worked with local colleges to develop a hospitality award or customer service training which the staff found beneficial.

The development of a training manual for the housekeeper, which they could keep for day-to-day referencing, was one particularly good example of best practice. Within this manual was information on the NHS Plan and how the housekeeper’s role fits into this, details of the NHS’ better hospital food initiative with serving and

presentation suggestions for meals, details of the NHS' patient environment action teams (PEAT), auditing and a service level agreement for the ward to communicate the standard expected of the service delivered.

Integration

The case studies demonstrated that failing to communicate effectively with both the clinical and non-clinical ward-based staff about the new addition to the ward has been shown to cause problems in some of the case studies. For example, domestic and catering staff were unwelcoming to the housekeeper at one Trust as they thought they were monitoring their work and occasionally undertook the same tasks as them, so they were uncertain about their own future on the ward and in the organisation. Auxiliary nurses were also concerned for similar reasons, which again highlights the importance of communicating with staff.

Management

The case studies showed that to avoid confusion or tension it was necessary to define clear lines of management for all involved in the housekeeper role. In many case studies the hotel services/FM departments took the lead on the role specification, advertising of the post, interviewing and the final recruitment of the housekeeper with some involvement from the ward manager. Once recruited though, the ward manager was given overall responsibility for the housekeeper including their rostering, holidays and organising cover.

Best practice guidance

The case studies demonstrate that a variety of approaches have been used in designing, recruiting and managing the ward housekeeper role that were influenced by the local management culture, conditions and the scope for adapting existing support provision to the hospital ward. However some areas of best practice are suggested that will contribute to the implementation of a successful ward housekeeper.

The research has shown that adopting a structured approach is crucial when designing the position, recruitment and implementation of the ward housekeeper role.

One of the most important aspects of the role is that it can be tailored to meet the needs of the ward. A generic job description should be developed jointly by FM and ward staff and then adapted to the specific requirements of the staff and ultimately the patients on the ward.

By involving ward staff in the development of the ward housekeeper role right from the start, it encourages their acceptance of the role as they understand its function and how it will assist their work load and promotes integration of the new member to their ward team once recruited.

The ward managers, nursing and other non-clinical staff should also be involved during the recruitment process. This helps to ensure that the right person is chosen for the job, and that he/she will perform the role to the clinical staffs' expectations, and will fit in with the ward team. Their involvement at this stage also helps to emphasise the role as being a member of the ward team.

Housekeepers should receive a full induction to the Trust, as is the case with all staff. The concept of identifying a "buddy" from the ward team who can act as a point of contact during their induction period is an effective one. The "buddy" can explain the ward structure, roles of the rest of the team and the general ethos within the ward. During the induction period the ward housekeeper should also be introduced to other hotel service departments, with which they may have to liaise; this enables them to understand the wider fabric of the organisation.

The training programme for the housekeeper should be structured and cover skills needed for use on the ward, in the wider department and the Trust. It ought to encompass the mandatory training for the NHS such as lifting and handling and health and safety. Ward-based training will cover catering and domestic duties, as well as understanding the structure of the ward and team members' roles and responsibilities that will help integrate the housekeeper into the ward philosophy.

The integration of the housekeeper into the ward team is considered most important to making the role successful, and is strongly recommended in the NHS Estates guidance (2001). As with any role the team integration will largely be down to individual personalities, however there are practices that can aid this. The "buy-in" from ward staff at an early stage will help gain their commitment to the role and may avoid any feelings that changes are being imposed. This can be done by involving them in the role's development so that they will be able to see the value of the new worker[6].

It is also important to explain the new role to other non-clinical staff on the ward, such as dedicated domestic or catering assistants, as they also need to accept the new worker for them to be fully integrated into the ward.

The ward manager or sister needs to have some form of management responsibility over the roles that the housekeepers undertake. Although they are initially involved in tailoring the generic job description to the needs of their ward, the role has to be flexible enough for the ward manager to be able to assign other tasks. This will avoid conflicts between the ward and hotel services/facilities departments and confusion for the housekeeper over who they are responsible to. Ideally the housekeeper should be treated like any other member of the ward team, which of course will help integration.

Ward housekeepers in the mental health setting

Much of the guidance for the ward housekeeper role given by the NHS has focused on its development and implementation in an acute hospital setting. Members of FMGC's NHS FM Research Fora this year commissioned case study research into the ward housekeeper role in the mental health setting to identify how the role needs to be adapted for this environment.

Four case studies have been undertaken in a variety of mental health settings ranging from acute, long-stay wards in hospitals to community extended care units, that are essentially homes in the community. A number of variations were identified in the ward housekeeper role due to the nature of the patients in these settings. The first difference is understanding that the community extended care units and long stay wards are essentially the patient's home and so 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 abilities and this is an important part of their treatment. Often patients/residents 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 residents' activities and be flexible to their needs, although they do still have the same core responsibilities as those identified for the acute ward housekeeper.

In these settings 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. A further responsibility of the ward housekeeper that is not common in the acute setting is the laundering, ironing and return of patient's clothing. Because of the time and equipment involved in undertaking these activities, the ward housekeeper tends to have the sole responsibility, but if the patients want to continue with this duty then the service must be sufficiently flexible to adapt.

The case studies also 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", with whom patients are happy to chat with and confide in, compared to the more formal arrangement that exists between patients and the nursing staff or doctors. One ward housekeeper in this setting explained the relationship they have with the patients:

... they [the patients] will come and talk to me about anything, I mean not necessarily problems they're having. They'll cuddle me [and say] "I'm glad you spoke to me". But I've got time for everyone, and I like it when I come on the ward and people say "ooh I missed you yesterday". They deserve having somebody sitting listening to them and I'll sit making beds and I'll chat away to them and I think they appreciate that.

Because of this informal contact, nurses or doctors occasionally approach the ward housekeeper and ask about what a particular patient has been talking about. In one of the case studies the ward housekeeper was observed chatting to a patient who would hardly talk. They were able to get a patient to eat who had not eaten for three days because they knew the patient from a previous stay and remembered their dietary preferences. The significance of the ward housekeeper role as an “information gateway” between patients and doctors is highly valuable, arguably more so in a mental health unit than an acute ward.

This year’s research has highlighted several areas in which the ward housekeeper role in the mental health setting is different from that in the acute setting. As found in the original research though, it is important for the ward housekeeper role to be tailored to the needs of the patients on the ward and this appears to be where the fundamental differences are in the mental health setting.

Conclusion

Overall the housekeeper role is one that is highly valued by ward clinical staff and welcomed where it has been introduced. The main aim of the role is to take non-clinical duties off clinical staff so they can spend more time with patients. Previously nurses were responsible for monitoring and ordering stores and supplies, organising repairs, maintenance and chasing these jobs as well as the general tidiness of the ward, all of which leaves them little time to spend with the patients. At those Trusts where the housekeeper role has recently been introduced, clinical staff see the benefit most since the previous way of working is all too clear to them and still exists on other wards. They are now able to go to a cupboard and the supply will be there rather than chasing round to see where it has been left or find they have run out. The value of the role was summarised by one nurse as:

My cupboards are tidy for the first time ever, I can put my hands on things, my stock rotations’ correct, I know I never have to look in the kitchen and think what a mess cause everything’s done ... its how I want my house to be!

The feeling of being needed, appreciated and respected also encourages the worker to take pride in their work to provide a better service to their colleagues and the patients. The variety in the role and ownership of the ward is also a fundamental contribution to the worker’s job satisfaction. As one ward housekeeper commented:

I really love the job, I’m so glad that I changed and I don’t think I will ever be bored on here, you don’t have time to think about being bored. I really think it is the best thing that I’ve ever done and when I first came on here I was like “heck it’s a bit scary” but now I think it’s great.

In May 2002 Doncaster and South Humber NHS Trust evaluated the implementation of their ward housekeeping service. During the trial the Trust assessed the time spent by staff on catering and household tasks before and after the implementation

of the ward housekeeper. The quantitative data showed that after the ward housekeeper was introduced, nursing time spent on the non-clinical tasks was significantly reduced. The data also showed that the percentage of patients who thought that the food service was rushed fell from 31.4 per cent to 11.4 per cent of patients (NHS Estates, 2003).

The research conducted by FMGC and Doncaster and South Humber NHS Trust has illustrated where a significant reduction in the time spent by nurses undertaking non-clinical work can be achieved as a result of implementing ward housekeepers. The best practise described in this paper has shown that where the housekeeper role has been successfully implemented there is a clear benefit reported from both clinical and non-clinical staff.

Notes

1. This refers to NHS Trusts in England only.
2. http://patientexperience.nhsestates.gov.uk/bhf/bhf_content/home/home.asp (accessed 22 April 2003).
3. The executive agency of the Department of Health responsible for hospital estates and facilities management.
4. www.nhsestates.gov.uk/patient_environment/index.asp?submenu_ID=ward_housekeeping (accessed 13 March 2003).
5. This meant the ability to offer higher pay.
6. FMGC are currently involved in research with the University of Leeds and East Sussex Hospitals NHS Trust to evaluate the integration of a ward co-ordinator (housekeeper) role into the ward team using the practice development model.

References

Akhlaghi, F., Mahony, E. (1997), "Service integration and multiskilling in facilities management within the UK National Health Service", *Facilities*, Vol. 15 No.3-4.

Department of Health (2000), *The NHS Plan: A Plan for Investment. A Plan for Reform*, HMSO, London.

Mahony, E., Price, I., Akhlaghi, F. (1997), "Multiskilling, generic working and the unwritten rules of the game in NHS Trusts", *Health Service FM Research and Application Forum*, Sheffield Hallam University, Sheffield.

NHS Estates (2001), *Housekeeping – A First Guide to New, Modern and Dependable Ward Housekeeping Services in the NHS*, HMSO, London.

NHS Estates (2001), *National Standards of Cleanliness for the NHS*, HMSO, London.

NHS Estates (2003), "The word on the ward", *Ward Housekeeping Newsletter*, HMSO, Leeds.