



RESEARCH

Caring Relations at the Margins of Neurological Care Home Life: The Role of 'Hotel Service' Staff in Brain Injury Rehabilitation

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Context: Domestic staff in hospitals and aged long-term care have been shown to perform a range of caring roles alongside their cleaning work.

Objective: This paper explores the roles these people and other 'hotel service staff' (catering, domestic, maintenance, finance and administrative) play in the rehabilitation of people with brain injuries residing in long-term care settings.

Methods: This research draws on in-depth ethnographic data collected in 2014–15 over five months at two neurological long-term care settings in the UK; including interviews and observations of day-to-day happenings in the lives of around 60 brain injured residents and the work of 16 hotel service staff. The data was subject to a situational analysis – underpinned by grounded theory and discourse analysis.

Findings: Hotel service staff contribute to and compliment the rehabilitation of patients' cognitive skills, communication and physical functioning, and provide opportunities for occupation and interaction. The therapeutic accomplishments achieved by involving patients in mundane tasks of everyday life (e.g., gardening, managing money, sharing food), fit with the aims of more 'formalized' rehabilitation – to restore patients' abilities to carry out 'activities of daily living'.

Limitations: This study has been unable to fully explicate how hotel service staff have, or gain, the skills to interact so positively with brain injured residents. The study was confined to two sites and may not be reflective of practice elsewhere.

Implications: The study findings highlight how the work and interactions of hotel service staff contribute not only to care but to the *rehabilitation* of people with severe brain injuries. This has implications for service design as well as health and social care education.

Keywords: Brain injury; neurological long-term care; non-clinical workers; therapy; rehabilitation; domestic staff

Context

Acquired brain injury rehabilitation

Acquired brain injuries (ABI) can result in catastrophic impairments that are life changing. Often affecting previously healthy individuals, ABI is one of the leading causes of death and disability in younger adults (aged under 40) in the western world (Maas, Stocchetti and Bullock, 2008). Injuries are caused by incidents such as road traffic accidents, falls, sporting injuries or assaults (Kraus and McArthur, 2006), cerebral vascular events such as stroke (infarct or haemorrhage), hypoxia, encephalitis or viral infection (Owen, 2008).

Once physiologically stabilized, brain injury survivors enter a rehabilitative period. Although not all patients receive it, at the centre of brain injury rehabilitation (and

neurological rehabilitation more broadly) is assessment and treatment by a multidisciplinary or specialist team (Wressle et al., 1999; Turner-Stokes et al., 2005; Wade, 2015). Those considered core to this team are consultant physicians, nurses, physiotherapists, occupational therapists, speech and language therapists, clinical psychologists, rehabilitation assistants, and social workers (Brasure et al., 2013; Karol, 2014; Pierce and McLaren, 2014; British Society of Rehabilitation Medicine, 2019). In terms of rehabilitation these professionals (depending on, and linked to, their diverse professional discipline/training), focus broadly on five key intertwined rehabilitative domains – cognition, occupation, physical functioning, communication, behaviour/sociability (Turner-Stokes et al., 2005; Triogros et al., 2014).

Restoring function – the ability to carry out activities of everyday life, through the practice of these tasks and/or the development of problem-solving skills to adapt to chronic impairments – is synonymous with much rehabilitative

practice. There are, however, vast differences in rehabilitative approaches offered to achieve this, particularly in how everyday tasks are approached and practiced. Rehabilitation which focusses predominantly on the conduct and practice of everyday tasks within a meaningful context is considered to be a functional rehabilitative approach, such as that of a neurofunctional approach developed for people with severe brain injury. This approach is characterised as 'learning by doing and occurs within the client's natural environment or as close to this environment as possible.' (Clark-Wilson, Giles and Baxter, 2014, pp.1647). It is this functional aim and practice of rehabilitation in everyday contexts which is a core focus of this paper.

Long-term neurological care and rehabilitation centres

Younger adults with brain injuries are recognized as being able to make improvements, both functional and neurological, over a much longer period of time compared to older people (Turner-Stokes et al., 2005). Such younger patients can therefore be provided with formalized rehabilitation over years rather than months. Length of stay in rehabilitation beds in the United Kingdom within Level 1 Specialist Units in National Health Service (NHS) settings are, however, often capped at 6 months for most patients' post-acute care. Once this time has passed, patients whose recovery is far from complete, who have multiple and complex needs, and are unable to return home may then be transferred from NHS services to rehabilitation centres or specialist neurological nursing homes owned and run by charities or independent health care companies (British Society of Rehabilitation Medicine, 2013). Due to insufficient NHS rehabilitative beds (All-Party Parliamentary Group on Acquired Brain Injury, 2018) and neurorehabilitation provision in the community (Clark-Wilson and Holloway, 2015; Clark-Wilson et al., 2016), these patients can reside in specialised long-term care settings for many months or years; some, though not all, receiving multidisciplinary rehabilitation. Although these places of care offer only a fraction of the rehabilitation services and long-term care needs of the severely brain injured population in the UK, they are key sites for studying the delivery of rehabilitative services in long-term care.

While the core set of professionals named earlier work with patients over long periods of time, there are others who provide services for severely brain injured people in these care settings. These include cleaners, cooks, maintenance personnel and administrative staff, people collectively referred to here as 'hotel service staff'.

Hotel service staff working in care settings

The contribution hotel service staff make to health and long-term care has received some limited attention in the literature. The contributions cleaners in particular make to the health of patients and staff and the caring role their interactions provide has been explored in hospitals and aged long-term care settings (e.g., Messing, 1998; Denton et al., 2005; Dancer et al., 2009; Chesley and Richard, 2004). The role they play in infection control is widely acknowledged (Dancer, 1999; Wu et al., 2005), with the

relational role cleaning staff also play in care slowly being recognised. For example, Jors et al. (2017), examined how cleaning staff on palliative care wards interact with seriously ill and dying patients, and Schulman-Green et al. (2005) explored the role cleaners and reception staff play in the care of cancer patients in pain. Both describe how the informality of a cleaners' role enables patients to express emotions about their condition/situation to them.

Similarly, Müller, Armstrong and Lowndes (2018) describes the care work of cleaners in long-term residential care in Canada, US, UK, Norway, Sweden and Germany, demonstrating how the relational work they do is an act of care and caring. In doing their work cleaners may develop relationships with residents to such a degree that they know resident preferences regarding food and clothing, and often provide additional small acts of care such as helping residents put on clothing.

Outside of this work however, little literature examines the role of such workers in long-term care, and especially long-term *neurological care*. Furthermore, little attention has been paid beyond cleaners to the contributions to care made by other hotel service staff. They are rarely defined as health care workers (Armstrong, Armstrong and Scott-Dixon, 2008) and are more readily compared to those working within hotel or tourism industries (Müller, Armstrong and Lowndes, 2018).

This paper examines the contribution hotel service staff make to the care of people with severe brain injuries in specialized neurological rehabilitation and long-term care settings.

Methodology

The data analysed here were collected as part of an ethnographic study of two neurological long-term care settings in England run by two independent care companies: Bracken Lodge and Goodleigh Hall. Exploring how the futures of people with severe ABI are conceptualized and shaped during their rehabilitation in these specialist units, over 500 hours of observations and 60 interviews with staff members, residents, and their families were conducted over a five-month period.

The two sites were purposively sampled as both serve patients with ABI as their largest resident population (although both also provide care for people with a range of different neurological conditions including neurodegenerative diseases such as multiple sclerosis and Huntington's disease). Observations were conducted in communal spaces, residents' bedrooms, therapy, nursing and management offices, corridors, gyms, kitchens, staff rooms, smoking areas and laundries. The conduct of observations in communal areas or at the bedside meant that the dominant presence of hotel service staff (their work and the interactions they have with patients) and the relative absence of the members of the core multidisciplinary team quickly became apparent and directed more focused observations and discussions with these non-clinical staff.

For this sub-study, fieldnotes of observations and informal conversations with 16 hotel service staff, (six housekeepers, one chef, two catering assistants, three administrators, and four maintenance personnel) and

audio recorded interviews with eight of these individuals (two housekeepers, one chef, two catering assistants, two administrators and one maintenance personnel) were analysed using situational analysis (Clark, 2011). The chef and maintenance personnel were male, the others were female. Participants were aged between nineteen and sixty years old. The majority were white British, but the sample also includes British-Afro-Caribbean, Eastern European and British-Asian participants.

Starting from a position of identifying social groups within the data collection sites, analytical questions posed by Clarke (2011) were used to work through the data, first asking questions of the data rather than using it to provide answers. Memos were made of themes, ideas, and reoccurring discourses identified which could be held to feed into more focused analysis or be discarded. From this initial position of fragmentation, the data were looked across and a process of relational analysis, as outlined by Clarke (2011), followed. This is a process where relations between elements (groups, practices, discourses), their nature, strength or weakness is drawn, to 'help the analyst to decide which stories – which relations – to pursue' (Clarke, 2011, p.102). It is this relational analysis which drew out and foregrounded the presence and contribution of hotel service staff and the findings reported here.

Ethical considerations

Ethical approval was obtained from the Social Care Research Ethics Committee. Application number 14/IEC08/0014. All participants reported on in this paper consented to being observed and/or interviewed. For all those who lacked capacity to consent on their own behalf, a personal consultee had advised their involvement would be consistent with their prior expressed values and beliefs. For further discussion about the involvement of people who lack capacity in this study see Latchem (2016).

Pseudonyms are used throughout. Due to the relatively small numbers of each type of worker and places of care some quotes are left unattributed, and at times, additional non-essential details may have been changed to increase anonymity and prevent jigsaw identification (Saunders, Kitzinger and Kitzinger, 2015).

Findings

Key practices/actions were identified which mapped onto each of the five key formal rehabilitative domains defined and delivered by clinical rehabilitative professionals: Cognition, physical function, occupation, communication, behaviour/sociability. The findings presented here explore how the work of hotel service staff and their interactions with patients fit each of these domains and echo the findings summarised about relational care in the work of Müller, Armstrong and Lowndes, 2018; Jors et al., 2017; and Schulman-Green et al., 2005.

The rehabilitative work of hotel service staff in neurological care

Cognition

The work of hotel service staff involves significant interaction with patients around complex social and functional

processes. Through the conducting of the everyday, these staff often assist residents whose abilities to communicate, interact, and remember are impaired – helping them with memory, orientation to time and place, and planning. For example, a finance administrator at Bracken Lodge interacts with residents as they come to her office to access or return money for safe keeping. The extract from field notes below charts one such scene.

[Luke, the resident, comes into the office and Ben, a carer, appears at the office door. Maxine, the administrator is standing at her desk searching through wallets and a cash tin containing individual patient money and financial information.]

Maxine [looking up at Luke enters the office]: *Luke wants his card.*

[Luke nods. Maxine stands behind her desk and holds a credit/debit card and a piece of paper looking at Luke.]

Maxine: *I'll give you the piece of paper. Have you got a pen?* [Looks at Ben.] *Luke wants to change his pin to one he can remember.*

[Maxine informs Luke that he needs to take the piece of paper with the pin number on it so that he can remember it. Maxine mouths to Luke what his pin number is. She tells Luke and Ben that they need to write down the new pin number once they've changed it so that Maxine can put it back with Luke's card in the money wallet when they come back in case Luke ever forgets the new number.]

Luke: *You've got enough money* [nods towards the money wallets on the table and the cash tin.]

Maxine: *How much do you want?*

Luke: *Three hundred.*

Maxine: *What for?*

Luke: *Going with mum.*

Ben: *He's going to [English town] with his mum to buy clothes.*

Maxine: *That'll have to last you all month, ok?*

Luke: *Ohhhkaay.*

[Maxine finishes the interaction by explaining to Luke that he needs to return any unspent money back to her so she can put it back into his 'account'.]

What Maxine has done here is to contextualise an everyday activity (the management of money) within a familiar real-life structure – a banking system to access and deposit money. Creating an interactive situation akin to a normal banking system, Maxine provides a process and structure which grounds Luke and enables his participation in an everyday activity which requires a series of executive and cognitive skills – including comprehension and planning.

In similar interactions Maxine could also be seen monitoring patients' understanding of the value of money and current prices of items, asking them what they are going to use money for and checking that they understand how much items cost. Brain injured patients can significantly under or over-estimate the cost of a train ticket, a meal out, or a packet of cigarettes and when they do Maxine corrects them. She

also has a protective, safeguarding, role: Talking to patients about the need to safeguard money; showing how money is locked away; reminding them that excess monies must be returned to her; and showing them how it goes back in to their individual money wallets, their own 'account'.

Maxine's technical work provides an informal banking system for patients, but her interactional work with them enables an opportunity for contextualising processes which both mimic and feed in to real life banking, accounting skills, understanding of today's contemporary costs, safeguarding monies, and co-designing adaptive strategies to combat short-term memory issues. While the impact or effectiveness of these interactions are not (and cannot) being assessed here, Maxine's actions 'fit' with cognitive rehabilitative techniques which a health care professional such as an occupational therapist would look at when assessing a patient's cognition and communication during a functional task such as banking.

Orientation to time and place

Health care providers (HCPs) working in brain injury rehabilitation continually assess whether or not the patient is orientated to time and place. In medical, nursing and therapeutic practices, this checking of orientation is often done as part of cognitive assessments but orientating the patient is also done as a practice, as an intervention. At Bracken Lodge and Goodleigh Hall – daily orientations were practiced as the one-off tasks of therapy or health care assistants, or combined within therapy sessions conducted by qualified professionals. Orientation as it is practiced is, in effect, a repetitive series of questions about calendar dates, days and clock time, about institution and geographical location. However, there is more to being orientated than orientation-as-practice, and to being orientated to any given moment, e.g., orientation to an individual community, to spring to summer, to lunch-time, or Christmas-time.

In comparison to the formalised therapeutic practice of orientation reported above, hotel service staff provide orientation for patients in ways more akin to a sense of local time. They do this through the routinisation of their work, for example cleaning of communal areas and patients' bedrooms at the same time each day. These repetitive working processes provide a sense of local time, specific to the setting but which passes and indicates the time of day in this place. The sounds of their work and their presence alone could act as a form of time-telling: The clattering of pans and cooking smells, the intensification of chatter, singing in the kitchen, and the arrival of catering staff on the unit announces that it is time for breakfast, lunch or dinner.

The passing by of maintenance personnel and their holding of brief conversations with residents is a further example of assisting orientation to local. In the observational extract below, maintenance man Mick orientates resident Dave to the time of year through a discussion about football.

[Maintenance man Mick walks through the dining room. Dave is sitting in his normal spot flicking through a newspaper.]

Mick: *Alright Dave*

Dave: *Yeah*

Mick: *Looking forward to the match of Saturday?*

Dave: *Yeah, what match?*

Mick: *The footie mate, it'll be the first match of the season.*

Through these daily practices and passing interactions, orientation is not a singular therapeutic practice but an ongoing and continual one, contributed to by all types of staff.

Physical function

Alongside cognitive needs, hotel service staff also aid patients with physical functioning. ABI can cause significant motor disturbances – abilities to both activate and control muscles and movement, co-ordination, and sensation can be severely damaged. Common in ABI are problems with oral-motor control (chewing and swallowing), mobility (moving, walking) and upper limb function (reaching, grasping).

At Bracken Lodge and Goodleigh Hall catering services paid real attention to the production and presentation of meals for patients who have modified diets, those requiring food of a certain consistency due to difficulties with chewing and/or swallowing. In addition, catering staff think about and through food to enhance both resident mealtime experience and create rehabilitative opportunities. For example, in an interview with catering assistants Allegra and Tracey, Allegra talks about how they use the colour of food to help residents who have pureed and fork-mashable foods to be able to identify what they are eating:

If we're making a stew, for example, you'd whack everything in a pan. To a person on a normal diet, you'd have a stew with mash and veg, but someone with a specific diet requirement like fork mash or puree, instead of putting the carrots in the stew, because when you blend it, the colour just looks a bit gooey, you cook it separately. So it's just the lamb, with the carrots with gravy and some mash [all separated on the plate] so you can actually distinguish, see what's what. It's nice for them to identify what they're having, and usually, the foods relate to colours and you know [what food is on the plate] so it helps. [Allegra – catering assistant]

Brain injured patients may have both altered taste and visual deficits so identifying foods can become very difficult for them. Allegra recognizes that food losing its form when pureed contributes to this problem. In response she separates food and enacts other techniques such as using food colour, shapes and space when plating puréed meals to assist patients in identifying what they are eating.

In terms of mobility, during an interview with a housekeeper, Ally highlights that when she is cleaning on the units and a resident comes to the cleaning trolley, she will walk with them.

When I am on the unit working regular...I suppose we give them quite a bit of attention really, give them a walk if they come to the trolley. [Ally – housekeeper]

Cleaners providing assistance with 'little things' is also noted by Müller, Armstrong and Lowndes (2018), with cleaners at an aged long-term care setting in Germany. In addition, some of the actions by hotel service staff at Goodleigh Hall and Bracken Lodge are undertaken with rehabilitative purposes in mind *and* with some understanding of rehabilitative principles.

The cross-over of their technical role with caring or even therapeutic activities was at times overtly recognised by hotel service staff. In an interview with catering assistant Allegra she highlighted how picking up small tasks normally attributed to carers was part of providing consistent care and support for residents.

Allegra: We've got an amazing team, we never, it's not been 'that's your job'. If Alex (health care assistant) asked me 'oh I just need to pop to the loo can you just look after Andy (resident) for me' we're there you know. The clients need consistency at the end of the day. They're looking at people with yellow tops and they associate the yellow tops are their carers, the people in aprons, they're the catering, but we tend not to keep it so, as much as they recognise that, we tend to mix and match on jobs and roles and responsibilities and you know, it's a family unit basically.

Elements of the technical work hotel service staff does can contribute to and enable the rehabilitative efforts of specialist staff (providing trial pureed food for a speech and language therapist) and the readiness to support rehabilitation (housekeepers walking with patients) contributes to aiding patients physical functioning. Beyond this, some hotel service staff demonstrated a capability to independently recognize patients' physical impairments and sought to build these concerns into the technical work they do. The attentions of these staff to the challenges that neurological deficits cause for patients in the everyday make a rehabilitative contribution and are also acts of care.

Occupation

A wide range of activities for patients are organised, run by, or supported by hotel service staff at Bracken Lodge and Goodleigh Hall. For example, at Goodleigh Hall, a gardening group was planned, organised, and run between a maintenance man, Geoff and therapy assistants. In one session the task was planting seeds. A group of five residents, all with very different impairments, attended. Residents welcomed others as they came in and asked how each other were – a level of engagement between them that wasn't visible day-to-day. They filled pots with soil and planted seeds – providing purposeful use of upper limb (arm and hand) function and meaningful practice of fine motor skills. Patients attended to the task while engaging in intermittent banter with one another and the

staff present, especially with Geoff. In addition, conversation about and through the task was generated: What seeds were being planted, how they had to be planted, how deep, and how long they would take to grow, etc. was discussed. This provided some patients with the opportunity to share their own gardening knowledge, with Geoff being there for the facts to be confirmed or corrected.

An example of Geoff's assistance and instruction around the gardening task is captured in this short field-note extract:

Geoff gives Louisa [therapy assistant] a packet of cucumber seeds and a pile of pots. There is an open bag of compost on the table. Louisa pushes soil into the pot and holds the pot for Tess [resident] to push her thumb in to make a hole. Geoff instructs that they need to put two seeds in each pot. Sally [occupational therapist] helps Matt [resident] fill pots with soil and he pushes courgette seeds in. Geoff explains to everyone that the seeds need to go in at an angle. Matt concentrates on his task with Sally.

At Bracken Lodge however 'occupation' was taken much further. Two maintenance men, Mick and Asher, engaged patients in maintenance work for the centre – including both residents currently rehabilitating and those who had left but were still requiring high levels of care in the community. Those still rehabilitating at the centre would work with Mick or Asher, being started with a few tasks such as painting rooms or basic plumbing. Patients were instructed step by step in their work, and some were afforded a broader work experience by being invited to take a break in the staff room. One such break is captured in this fieldnote excerpt:

Asher comes into the staff room with the resident Andy. Andy sits on the sofa and Asher makes him a drink. They talk about sports and what they like to do. There is lots of laughing and joking. Mick comes in and talks to Andy. He tells him how well he thinks he's done today and lists all the tasks he's helped them to complete that morning. He asks Andy if wants to do more work with them tomorrow. Andy says that yes, he would like to work with them again tomorrow.

For nursing and therapy staff working within Bracken Lodge, residents working with Mick and Asher was considered a key rehabilitative step – and something often more readily accepted by residents than formal therapy with qualified therapists. This is reflected in a fieldnote extract taken in a multidisciplinary team meeting:

Dean: He won't accept any therapy; we've tried therapy to improve his walking etc. [...] we need to think about what it is we are trying to achieve with him and to work towards getting the nod for a community package. I'd like to get him to college. [A dis-

cussion follows about the resident failing access courses].

Alice: *Could he start work with Mick again? Since he's been on this unit, he's been up no later than ten and showering every morning.*

For one man, Simon, who had been discharged from the rehabilitation centre and was now living with 24-hour support in the community, his work with Mick and Asher had led to part-time employment, as he had been contracted to work back in the centre three to four days a week. For Simon, not only did the work provide occupation and payment, but keeping his job required following rules and fulfilling certain requirements – attending to personal hygiene, for example. What was required of Simon in order to keep his job were discussed in a meeting with him, captured in the short fieldnote extract below.

Simon: *Mick has said that my job's still here if I want it. I want to come back, I like the money.*

Social Worker: *Are there any more stipulations about the work?*

Care Assistant: *Um, the personal hygiene was the main thing.*

Social Worker: *What hours was it before?*

Care Assistant: *Nine thirty 'til three thirty.*

(Dean [Nurse Manager] outlines to Simon that if he wants to come back to work and keep his job he needs to wash daily, turn up on time and to be free from drugs and alcohol during working hours. Simon is directly asked to confirm that he understands these requirements and to reconfirm whether or not he wants to work with Mick and Asher).

Alongside the technical work done by maintenance personnel at Goodleigh Hall and Bracken Lodge, the examples given above demonstrate how they also offer and create a variety of occupational opportunities for residents. Not only are these rehabilitative opportunities, but in the case of Simon, they also carry over into paid employment.

Personalisation, communication and everyday interaction with residents

Readily recognised in the work of Müller, Armstrong and Lowndes (2018), Jors et al. (2018), and Schulman-Green et al. (2005), is the ability of cleaning staff to learn about patients and come to know them well; so much so, they are often the first to identify that a resident is feeling unwell and reporting this to care staff (Müller, Armstrong and Lowndes, 2018, pp.59–60). Similarly, the hotel service staff at Bracken Lodge and Goodleigh Hall frequently demonstrated and put into action their knowledge of individual residents characters and preferences. For example, on hearing that Michael, a resident was being discharged, maintenance man Mick requested that a leaving cake be made for him – in the shape of a football shirt, and in the colours of the resident's favourite football team – Chelsea. This request was discussed in an interview with two catering assistants Allegra and Tracey.

Interviewer: *So I noticed the other day when Michael was leaving someone had made him a cake.*

Allegra: *Get me! Yeah*

Interviewer: *Whose idea was it to make him a cake?*

Alex: *I think Mick. We had him coming in going 'I wanna cake for Michael, a Chelsea one!'*

Allegra: *This is the perfect example of the, how we work well as a team because Mick is a maintenance manager, he's got naff all to do with care or cooking and he's come asking for a Chelsea cake for Michael.*

Learning about and remembering resident preferences is something that Allegra and Tracey demonstrated daily. With over 40 residents to cook for, they spent significant time getting to know what residents did and didn't like and who they were as people. While they made notes detailing the clinical needs of residents, they did not make notes about food preferences but instead memorised individual likes and dislikes with ease. In an interview with them, they spoke about how they get to know residents and focus menus around resident preferences.

Tracey: *We know what the clients like, we get to know them – like Sam loves cheese omelette's and things like that.*

Allegra: *Obviously as catering staff we have to make sure we give clients what they want. When a new client comes, the first thing we do is find out the dietary requirements, likes, dislikes so we get a general idea, and obviously as days and weeks go on we get a better understanding.*

[...]

Interviewer: *So do you write any of that down or do you just remember it?*

Allegra: *Nah we just remember it.*

The amount of time hotel service staff spends with or near residents has been noted by Müller, Armstrong and Lowndes (2018) as a key facilitator for the cleaning staff they studied getting to know residents, interacting, and building relationships with them. There are, however, many other ways, spaces, and methods through which cleaners/housekeepers and other hotel service staff get to know residents. For example, by working in the laundry and cleaning resident bedrooms housekeepers learn to recognise who items of clothing belong to, as in this fieldnote of an observation of a housekeeper working in the laundry:

Ally stands in the laundry ironing a pile of clothes. She irons a t-shirt, then holds it up saying *'This looks too big for Tony.'* before folding it and putting it away in the laundry trolley. Pam, holds up a chiffon top which she thinks is:

Pam: [...] *one of Carole's new ones.*

Ally: *There's not a tag on there now?*

Pam: *No. I'll put it in there and ask when I go up.*

[...]

Ally calls out to Pam and holds up a pair of pyjama bottoms for her to see.

Pam: *Um, what size are they?*

Ally: 16–18

Pam: *Juliet, they're Juliet's.*

More than that, through doing laundry, they also learn about the health and impairments of a resident. For example, they know the levels of (in)continence for each resident and if they have infections which means their laundry must be processed in a certain way. In the field-note extract below, housekeeper Ally reflects how types of bedding and doing residents' laundry tells them about their health and their care needs.

Ally begins to fold some towels from a load that Pam has just pulled out of the drier. As she folds, she tells me that the green and blue towels are used for residents with MRSA, and that they also have matching green bedding. She tells me that they once had a resident, who has now died 'bless him' but that they had to wash all of his bedding separately because he had an allergy, so serious it would cause –

Ally: *Ana, what is it called?*

Researcher: *Anaphylaxis*

Ally: *Anaphylaxis yeah.*

Hotel service staff also spend a significant amount of additional time interacting with residents. They could often be observed working in tandem with nursing/health care assistants, picking up interactions where health care assistants (HCA) left off to attend to other residents or take a break, as in this example of a cook taking over interaction with a resident from an HCA.

[HCA comes in from the corridor wearing a blue disposable apron and pushes a resident in a wheelchair. She wheels her up to a table and leaves. Cook comes in immediately after her and sits in a chair next to the resident.]

Cook: *Did you enjoy your food?*

Resident: *I'm starving*

Cook: *Do you want a yoghurt?*

[HCA's voice can be heard from the corridor]: *'Shall I get you one?'*

Cook: *Yeah please.*

In this short excerpt the HCA and cook swap roles, with the cook taking over interaction with the resident and the HCA collecting an item of food for the resident. Such quick (and always seamless) shifts between HCA and hotel service staff interactions with residents were a daily occurrence at Bracken Lodge. Often short in nature, they ensured residents were provided with frequent opportunities for interaction with staff and bought HCA staff the time they needed to take short breaks and/or attend to other residents with more immediate needs.

In interviews or conversations in corridors, hotel service staff were asked what they thought was good for or helpful to residents. They repeatedly reported that residents needed more stimulation than they received, staff that they trust and that know them, and the appropriate therapies to help them rehabilitate. Although these staff had a strong sense of what was good for

residents they often missed the magnitude of the positive impact they themselves had on residents' care and rehabilitation.

Having asked Hilary, a receptionist, how she found interacting with patients she responded:

I like speaking to them and I say morning to them, even, like Donovan, sometimes he'll put his hand up and whatever he can manage, but I always say hello or morning to them, I could never sit there and just ignore them [Hilary – administrator].

Donovan was profoundly impaired and his cognitive processing very slow, with a long delay between any command and action. Donovan being able to raise his hand in the moment – in response to Hilary's daily greeting – was something that was only being generated by her spontaneous social interaction with him.

The domestic and administrative staff across both sites talked about how the interactional work they did with patients gave them a feeling of worth and added value – something they did not feel they attained through the technical work they were employed to do. In a conversation with Megan (a housekeeper) at Bracken Lodge, while she was mopping the corridor floors, on asking her how she felt about her work, and how she came to work there she said:

Megan: *If I'd known what it'd involve, I wouldn't have gone for it, but it's too late now, I'm here and I love it.*

Researcher: *Why do you love it?*

Megan: *The people, people are really nice here [pause] and I've gotta sing to Frankie.*

Frankie is a young man who is minimally conscious. Staff who work regularly with Frankie believe that he recognises voices (although this had not been formally assessed at the point of data collection). Every day Megan cleans his room and sings as she cleans. She notes her singing to Frankie as an important part of her daily work. Ally, a housekeeper at Goodleigh Hall highlighted that her job entails much more than what is in its title.

We're housekeeper, part carer. Everyone has the same role – we're all responsible for the health and wellbeing of patients, in whatever way. [...] I like the interaction with patients. It gives you a bit of feeling of worth instead of mopping floors [Ally – housekeeper].

Interacting with patients, transforms the mundane technical work they do into care work, giving these staff an added sense of value and increasing job satisfaction. The presence and valuing of such interactions with residents is mirrored in the findings of the study by Schulman-Green et al. (2005) with non-licensed workers on an oncology unit and in the research by Jors et al. (2018) exploring the experiences of cleaning staff with dying patients on palliative hospital wards. Similarly to Megan's act of singing, cleaners in Schulman-Green et al.'s (2005) study highlight the role they can

play in cheering up or entertaining patient's in pain. During interviews and focus groups with palliative care cleaners, Jors et al. (2018) notes that many of this group consider the interaction they have with patients to be the best part of their job. Unlike hotel service staff at Bracken Lodge and Goodleigh Hall however, all of the hospital service staff reported on in the Schulman-Green et al. (2005) and Jors et al.'s (2018) studies were overtly aware that the informal conversations they had with patients made a positive contribution to the health of patients.

Behaviour

People with severe brain injuries often experience changes in personality and can display episodes of disinhibited behaviours such as physical and verbal aggression or the use of sexual language in inappropriate social contexts. Rehabilitative techniques to manage and improve behaviours that challenge include identifying triggers (antecedents) to the inappropriate/unwanted behaviour, assisting individuals to recognise that a behaviour is either desirable or inappropriate, de-escalating negative behaviours, and/or redirecting the attention of a brain injured person to trigger a positive change in behaviour.

Through their day-to-day observation and interaction with residents, hotel service staff at Bracken Lodge and Goodleigh Hall came to know residents in significant detail as highlighted above. At these locations, such knowing was implemented to support the management of behaviours that challenge. Hotel service staff were able to identify behavioural patterns and attempted to correct behaviour deemed inappropriate or dangerous. They did this primarily by using verbal prompts informing the resident that their behaviour was inappropriate, e.g. 'That's not a very nice thing to say, Mark,' and where appropriate, giving a short and single instruction requesting the resident cease their behaviour. Hotel service staff also recognise that single requests or statements are often ineffectual at managing changing behaviour and so their prompts are often followed by an attempt to distract or re-direct. This is done by either attempting to engage the resident in conversation, i.e.: 'I saw your mum came in to

see you last night,' or an attempt to re-orientate with the reminder of a forthcoming event, i.e.: 'Come and sit down, dinner will be ready in a minute,' all of which relied upon knowing detailed social context of each resident and their likely response to any instruction/intervention.

Hotel service staff also make significant contributions which appear to positively affect patients' mood and behaviour through the provision of occupational tasks, conversation and socialising opportunities. For example, at one site, an entire afternoon of entertainment was organised by Asher, one of the maintenance men. The party was arranged weeks in advance and everyone was invited. Asher cooked for all the patients, staff, and visitors aided by the regular chef and the catering assistants. A band set up on the lawn and at mid-day everyone gathered inside and out and ate/were fed. Residents who often appeared depressed, danced; men who frequently displayed aggression and fought with one another sat together talking and joking. Staff themselves identified the positive impact the event had on residents. From fieldnotes taken at the party, health care assistant Marta reflected: 'Jack hasn't cursed once since he's been out there and he's forgotten the pain in his leg,' and points out three male residents who normally fight or swear at one another are instead sitting together, laughing and joking.

Sociability/social inclusion

At both sites, food is the centre of all celebrations. Catering staff create seasonal spreads, which include pureed, fork-mashable, and normal diet options creatively presented as demonstrated in the Halloween feast prepared at Goodleigh Hall pictured in **Figure 1**.

Catering assistants spoke about how they made sure that at celebrations, everyone is enabled to be included and eat (or taste) the same food (if not entirely fed by percutaneous endoscopic gastrostomy) by it being carefully modified. In an interview with catering assistant Allegra she explains:

We got bonfire night coming up so we'll do some research. Obviously, they'll be the normal diet clients,



Figure 1: An inclusive Halloween feast.

the fork-mashable ones, we'll see what we can combine. We had the [themed] day, the normal [diets] had [flavoured] chicken, the fork-mashables and the purees had the same thing but we just had to make sure there was no bone in the chicken, so, they're enjoying the same foods, the same calories, same protein, same fun, same [flavoured] chicken but just different consistencies. It's just not making that person feel left out. [Allegra – catering assistant]

As noted above, hotel service staff think about the food they provide and how they provide it to keep patients safe while making it engaging and enjoyable, but also how they can use food to express and celebrate cultural diversity within the care setting to enable inclusion through sharing food at social events and celebrations.

These findings support previous research highlighting the relational care that cleaners provide in care settings and adds to this literature in three key ways. First, it demonstrates that such acts of care by cleaners are carried out not only in hospitals and aged care homes but also in the care of younger people in specialist neurological long-term care settings. Second, it demonstrates that the caring acts predominantly attributed to cleaners in the literature are also conducted (albeit in different ways) by a broader range of hotel service staff. Finally, it highlights how hotel service staff contribute to not only the care but also the rehabilitation of patients with severe brain injury.

Limitations

Although these findings demonstrate the caring and rehabilitative acts of hotel service staff, this research does not illuminate how they learn to interact with residents. Neither does it indicate if interactions with or observations of rehabilitative professionals influence what they do. It also does not attend in any depth to the needs these staff may have in interacting with people with complex neurological conditions and associated impairments. Finally, the research was conducted in two sites, which may not be representative of other settings.

Discussion and Implications

Hotel service staff contribute to rehabilitation through the technical work they carry out which provides a service or fulfils a variety of day-to-day needs: Providing food, a clean environment, and maintaining the working of everyday things. They also carry out their work with the needs and impairments of patients in mind. In doing so they conduct their work in a way that acts as forms of rehabilitation – particularly akin to the approach offered by functional rehabilitation described earlier. Food is not just prepared, it is specially adapted and presented to assist the meeting of nutritional needs alongside helping patients to overcome visual deficits, potentially enabling more self-feeding. Interactions about money are crafted into informal cognitive sessions assisting with processing skills, memory, and orientation.

How hotel service staff conduct their technical job roles and what they do in addition, in their interactions with patients' maps directly to the areas and key concerns of

rehabilitation conducted by qualified HCPs. The identification of this informal rehabilitative work is important because hotel service staff achieve positive responses and interaction with brain injured patients which are not always generated in, or by, formalized therapeutic treatment sessions. It is important then that their interactions with patients are recognised, supported, respected, and go uninterrupted.

The relational acts of care, and the importance of them may be best understood as humanising practices: Practices of care which uphold particular views or values of what it means to be human (Todres, Galvin and Holloway, 2009). This concept and much related work arose in response to the Francis report (2013) which exposed systemic care failings at Mid Staffordshire Foundation NHS Trust, and demonstrated how a focus on meeting operational targets had, in part, prevented a focus on meeting patients' basic human needs, which in turn resulted in poor-quality care (Scammell and Tait, 2014).

The provision of such humanising care – or acts which fit with similar concepts (e.g. compassionate care), now populate a plethora of national, international, and care sector-based policies and guidance (e.g. Care Standards Act 2000; NHS Commissioning Board, 2012; The Health and Social Care Act 2008; Welsh Government Health and Care Standards, 2015; Australian Health Ministers' Advisory Council, 2017; Patient Experience Improvement Framework, 2018). For care providers attempting to fulfil such policies and for policy makers seeking new ways to direct care provision, the inclusion of the role and opportunity provided by the work of hotel service staff could make an important addition.

Through the provision of acts of care which are arguably at the heart of providing compassionate and humanised care, hotel service staff are not just *other* members of staff (defined by what they are not e.g., non-clinical or un-registered) but in practice are part of the care team. It is critical to note that as part of the care team, like all other members, they are not only *sources* of care provision and information but in *need* of information themselves in order to conduct their work in ways which compliment or contribute to patients' care and rehabilitation.

These staff notice and get to know patients in unique ways through the routinization of their work. They are therefore an important source of information about patients' behavioural patterns, mood, social capabilities, and functional capabilities. Through such close proximity to residents and their involvement in their care, as well as the, at times, distressing reality of profound impairment, they are exposed to the perils of healthcare work like all other health care professionals. Latchem's (2017) work is a source of further information about the experience of hotel service staff caring for patients with neurological conditions. Care organisations, and in-particular, those responsible for induction programmes, therefore need to ensure that new hotel service staff are supported as they deal with the perils of working in these places and as they get used to how neurological conditions affect persons.

Hotel service staff, as presented above, readily recognise how care formed part of their role but also noted how

the interactional work they did with patients gave them a feeling of worth and added value – something additional to anything attained through their technical work. Recognising that caring interactions are a part of these workers jobs, that they are valuable within the care service, and that providing suitable education, support, and space for those interactions to occur should play a part informing job descriptions, recruitment processes – and improve the retention of staff employed, for whom turnover can be high (Zuberi, 2013).

Given the importance of interactions such as those highlighted here between hotel service staff and residents, there may be scope for these relations to be utilized further and/or expanded, both for the sake of patients and for these staff who find value and worth in their interactions with residents which they don't always get from the routinisation of their technical work. Could, for example, residents be aided by housekeepers and other hotel staff to help put laundry away, to lay tables, or to replenish supply cupboards? And can other places of care learn from the maintenance men at Bracken Lodge in providing opportunities for residents to carry out real work. While it is evident that such interactions are achieved in other care settings internationally and that (in some settings) hotel service staff already work extensively with residents, there may be scope for these staff to be better empowered, to be encouraged in their organisations to explore ideas which build interactional work with residents into their daily work, and to be given time to do it.

The value in, and effectiveness of, hotel service staff-resident relations seem to be generated through and in the everyday – spontaneously and naturally. Any attempt to formalize this interactional work could be disruptive. Instead, this paper advocates recognition of these people as part of the care team, respecting interactions they have with residents, and supporting hotel service staff-resident activities and engagement.

Conclusion

This research, through field observations and interviews, examined the work of hotel service staff in long-term care settings for people with ABI. It was found that residents' days are filled with critical interactions with staff not traditionally conceptualised as those doing rehabilitation. By focusing on the work and the everyday methods of core professionals interactions with patients, the extensive infrastructure surrounding care is hidden. As need for long-term care environments continue to grow, both in terms of an increasing elderly population and those who are younger with neurological conditions, a broadening of focus is needed in order to better understand these environments, the care delivered, and lives lived within them.

This research has shown that hotel service staff are not marginal to caring relations but central. They play a key, but often hidden and relatively unnoticed, role in both the residing and the rehabilitating of people with severe acquired brain injuries. Their work in humanizing care should be more actively examined and planned.

Acknowledgements

The author would like to thank the journal editor and reviewers for their helpful comments and suggested edits.

Funding Information

This research was funded by the Economic and Social Research Council.

Competing Interests

The author has no competing interests to declare.

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How to cite this article: Latchem-Hastings, J. 2021. Caring Relations at the Margins of Neurological Care Home Life: The Role of ‘Hotel Service’ Staff in Brain Injury Rehabilitation. *Journal of Long-Term Care*, (2021), pp. 12–23. DOI: <https://doi.org/10.31389/jltc.49>

Submitted: 06 August 2020

Accepted: 03 December 2020

Published: 18 January 2021

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