'A nursing-focused study of the permeation of top-down patient safety initiatives into the organisational culture in an NHS Trust'

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ABSTRACT

Since the 1990s patient safety has been recognised as a major concern within healthcare worldwide, as well as within the National Health Service (NHS). There is evidence to suggest that contact with healthcare can cause avoidable harm and unnecessary death. In the literature, these significant safety failings have often been linked to the prevailing organisational culture in the NHS. However, the exact nature of this culture and its connection to maintaining patient safety is unclear, despite the reported implementation of strategies to improve patient safety across the healthcare system. As a key staff group within the NHS, nurses have a key role to play in protecting the public and keeping them safe. However, the lack of clarity relating to the links between culture and patient safety initiatives potentially compromises the degree to which nurses can have a positive influence. This qualitative study therefore aimed to better understand, from a nursing perspective, the links between organisational culture and the implementation of patient safety initiatives in one NHS Foundation Trust in England. The following research question provided a focus for the study:

'How do top-down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust'?

A naturalistic inquiry methodology was used to gain an insight into the socially-constructed safety culture within the Trust. A purposive sampling method was used to recruit 16 participants. The sample comprised participants from the Trust executive team, the Trust operational management team, and 2 clinical ward teams, in order to capture staff perspectives from "board to ward". Data collection included individual interviews and focus groups with the participants about patient safety generally, and their involvement in a selected range of patient safety initiatives including: falls, medications, infection, recognising the sick patient, and pressure sores. Data were collected via direct observation of participants' practice in addition to a focus group and secondary data analysis of minutes from a range of Trust meetings. Thematic analysis of the data yielded seven themes: cultural consistency; safety initiatives and focus; communication; measurement; development; leading and shaping; and communities of practice. It was also evident from the analysis that only one of the five safety initiatives had fully permeated from board to ward (falls), demonstrating an inefficient flow of information through the Trust. The outcome of the study suggested that "climate", rather than "culture", was perhaps a more sensitive indicator of the receptivity of the ward team to the implementation of top-down patient safety initiatives in the NHS Trust studied. It is suggested that rather than focussing on the intangible notion of a "safety culture" as an indicator of safety risk, "safety climate" perhaps offers a more appropriate alternative. Assessing the safety climate of an organisation, and settings within it, offers the opportunity to focus on concrete issues such as nursing staff behaviour and communication mechanisms. This allows identification of organisational barriers to information permeation, and implementation of change. This, in turn, will improve the patient safety climate in the NHS.

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I dedicate this study and thesis to my father Ivan. Dad, I know you would have been so proud of my achievements. Dad, I don't think I ever told you that I loved you in the short years we had together, but I'm saying it now. I LOVE YOU.

DECLARATION

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others. The work has been done in collaboration with a local NHS Foundation Trust.

Any ethical clearance for the research presented in this thesis has been obtained. Approval has been sought and granted by the University Ethics Committee, and a local NHS Foundation Trust Research and Development Committee.

I declare that the word count of this thesis is 68,101 words

Name Anthony Conner

Signature

Date

CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

Patient safety is as much a concern today as it was in the time of Florence Nightingale, illustrated by the continuation of serious safety breaches which have caused patient harm worldwide. Dysfunctional healthcare organisational culture is often afforded the blame, however a definitive link is difficult to determine. Understanding how mistakes happen and how they can be prevented is an important step in reducing risks inherent in complex healthcare systems. Nursing is the largest profession working within healthcare and, as such, has considerable influence on the safety of patients. How nurses view patient safety within the organisation they work in and their associated behaviour are important considerations. This thesis explores the relationship between organisational culture and patient safety from a nursing perspective in one UK National Health Service (NHS) Foundation Trust. There is a dearth of research literature that focuses on all levels of NHS staff within a Trust; from the Chief Executive Officer on the board to the Health Care Assistant on the ward. This thesis aimed to gain multi-layered insights into the organisational culture and how this permeates throughout a Trust from 'Board to Ward' (Machell, Gough, & Stewart, 2009). This chapter provides an introduction, the rationale for the study and its aims. It concludes by setting out the structure of the thesis.

Why the focus upon patient safety?

I began working in healthcare in 1988, primarily in a critical care setting. This environment provided valuable insights into patient safety, and an understanding that some admitted patients from other areas could have been managed better medically. The Resuscitation Council (UK) (2010) report that up to 80% of admissions to an intensive care unit could be prevented with improved recognition of patient deterioration. Within the United Kingdom (UK), approximately 850,000 patients will experience some adverse event within a healthcare establishment and, of these, 25,000 per year have led to patient death (Vincent, 2010). It is important that individual healthcare practitioners are personally and professionally accountable for their actions, and ensure that they are safe practitioners. Systems and organisational culture also influence shortfalls in care. My interest in the complex concept of patient safety helped inform the development of this study.

1.2 AIMS OF THE STUDY

The aim of this study was to examine 'top-down' patient safety initiatives and organisational culture to better understand how safety initiatives can permeate throughout the layers of the organisation. To address this aim, the research question that guided this study was:

'How do top-down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust'

In order to address the aim of the study, the following questions were formulated.

1. How is organisational culture understood throughout the organisation? Do all staff from the Chief Executive to the ward team have the same understanding?
2. What safety initiatives have been conceived by the executive team, and how have these been communicated throughout the organisation?
3. How were the safety initiatives introduced on the ward? Were these understood, and how have they been implemented?
4. How do the executive team's conception of safety initiatives align with ward staff's implementation of them?

Structure of the thesis

This thesis comprises ten chapters.

Chapter 1 introduces the thesis, its origin in policy and practice, its aims and its structure.

Chapter 2 'sets the scene' for the study by presenting an analysis of the literature surrounding organisational culture. Some of the references presented are classical. This reflects a historical perspective on the concept of organisational culture. It is noted within this chapter that defining organisational culture is difficult. The literature that surrounds safety cultures and their historical development is analysed, and how safety cultures are recognised within healthcare is also discussed. Tools and techniques that have been developed to help create a safety culture, based on the premise that creating such a culture is achievable, are also discussed.

Chapter 3 analyses organisational culture within the NHS, providing background for answering the research question. Measurement instruments are explored, linking culture and performance. This will develop insights into the lack of a developed tool that can measure performance. The importance of leadership in promoting a safety culture is also discussed.

Chapter 4 details the methodology utilised within the study, including the sample, context and the analysis of the data. This chapter provides the rationale for the multi-dimensional approach used to study the multiple facets of culture and patient safety. Each phase of the research undertaken is presented.

Chapter 5 presents the themes that were generated from analysis of the interviews, focus groups, observations and the minutes from the executive and ward teams, supported by verbatim quotes and data extracts.

Chapter 6 provides a conceptual analysis of permeation providing greater insight into this terminology and its potential use in a patient safety context. This chapter also proposes a model to facilitate permeation of safety initiatives in an NHS Trust context.

Chapter 7 discusses the seven themes that have emerged from the analysis of the data, demonstrating how my research can advance theory and practice in this area.

Chapter 8 considers the strengths and limitations of the study, presenting recommendations for practice, education and research emerging from the findings.

Chapter 9 concludes the thesis by drawing together and summarising the key findings.

1.3 Conclusion

This chapter has identified patient safety as a concern within international healthcare. There is very little research that considers patient safety culture at all organisational levels from a nursing perspective within the context of UK NHS Foundation Trusts. The research question and aims of this study have given a focus for this study. The thesis structure has also been outlined. The following chapter explores the concept of organisational culture in more depth, to provide context for the study undertaken and this thesis.

CHAPTER 2 ORGANISATIONAL CULTURE

2.1 INTRODUCTION

This chapter examines the concept of organisational culture and its application to healthcare. It explores concepts of culture generally, organisational culture, and the complexities and challenges of their investigation. For the purpose of this study, a working definition is presented, informed by the literature, acknowledging the difficulties in establishing a definitive definition. There is also a focus on the concept of safety culture, the focus of this thesis.

2.2 DEFINITIONS OF CULTURE

Despite its use in everyday language, finding a definitive definition of the term culture is elusive. Cultural definitions are often multi-factorial and context-dependant, i.e. they are often constructed by individuals around a particular context. Smith (2001) suggested that culture is surprisingly difficult to define. Williams (1976) suggested that culture is one of the two or three most complicated words in the English language to define. The very notion of defining culture is further complicated by Tharp (2009), who postulated not only that a fixed universal understanding of culture does not exist, but also that there is little consensus within and across disciplines. Konteh, Mannion and Davies (2011) supported Smith, Williams and Tharp by suggesting that there is no clear agreement on the definition of culture.

Clegg, Kornberger and Pitis (2011) suggested that culture has its own complex history that stretches back long before organisational theorists began to study it. While it is suggested that this concept has been studied for over a hundred years by anthropologists, psychologists, sociologists and business management gurus, each discipline has struggled to find a definitive definition of 'culture' (Straub et al 2002; Groeschl & Doherty, 2000). Kroeber and Kluckholm (1952) identified over 164 differing definitions of the term 'culture', however within the literature the number varies from 156 to 164 (Seel, 2000; Straub, Loch, Evaristo, Karahanna & Strite, 2002). Ajiferuke and Boddewyns (1970) reported that culture is one of those things that defies a single all-purpose definition, whilst White (1959) reinforced a consensus view that it is difficult to define.

Seel (2000) warned that a definitive definition of culture may be unhelpful since it may result in a view that culture is a concept or a state that belongs to an organisation. There is a wide difference in opinions as to what culture actually means and whether there is a need for a definition of the term culture at all. Tayeb (1994) agreed with the notion that there is a lack of definition surrounding culture and suggested that culture is too fundamental to lend itself to a definitive definition. Tayeb (1994) also supported Hofstede (1983) by suggesting that culture is too complex a concept to label, and that that there is no commonly accepted language to describe a complex thing such as a culture. Arguably, culture is entirely subjective, existing as a socially constructed

concept amongst individuals in a given context. One reason for the lack of clarity is that culture is a term used in a wide range of social sciences with a range of meanings:

> "The cultural world is the creation of man himself as he has learned how to manage nature and himself throughout his entire existence" (Blumenthal, 1940, p. 572)

One historical definition is that culture is man's creation, encompassing his knowledge, beliefs, morals, and attitudes, 'the analog of life' (Weiss, 1973, p. 1376). Williams (1976) proposed three uses of the term culture:

1. Intellectual, spiritual, and aesthetic development of an individual, group or society.
2. A range of intellectual and artistic activities and their products i.e. the arts.
3. The entire way of life, activities, beliefs and customs of a people, group or society.

The first two uses have been noted as the most common. The third, used by anthropologists, remains central to the definition of culture (Williams, 1976). This definition asserts that culture is found everywhere (Smith, 2001). If the definition of Smith is accepted and applied to everyday life, then culture involves people, and consists of the individual and their own values, basic assumptions, behaviour and interactions with others (Groeschl & Doherty, 2000).

Arguably, each person has their own unique and individual culture. Hofstede, Hofstede and Minkov (2010) proposed that each person has their own thinking, feeling, and way of acting that has been learnt throughout their life-time. This programming of the mind derives from a lifetime of learning, in which culture is shaped and developed through many social interactions, differing environments and consistent unwritten rules of their social world (Hofstede et al. 2010). Hofstede et al. (2010) further suggested that people are not born with culture; it is learned and developed.

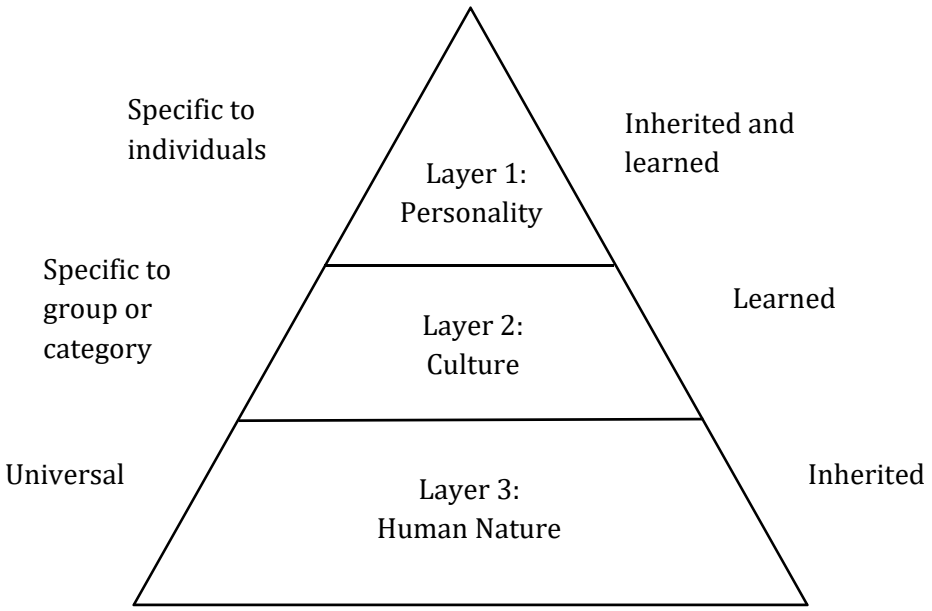


Figure 1: How humans act, think and are programmed

(Hofstede et al. 2010, p. 6).

Figure 1 demonstrates the three layers of human mental programming. Layer 1 is that of personality and is specific to the individual. It is made up of inherited and learned actions over an individual's life time. Layer 2 is separated from personality and represents culture. It can be seen as specific to a group. This layer is shaped by social learning, group behaviour, and environment. Layer 3 is human nature. This is universal to all, and can only be inherited. Culture differs from the person's personality and human nature, however where the boundaries lie between the layers is difficult to determine. Attempting to change the culture of a person would require consideration of the inherent impact of personality, and their own inherent human nature (Hofstede et al, 2010).

Figure 1 also demonstrates that culture is influenced and learned from others. However, individualism was defined by Bilton et al. (2002) as uniqueness, with each person having their own social qualities and idiosyncrasies, responsible for their own actions. This becomes less clear, however, when groups form. Wenger (2008) supported this by suggesting that people are interdependent of each other.

A group of interdependent members forms when individuals spend time within a socially constructed context. As a consequence, they begin to share a culture, for example by working as a team with the same goals. A social or group culture may emerge due to group influences and behaviours, as more of a micro-level culture than broader organisational culture. Willcoxson and Millett (2000) proposed that cultures are based within history, developing over time as groups establish clear patterns of behaviour. Lewis (1982) suggested culture is the integrated system of learned behaviour patterns which are characterised by members of a society, instilled from generation to generation. Schein (1992) supported this move from individual culture to that of a

social group culture by suggesting that the culture of a group develops from shared basic assumptions that result from shared experiences. Individuals can be influenced by others, with each person learning from a range of different social groups and their social environment. As a result, the individual begins to share a group culture with a 'bond' uniting that group. Culture in a group setting, therefore, consists of the collective values, basic assumptions and behaviour of a given group (Groeschl & Doherty, 2000; Schein, 1992; Lewis, 1982).

2.3 Defining organisational culture

Organisational culture has a complex history, as culture and organisations have been linked for at least 2,000 years (Clegg et al. 2011). However, the notion that an organisation has an identifiable culture was only recognised in the modern sense in the 1970s (Turner, 1971; Eldridge & Crombie, 1974; Pettigrew, 1979; Hofstede, 1980; Handy, 1999). The concept then gained further popularity in the early 1980s (Stanford, 2010). There was general agreement that every organisation has a culture, and that this develops from the social groups within that organisation (Brown, 1998; Peters & Waterman, 2004; Schein, 2010; Stanford, 2010; Clegg et al. 2011; Robbins & Judge, 2012). To some extent the literature that addresses organisational culture recognises that culture may be treated as a property of an organisation, i.e. something it possesses (Meek, 1988). However, this is in conflict with Seel (2000) who cautions against a definitive definition of culture. Most other authors have supported the existence of organisational culture, as something it has (an attribute) as opposed to something it is (a quality) (Scott, Mannion, Davies, & Marshall, 2003a). Therefore, Seel's perspective is somewhat at odds with the views of others. The idea of the organisation having a culture as an entity existing outside of the common beliefs or values of the organisational members was also challenged by Smircich (1983), who suggested that, collectively, members of the organisation are constituents of the culture. This belief is shared by Konteh et al. (2008), yet they suggested that organisational culture is still difficult to define due to overlapping and competing definitions. Konteh et al. (2008) further suggested that beliefs, values, attitudes and norms of behaviour are a shared way of thinking and behaving, helping to define what is legitimate and acceptable within a given organisation. Robbins and Judge (2012) proposed that it is the people within the organisation that recognise that culture exists, arguing that culture is hard to measure precisely. Robbins and Judge (2012) further suggested that organisational culture is the system in which there is shared meaning held by its members, and it is this shared meaning that differentiates them from other organisations. Schein (1992) shared these thoughts and identified that there are different levels of organisational culture: artefacts, espoused values and basic underlying assumptions:

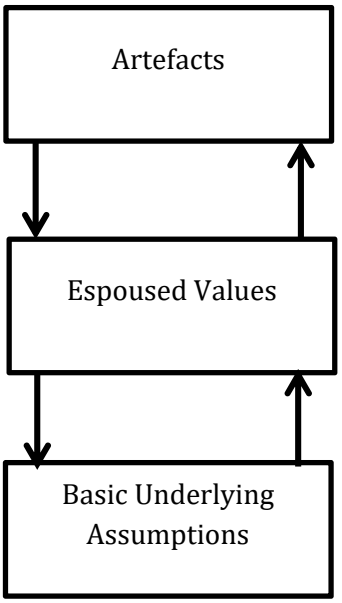


Figure 2: Levels of Organisational Culture (Schein, 1992, p. 17)

The artefacts, Schein et al. (1992) suggested, are superficial in that new members or outsiders of a group can see, hear and feel what is surrounding them. This includes the physical and social environment of that group. This superficial level is easily observed by the new member of a team, but they may be unaware of any deeper meaning of their experiences. **The espoused level** is less superficial and includes the strategies, goals and philosophies of the organisation. These are often seen as the moral and ethical codes of behaviour. Schein et al. (1992) conclude their model by suggesting that **the basic underlying assumptions** are the deepest level of culture. These are the accepted rules of the group, what works and what does not, and customs and practice within the organisation.

Brown (1998) added to the work of Schein (1992) by suggesting that the artefacts are the most visible and superficial manifestations of an organisation's culture. Indeed, Brown (1998) suggested that the term artefacts often refers to the total physically- and socially-constructed environment. The values and beliefs refer to the moral and ethical codes, and often determine what people think ought to be done. The basic underlying assumptions are the taken-for-granted solutions to identifiable problems. These are often held sub-consciously and are difficult to define, i.e. they are tacit in nature.

The figure below identifies Brown's (1998) perspective on the levels of organisational culture and their significance:

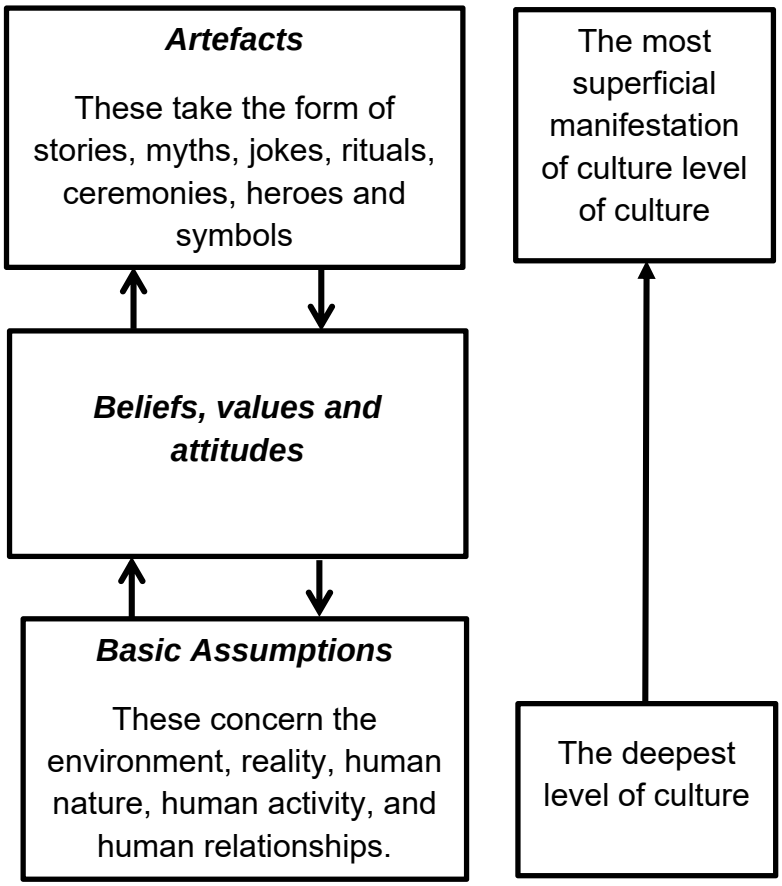


Figure 3: Levels of Culture and their Interaction (Brown, 1998, p. 12)

Johnson, Scholes and Whittington (2008) suggested that organisational culture also have three layers: **Values of the organisation,** which tends to be written down as statements, about the organisation's mission, objectives or strategy, but they can be vague; **Beliefs,** which are issues that people within the organisation can bring to the surface and talk about; and **Taken-for-granted assumptions** which are the core of the organisation's culture. They are the aspects of organisational life. From this perhaps simplistic view of organisational culture, Johnson et al. (2008) suggested that understanding culture at all levels is important, but not easy to achieve due to organisational complexity. They suggested The Cultural Web as a tool to help identify all of the influences that make up organisational culture. The web includes identification of both the taken-for-granted assumptions and the physical manifestations of organisational culture:

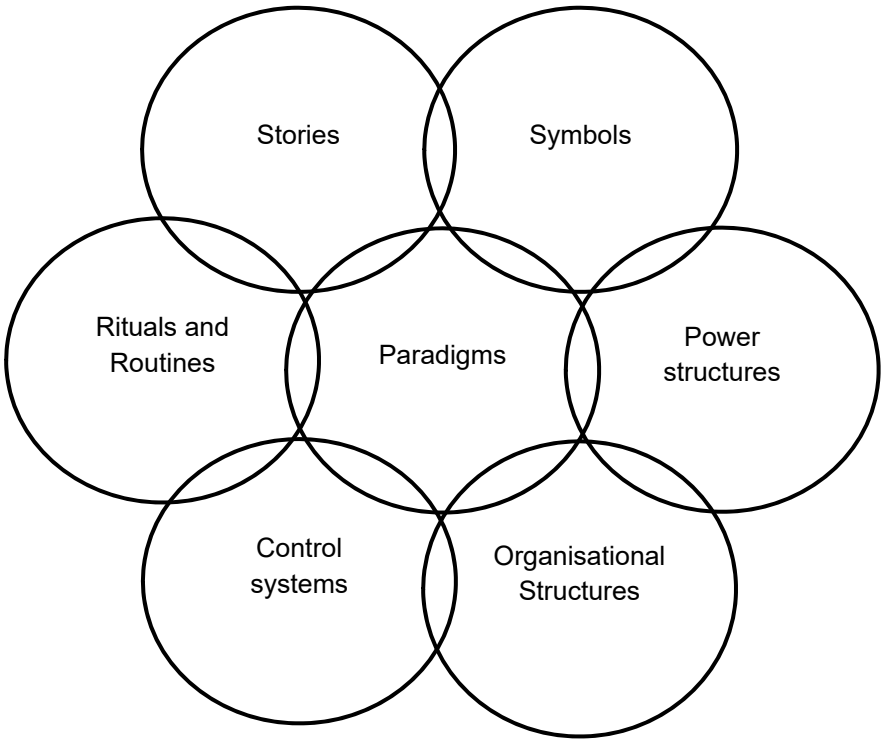


Figure 4: The cultural web (Johnson et al. 2008, p. 198)

Understanding the cultural web leads into insights and understanding of any organisation's behavioural, physical and symbolic manifestations of the culture (Johnson et al. 2008).

Paradigms	Organisation's core assumptions.
Rituals and routines	The way things are done on a day to day basis.
Stories	Told by members of the organisation to each other, outsiders and to new recruits.
Symbols	Are objects, events, acts or people that convey, maintain or create meaning over and above their functional purpose.
Power structures	The most powerful groupings within an organisation.
Organisational structure	Shows important roles and relationships.
Control systems	Measurement and reward systems and what is monitored within an organisation.

Table 1: Areas of the cultural web,(Johnson et al. 2008, p. 197)

Figure 4 demonstrates the seven areas within the cultural web. Johnson et al. (2008) suggest that to gain a thorough understanding of an organisation these dimensions need to be analysed. However, Brown (1998) suggested that it is also important to recognise the organisation's identity (who and what it is). This identity is more about the cognitive traits and behavioural characteristics that participants have, and less about assumptions, symbols and rituals. Significantly, Brown (1998) and Johnson et al. (2008) agreed on the importance of understanding the organisational culture.

2.3 The Sociological nature of culture

To analyse the idea of organisations and their culture, exploring the sociological nature of culture was helpful. Durkheim, a classical social theorist, suggested that culture is an emergent web of representations: a holistic approach, encompassing the deep set of values, beliefs and symbolic systems of a natural collective, such as tribal societies (Emirbayer, 1996; Daugherty 2007). Durkheim (1961) suggested that it is society that binds individuals inextricably to it, and that society represents their whole reality. This society is the culture of the group, and the culture is the sum of the people's collective efforts. It could be argued that, within an organisation, staff, as a "society", form inextricable links together through personal, professional relationships and the nature of their work. It could be assumed that they have a common purpose, for example to provide safe and effective care. Emirbayer (1996) suggested culture is a set of shared subjectivities that allow groups to act more cohesively. These shared subjectivities could be seen as the tasks and duties undertaken by the staff to provide safe healthcare. Daugherty (2007) cited Tylor (1871) to also recognised the link between a society and culture, explaining culture as the complex whole. This includes knowledge, beliefs, arts, morals, law, customs, and other capabilities and habits acquired by a human being as a member of a society. Durkheim and Tylor both suggested that culture and the society (or group) are interdependent on each other, with Weber (1930) proposing that culture is a cohesive building mechanism that binds a society together.

Durkheim developed the notion of a 'conscience collective' i.e. a shared set of subjectivities that allow a group to act more cohesively (Eckstein 1996). It is interesting to note that Durkheim, Tylor and Weber all dismissed the 'individual' as unimportant within a culture, and focussed more on groups and the members of a society as a collective. Brinkman (1999) concurred, proposing that culture is entirely outside of an individual, an 'autonomous entity'. Daugherty (2007) clarified this further by suggesting that individuals may internalise culture, but do not shape it, as culture is viewed as existing beyond the individual. It was apparent from this overview of the sociological perspective that culture forms around groups, and is constructed from their social interactions. This social constructivist perspective of culture provided this thesis with a theoretical framework to underpin the research.

2.4 Dysfunctional organisational culture

Organisational culture has been characterised as the 'glue that holds an organisation together' (Dennison, 2001, p. 347). Harrison and Stokes (1992) suggested organisational culture influences the behaviour of all individuals and groups within the organisation (Cameron & Quinn, 2006). Individuals within a culture, however, do not always have the same values as the organisation they work in, potentially leading to dysfunctional behaviour amongst individuals (Fleet & Griffin, 2006). It is interesting to reflect on Durkheim, Tylor and Weber's work here in that they discounted the individual, only seeing the group as influential. In contrast, Fleet and Griffin (2006) proposed the concept of individual destructiveness, in which dysfunctional behaviour can lead to decreased

efficiency, productivity and quality resulting in the interruption of services, and damage to the reputation and credibility of the organisation. Egan (1994) highlighted that culture can be overt but also covert, and that such covert behaviour can be dysfunctional and costly. Egan (1994) further suggested that the assumptions, beliefs, values and norms that drive the way we do things is the largest organisational control system because it affects not only overt organisational behaviour but also the shadow side behaviour (the dysfunctional side). This negative behaviour, at odds with the organisational culture was observed by Schein (1997) when he discussed workers' subcultures, which develop around the restriction of output and the hiding of ideas for improvement. This very idea that sub-cultures have such powerful influences over an organisation is well recognised, but the role of the organisation itself in the development of such sub-cultures is not well recognised (Fleet & Griffin, 2006).

Fleet and Griffin (2006) warned that the organisation itself has a pivotal role in allowing dysfunctional behaviour. Although it is a difficult task, organisations need to recognise any dysfunctional behaviour and address such threats early, because dysfunctional behaviour goes against the core values and beliefs of the organisations i.e. the culture. Lewicki, Greenberger & Coyne (2008) proposed that the idea of dysfunctional subcultures, or 'countercultures', are the result of the sub-culture members' values directly conflicting with the core values of the organisation. Balthazard, Cooke and Potter (2006) supported these views and added that dysfunctional organisations are synonymous with dysfunctional individuals who exhibit much lower effectiveness, efficiency and performance than their peers. Giacalone and Greenberg (1997) supported this idea and stated that dysfunctional behaviour falls within the category of anti-social behaviour, defined as any behaviour that brings harm, or is intended to bring harm, to an organisation, its employees or stakeholders (Fleet & Griffin, 2006). Fleet and Griffin (2006) suggested that anti-social behaviour can range from low levels of inappropriateness, to sabotage at the opposite end of the spectrum. For example, something as simple as not washing hands prior to any patient intervention could be regarded as engaging in anti-social behaviour or sabotage.

It was noted that organisational culture develops over time and is extremely powerful, and changing any dysfunctional culture is complex (Fleet & Griffin, 2006). To address this difficulty it was advocated that a joint responsibility approach could be applied by ensuring that every staff member understands, believes in and commits to the core values of the organisation. Cameron and Quinn (2006) appeared to contradict this in that they warned that these underlying values, assumptions, expectations, collective memories and definitions of an organisational culture are often taken for granted. If these are taken for granted, then the reason for this needs to be explored.

Lack of detection or problems within an organisational culture can lead to poor performance, resulting in failed changes within the organisation. (Cameron & Quinn, 2006). This lack of dysfunctional culture detection could be another factor in the non-congruence of the core values of

the organisation. Again, the need for the values of the organisation to be universally understood was reiterated by Martin (1992), who stated that there is a need for congruence throughout the organisation, as a lack of congruence will lead to a differentiation in perspectives and inconsistencies will lead to sub cultures. Within these subcultures individuals will perceive, remember, and interpret things in a way that is contradictory to the organisation.

The need to manage the organisational culture was recognised by Mannion, Davies and Marshall (2005), who identified that organisational culture is associated with performance. Peamelli et al. (2011) agreed and suggested that organisational culture is a necessary part of the healthcare reform, and culture needs to be measured in order to foster change and improved performance. Health care professionals are familiar with the concept of transforming organisational culture as the key to improving quality (Department of Health (DH), 2000b). However, Watterson (2010) stated that individuals need support in understanding the ways in which organisations can create and maintain a positive culture. Dysfunctional cultures can lead to poor performance, which in turn could lead to safety incidents, resulting in harm to patients.

2.5 Safety culture (the historical development)

The term safety culture emerged as a result of several catastrophic adverse incidents. For example, the 1986 Chernobyl nuclear power plant accident (Taylor, 2010; Lee, 1998; Cox & Flin, 1998), the Kings Cross fire, the Piper Alpha inquiry, and the train crash at Clapham Junction (Health and Safety Executive (HSE), 1999). Enquiries into these disasters suggested their cause was inadequate safety climates and safety cultures of the organisations (Advisory Committee on the Safety of Nuclear Institutions (ACSNI-HSC), 1993). As with the concept of culture, defining safety culture is difficult; despite a plethora of studies attempting to define and assess safety cultures in a number of high-risk industries (Zhang, Wiegmann, von Thaden, Sharma, & Mitchell, 2002). Hopkins (2006) warned that despite all that has been written about safety culture, there is no consensus on the meaning of this concept; further confusing the understanding of the term 'culture'.

ACSNI: HSC (1993) attempted a definition of a safety culture by stating:

> "the safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviours that determine the commitment to, and the style and proficiency of, an organisation's health and safety management" (ACSNI: HSC1993, p. 3)

There have been several attempts to define safety culture. Guldenmund (2000) linked it to organisational culture, and stated that a safety culture is an aspect of organisational culture, one which will impact on the attitudes and behaviour related to increasing or decreasing risk. Cooper (2000) supported this view and suggested that safety culture is just one 'sub facet' of organisational

culture which is thought to affect members' attitudes and behaviours in relation to an organisation's ongoing health and safety performance. Hale (2000) supported these views and suggested that it is the attitudes, beliefs and perceptions shared by natural groups as defining norms and values which determine how they act and react in relation to risks and risk control systems. Although all these definitions differ slightly, they all have the individual, as well as groups, at their focus (Zhang et al. 2002).

Taylor (2010) made the link between organisational culture and safety culture by applying Schein's generic organisational culture generic model of:

1. Beliefs
2. Espoused values
3. Attitudes
4. Artefacts
5. Behaviours

The combination of beliefs, espoused values, attitudes, artefacts and behaviours manifest through behaviours or human performance. All these are integral, and can be directly related, to safety culture. Reason (1997) suggested that these cultural factors play a key role in creating patient safety failures, and that organisational culture can affect the integrity of the safety system within an organisation. If culture, and therefore safety culture, lacks definition, then this could lead to misunderstanding of the concept. Schein (1997) warned that the lack of organisational definitions leads to confusion. Reason (1997) agreed and proposed that while defining organisational culture is complex, what is evident is that organisational culture is a major contributing factor to safety.

Johnson et al. (2009) supported the work of Reason (1997), and suggested that organisational culture is made up from the assumptions and beliefs shared by members of the organisation. The authors defined these as the 'taken-for-granted view'. These assumptions and beliefs are likely to be handed down over time within a group, and so any dysfunctional behaviour may also be passed down.

2.6 THE DEVELOPMENT OF THE NHS PATIENT SAFETY CULTURE

Creating a positive patient safety culture in healthcare and the NHS is a response to the ever-increasing number of medical errors and harmful events occurring within healthcare over the last fifteen years (Ehrich, 2006). Tackling such errors is recognised as an international priority in healthcare (Milligan & Dennis, 2004). Although medical errors and patient harm have been discussed and studied for over a century, the seriousness and extent of these was not recognised until recently (Vincent, 2010).

The first key report into safety failures in healthcare was published at the end of 1999 by the Institute of Medicine; *'To err is human'* (1999). This report concluded medical errors kill between 44,000 and 98,000 people per year within the United States of America (USA) (Kohn, Corrigan & Donaldson, 2000). It provided the following recommendations:

- The US Congress was advised to create a centre for patient safety.
- The development of a nationwide mandatory standardised reporting system was recommended.
- The development of voluntary reporting efforts was advised.
- It was advised that peer review protection should be extended to data related to patient safety.
- Health organisations and health professionals were advised to have performance standards and expectations focussed around patient safety programmes.
- Professional societies were advised to make a visible commitment to patient safety by establishing a permanent committee dedicated to safety improvement.
- The Food and Drug Administration was instructed to increase attention to the safe use of drugs.

These recommendations were the first of their kind in the USA to address the serious issue of people unnecessarily dying within healthcare. The report also identified that healthcare organisations should develop a culture of safety, and that reliability of care processes and the workforce should improve to maximise safety for patients. Vincent (2010) concurred, suggesting that the report is a stark, lucid and unarguable plea for action on patient safety at all levels of the healthcare system. This report was, without doubt, pivotal to the development of a patient safety culture, and raised public and political awareness significantly.

Similarly, the Department of Health (DH) (2000a) published a report recognising that the UK healthcare system also causes incidents of preventable deaths and harm to patients. In 2000, Vincent (2000) suggested there were approximately 25,000 deaths from preventable patient safety incidents each year. The DH (2000a) also suggested that out of all the admissions to UK hospitals per year, around 10%, or 850,000, patients will experience an adverse event. This has led to an

estimated £2 billion in additional hospital stay costs alone. This does not take into account litigation payments and the cost of human suffering. The World Health Organisation (WHO) (2009a) explored the issue of harm to patients in more detail and suggested that every year tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care. These high numbers may be only the tip of the iceberg, as WHO (2009a) stress that estimates of the size of the problem are imprecise.

The UK government (DH, 2000a) responded to the USA report (Institute of Medicine 1999) actions by producing a report entitled '*An Organisation with a Memory*'. This report was designed to outline NHS failings within healthcare, however it was recognised that the NHS reporting and information systems provided an incomplete picture of the scale and nature of the problem of serious failures within healthcare. The report recognised the importance of organisational safety culture, and its key role in the institutional context of adverse events. Furthermore, it suggested that, despite staff turnover, what needs to remain is an effective safety culture where people learn from, and respond to, failures. They further suggested that healthy safety cultures have a positive and quantifiable impact on the performance of organisations. Measuring performance and culture is difficult. However, the DH (2000a) proposed that an informed safety culture should have four critical sub-components

1. A reporting culture - people are prepared to report the errors or near misses.
2. A just culture - an atmosphere of trust in which people are encouraged to provide safety-related information, understanding acceptable and unacceptable behaviours.
3. A flexible culture - which respects the skills and abilities of frontline staff.
4. A learning culture - the willingness and competence to draw the appropriate conclusions from its safety information system.

The potential of safety cultures to have a very positive and quantifiable impact on the performance of organisations is well illustrated by the experiences found in industry and aviation contexts. Between 1981 and 1992, the Shell Oil Company experienced a number of accidents and six employees lost their lives. The accidents forced the organisation to critically analyse their practices (DH, 2000a). However, there are significant difficulties when comparing healthcare providers who treat the seriously ill, to non-healthcare organisations. It could be argued that industries like manufacturing use very protocol-driven procedures (rule governed) so that behaviours can be reproducible, for example in order to operate machinery in a consistent, safe manner. However, within healthcare the behaviour of individuals, including general reactions and reactions to treatment specifically, and their needs are unpredictable and variable, rendering protocol-driven practice difficult, or even inappropriate, at times.

Dennis (2005) suggested that following the publication of the *Organisation with a Memory* (DH, 2000a) the government recognised the need to address safety issues within the NHS, and thus

commissioned a statutory organisation in 2001 known as the National Patient Safety Agency (NPSA). Its statutory function was to:

1. Devise, implement and monitor a reporting system.
2. Collect and appraise information.
3. Provide advice and guidance.
4. Promote research and development.
5. Report to, and advise, ministers on matters affecting patient safety.

The first publication from the NPSA was *Seven Steps to Patient Safety* (NPSA, 2004). This publication identified the link between culture and patient safety; and how organisations could achieve their clinical governance goals through this new concept. It suggested that a safe organisation is an informed organisation. This document did recognise that changing a safety culture is a difficult task. It requires strong leadership, careful planning, monitoring and change at every level of the organisation. This publication provided a toolkit to help in the change process (NPSA, 2004).

The NPSA (2004) acknowledged for the first time that changing culture is difficult, and again recognised that culture is made up of values, beliefs and attitudes. As indicated earlier within this thesis, culture is also often comprised of assumptions, overlooked in analysis in safety failures. Schien (2010) also highlighted that culture can be defined as a pattern of shared basic assumptions, attitudes, values and beliefs. The DH (2000a) suggested that building a safety culture requires all staff, patients and carers to ask themselves, 'how can I help to improve the safety of patients?'

To build this safety culture, it is suggested that seven steps are vital (NPSA 2004):

1. Promote a safety culture that is open and fair for sharing information and ensuring lessons are learnt.
2. Demonstrate that patient safety is a top leadership priority, and foster effective teamwork.
3. Implement integrated risk management processes and routinely conduct organisation-wide assessments on the risk of error and incidents. Evaluate clinical care procedures, processes and the working environment.
4. Report patient safety incidents and identify trends. Give recognition for reporting incidents and safety-driven decision making.
5. Engage patients and families in their safety by asking them to provide feedback.
6. Undertake systematic investigations following incidents to guide continuous learning and system improvements.
7. Implement patient safety improvements that avoid reliance on memory and vigilance.

While these seven steps are concise and clear, in order to change the culture the hearts and minds of the individuals within the organisation need to be won. The challenge of changing to a safety culture led to the publication of the *Building a Safer NHS for Patients* (DH, 2006). This was to be used as a step-by-step guide to help implement the findings of the *Organisation with a Memory*. For the first time, not only were there safety recommendations, but a practical guide to implementing safety measures was provided, making a real change in the goal of safer care perhaps more achievable.

The publications discussed above provided a guide for organisations to help address the need to change their perceptions and behaviour to improve patient safety. However, while *Building a Safer NHS* (DH, 2006) suggested creating the right culture was a goal for increased patient safety, the complexity of this task was unacknowledged. The NHS Institute for Innovation and Improvement (NHS Institute) was established in 2005 to support the transformation of the NHS, through innovation, improvement and the adoption of best practice (NHS Institute, 2005). This facilitated the development of systems of safety across entire organisations, and provided structures to help to implement them (NHS Institute, 2005).

High Quality Care for all (DH, 2008) clearly identified the need for safe quality care, and putting the patients at the centre of healthcare delivery. Although in 2000 patient safety was afforded some priority within the NHS, a number of tragedies still followed including the inquiry from the Bristol Royal Infirmary (DH, 2001). This report investigated the care of children receiving complex heart surgery. The results from this investigation again linked culture with patient safety, suggesting the existence of 'club culture' (some team members belong and others are excluded) and a failure to put patients at the centre of care. The inquiry also found that there was a distinct lack of coordination, failure of communication, lack of leadership, and paternalism, resulting in a number of avoidable injuries and deaths to a number of very young children. Recommendations from the Inquiry (DH 2001) proposed that what is required to avoid similar tragedies are: a culture of safety and of quality; a culture of openness and of accountability; a culture of public service; and a culture of flexibility in which innovation can flourish in response to patients' needs'. It might be assumed that this type of incident would result in organisations at fault investigating their own services, in order to ensure that they had the patient at the centre of care, and generated a culture of openness to ensure future service quality and limiting reoccurrence of tragedies. However, evidence suggests this did not always occur.

The Health Care Commission (2009) published a report about their inquiry into high mortality rates, the number of complaints and poor care arising from Mid Staffordshire NHS Foundation Trust. The findings of the inquiry stated that the Trust lost sight of its real priorities in its drive to become a Foundation Trust. The inquiry found that the Trust Board and senior leaders did not develop an open and learning culture, but allowed the Trust to focus upon saving money without considering the effects of the cost saving on staffing and the quality of care delivered to patients.

The recommendations of the inquiry identified a number of actions for the Board:

1. Develop an open and learning culture.
2. Collect and report information accurately.
3. Identify and mitigate risks to the safety of its patients.
4. Identify correctly and then report on serious incidents and unexpected deaths.
5. Learn from incidents, near misses and complaints.
6. Engage clinicians and develop effective clinical audit.
7. Consider and act on views and experiences of patients and users of the service.

Again, the Trust was expected to develop an open and learning culture. As already identified, developing a culture is difficult, and three years later the same Trust was investigated again. A new inquiry concluded the Trust had developed an engrained culture of tolerance to poor standards. Indeed, the recommendations from the earlier report had not been carried out successfully. Instead, the culture remained dysfunctional, and one reason attributed to this was that of poor leadership and a tolerance of poor standards (Francis Report, 2013). Following this new inquiry a total of 290 recommendations to be actioned were developed. A common, caring culture was needed throughout the organisation, as well as leadership at every level. Another main focus was that of patient safety.

This realisation of poor standards of care led to the publication of *a promise to learn – a commitment to act, improving the safety of patients in England* by the National Advisory Group on the Safety of Patients in England (NAGSPE) (2013), led by Don Berwick. This document highlighted the failings of such hospitals, and made a promise to:

> *"Place the quality of patient care, especially patient safety above all other aims"*
>
> (NAGSPE, 2013, p. 4)

This report identified that there were still safety problems throughout the NHS, and too many patients and carers were suffering. There was an acknowledgement that:

1. Staff were not to blame, as most of the staff want to do a good job. Some of the blame must have been due to the working conditions.
2. Priorities were often not focussed on patient needs.
3. Warning signals were not responded to.
4. Responsibility was often diffused and not clearly owned.
5. There was poor support for improvement.
6. Fear was having a negative impact on consideration of safety and improvements.

Following these observations and findings, the NAGSPE (2013) highlighted the need for leadership, safety and learning, and also that achieving a safer NHS will depend far more on major cultural change than on a new regulatory system. This cultural change was also recognised by the DH (2000a) in their suggestion that NHS organisations need to develop an organisational culture that focuses on patient safety rather than a blame culture that can result in people covering up errors for fear of retribution (DH 2000a). England and Wales were not alone in recognising culture as an important aspect of safe patient care. The NHS Lothian Committees commissioned Price Waterhouse Cooper, a management consultancy organisation to carry out a review of 'waiting time management'. Their report showed that NHS Lothian had a blame culture that was a long-standing concern. As a result, staff used inappropriate management styles, and procedures for whistle blowing were not followed. Following the report, seven recommendations were made. These included improved leadership, and developing a values culture (Bowles and Associates 2012). It was evident that although lives were not lost, the NHS Lothian culture did impact on care as they had prolonged waiting times for procedures, and placed increased pressure on staff.

Attempting to improve the quality of healthcare so that it is clinically effective, person-centred and safe requires frontline practitioners to recognise that improvement is central, and requires an organisational culture that can connect with people's core values and imagination as a driver for grassroots change (Bate, Robert & Bevan, 2004). The phrases culture, organisational culture, safety culture, learning culture and no-blame culture are regularly used without recognising the challenges of developing them. According to Sovie (1993), the development of a healthy safety culture requires involving the people, using 'win-win' and 'non-blame' approaches, providing clarity of goals, objectives, purposes and tasks, focussing upon results, working from sound information, using change theory, integrating concern for people and achievements and emphasising the culture change. Sovie (1993) suggested that although it is the leaders who influence the culture, there is a need for them to fully understand the facets of the culture they are working in:

> *"Culture will trump rules, standards and control strategies every single time"*
>
> (NAGSPE, 2013, p. 11)

The growth of NHS safety culture is an important aspect of the overall culture of each NHS organisation (Gadd & Collins, 2002) and the broader NHS. However, as discussed, the notion of a positive safety culture remains poorly understood (Cooper, 2002). Vincent (2010) suggested that as with culture more generally, a safety culture also has multiple facets and meanings.

The definition of safety culture follows that of organisational culture in focussing on the way people behave and think in relation to safety. Safety culture has been identified as 'something an organisation has' rather than 'something an organisation is'. Safety culture is mainly viewed as comprising the values, beliefs and attitudes of social groups within the organisation i.e. an

interpretive, social constructivist view as opposed to a functionalist view (Cooper, 2002). Vincent (2010) and Schein (2010) both reinforced the definition of a safety culture as relating to and being influenced by the attitudes and values of individuals. This highlighted the importance that individuals share assumptions, beliefs and attitudes within a social group. However, not only is it important for the individuals to share assumptions, beliefs and attitudes but also the organisation as a whole to ensure that their views, values and beliefs are congruent with those of all members of the organisation. Culture is maintained and manifested in social processes and interaction. This includes every person in the organisation, from top to bottom and bottom to top, as everyone contributes, consciously or not, to its culture (Vincent, 2010).

It is vital that organisational culture is recognised throughout an organisation at every level, and if an organisation has culture as its attribute, it needs to be managed and nurtured. A safety culture is founded on the individual attributes and values of everyone in the organisation. Safety needs to be taken seriously at every level of the organisation (Vincent, 2010). As identified earlier in this chapter, dysfunctional behaviour can develop if values, assumptions, beliefs and attitudes are not shared, believed and congruent throughout the organisation. Trying to change or influence an organisation's culture is difficult, and engaging individual members is essential. Any change of organisation culture is dependent on the implementation of improved behaviours by individuals within the organisation that reinforce the new cultural values (Cameron & Quinn, 2006). Without changing the behaviours of the individual members within an organisation any change or influence of the implementation of a safety culture is likely to fail. Processes for enhancing and maintaining a safety culture need to be embedded and ongoing to avoid deterioration in standards (Vincent, 2010). Cooper (2002) suggested that culture does not operate in a vacuum; it affects, and in turn is affected by, other operational processes or organisational systems.

Sovie (1993) suggested that improving a safety culture requires the promotion of a shared ownership and commitment to the values of the organisation by every individual working there, regardless of their role. This requires permeation of the culture through every department and unit within an organisation. Sivie (1993) further suggested that permeation will help to ensure the organisation promotes and supports a structure where staff are encouraged to participate in problem solving and decision making. This permeation needs to reflect all aspects of the core business of every hospital, including patient care, education and research. Tingle (2008) warned that a patient safety culture is not always a priority of every nurse and doctor. Vincent (2010), similar to Sovie (1993), suggested that safety needs to be taken seriously at every level of the organisation. The importance of permeation was also recognised by Ashkanasy, Wilderom and Peterson (2000), who discussed the commitment of staff to 'goal alignment' (every member of staff having the same goals). This commitment creates symmetry, which promotes a more efficient organisation, leading to greater staff motivation (Ashkanasy et al. 2000). This notion of permeation of culture throughout

all levels of an organisation is clearly central to patient safety, yet few studies have explored this topic in depth. This gap in knowledge is addressed in this thesis.

2.7 Chapter summary

Culture is a result of influences by peers, family, and everyday experiences; it is informed by personality and human nature as a way of seeing the world. From this explanation of culture, there was a need to consider how individual cultures influence group cultures within an organisation. Organisational culture includes the attitudes, values, beliefs and behaviours of that organisation each of which are influenced by the people within that organisation. Organisational culture is not always positive, and covert behaviour can lead to dysfunctional cultures that fuel uncertainty, affecting the organisation's success. Commitment to a safety culture can have positive influences on patients, however permeation of the safety culture throughout each organisation at all levels is required. The following chapter explores the wider literature as further context for this thesis.

CHAPTER 3: LITERATURE REVIEW

3.1 INTRODUCTION

This chapter provides a review of the literature relating to the NHS: its organisational culture, NHS performance, patient safety culture, and the importance of leadership in embedding safety culture within an organisation. Focusing on these topic areas provides a more in-depth examination of culture, not only with regard to the organisation level (macro) or ward level (micro), but with regard to the importance of the permeation of the culture and its effect on safety.

Ridley (2010) suggested that the literature review is divided into two distinct phases, the product, which has been produced and appears at the end of the thesis, and the process or journey, whereby the review is conducted. This chapter is the latter.

3.2 SEARCH STRATEGY

Depoy and Gitlin's (1998) six steps to literature reviews were used. These are:

1. Determine when to conduct a search
2. Delimit what is searched
3. Access databases for periodicals, books and documents
4. Organise the information
5. Critically evaluate the literature
6. Write the literature review

The first step to any literature review is to conduct a search of the literature using a research question (Coughlan et al. 2014), as this will guide the focus of the literature review. The research question and the sub questions identified in chapter 1 helped to shape the search strategy (Figure 5). A preliminary literature review was conducted prior to the formulation of the research question and in an attempt to gain initial insight into the literature published (Depoy and Gitlin 1998). In order to ensure the literature review remained contemporary, the process started early and continued throughout the research. It was conducted both manually and via electronic alerts delivered to my university email address. The next step in the phase was 'delimiting' what was to be searched. Initially key words/phrases were identified within my research question and the sub questions, and then searches were performed on each separate word / phrase.

Figure 5: Initial topics derived from research question.

As guided by Depoy and Gitlin's (1998) strategy (step 3), the following electronic bibliographic data bases were explored (Coughlan et al. 2014):

1. Allied and Complementary Medicine Database (AMED)
2. British Nursing Index (BNI)
3. Cochrane Library
4. Cumulative Index to Nursing and Allied Health literature (CINAHL)
5. Medline/PubMed
6. Proquest Nursing and Allied Health Source
7. Health, Social Work and Education (HSWE)
8. Emerald
9. Health and Medical complete
10. Health Management
11. House of Commons Parliamentary Papers
12. Journals@Ovid Ovid Full Text
13. Medline (EBSCO)
14. Medline Proquest
15. Psychology Journals
16. ZETOC
17. Google Scholar
18. Grey Literature
19. National and Local Tabloid Press

Once a search using the initial keywords was exhausted, the search was broadened to include other words that may have been of relevance.

The search was expanded to examine the terms detailed in table 2:

Table 2: Terminology for the search strategy.

Organi?ational culture The ? allows the term to be searched with an ‘s’ or a ‘z’
Organi?ational culture* The asterisk indicates truncation so will include culture, or cultures
“Organi?ational culture” The quotation marks allow only the exact search term to be located
Organi?ational culture and NHS*
“Organi?ational culture and NHS”
Culture*
Safety
Patient safety and NHS*
“Patient safety and NHS”
Safety culture*
“Safety culture”
Patient safety culture NHS*
Leadership and NHS*
“Leadership and NHS”
Leadership and culture and NHS*
“Leadership and culture and NHS”
Human factors
“Human factors”
Human factors and the NHS
Human factors and patient safety
NHS communication*

The terms identified in Table 2 were then narrowed using more advanced techniques:

Inclusion		Exclusion	
Dates, 1940's onwards	Peer review journals	Non English	Non developed countries
Articles	English language	Prior to 1940	
Research studies	UK		
USA	Western European countries		
Australia	Full text and citations		

Table 3: Inclusion and exclusion criteria

This study focussed upon the Western countries, therefore the search was limited to relevant countries. The search was also restricted so that only literature from the 1940s to the present was included. This reflects the fact that organisational culture as a concept only began to be studied in earnest during the 1940s. The number of papers was further reduced using a deductive method (Depoy & Gitlin, 1998). This was conducted by breaking each of the above subjects into themes which were identified in the literature surrounding organisational culture as seen below in Figure 6. The literature search then focussed on each theme. This helped to limit the literature already obtained by focussing more specifically on key themes.

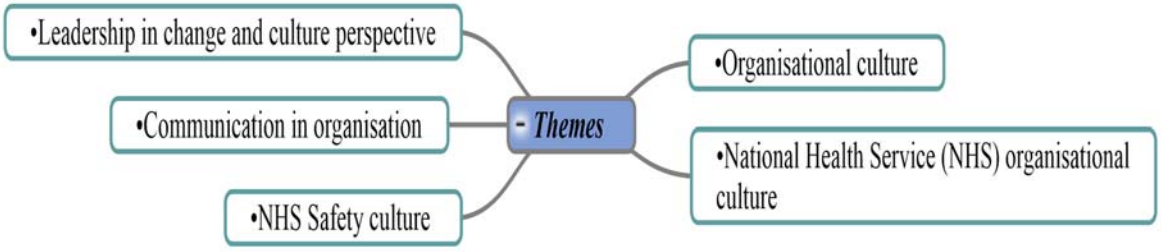


Figure 6: Themes developed from literature about organisational culture

Important government papers, and reports from statistical agencies, were included in order to understand the political context. These included reports from UK Department of Health (DH), UK National Institute for Health and Excellence (NICE), World Health Organisation (WHO), and various government reports. Grey literature explored included unpublished PhD and Masters theses, dissertations, non-government reports, and university repository internal work (Coughlan et al. 2014; Green & Thorogood, 2014). A scan of national and local tabloid newspapers yielded media stories following the Mid Staffordshire NHS Foundation Trust inquiry. However, only the official reports were included in the thesis.

The grey literature also included statistical information from the Trust's key performance indicators, (KPIs), including, Commissioning for Quality and Innovation (CQUIN), Safety Thermometer reports and meeting minutes.

A mind mapping technique, then a manual filing system, were used to prioritise literature according to the hierarchy of evidence (Aveyard, 2010). The process was facilitated by the use of bibliographical software EndNote, so that literature could be stored as attachments to references.

The next stage involved critically appraising any research literature that emerged using the eight steps by Aveyard (2010):

1. Who wrote the paper?
2. Where was the paper published?
3. Is there a research question and is the method appropriate for addressing the question?
4. Was the right qualitative research method used?
5. What was the sample for the study?
6. How big was the sample?
7. How were the data collected?
8. How were the data analysed?'

Other types of papers were judged for relevance, credibility, quality and outcome.

Depoy and Gitlin's (1998) sixth step relates to the writing up of the literature review. This review helped to establish how culture was created within the NHS at its inception, how this culture changed to a more performance-based culture during the 1980s and how this performance-based culture helped to develop a culture of safety in the 1990s.

3.3 Literature review context

Depoy and Gitlin (1998) suggest that naturalistic inquiry draws on the literature review at different points in time throughout the research. This method facilitated the literature to provide a direction for data collection once in the field. It supported the analysis and interpretation of the emergent themes during the study. It also directed the formulation of questions used in interview guides.

3.4 The development of NHS organisational culture (A Historical Overview)

The literature examined focussed upon the NHS within England. This was deliberate, as the research site was an NHS Foundation Trust within England. The concept of organisational culture has a complex history that stretches back long before being studied in any formal manner. The notion that an organisation has a culture was recognised within the 1940s, but only explored in the modern sense within the 1970s (Turner, 1971; Eldridge & Crombie, 1974; Pettigrew, 1979; Hofstede, 1983; Handy, 1999). This topic gained further popularity in the early 1980s, with several books published around this subject (Stanford, 2010). Organisational culture was not labelled as such until the 21st century. Although the NHS did not use the label of 'organisational culture' until recently, the concept of culture was evident much earlier. The NHS was formally established in 1948. This creation of a National Health Service was the product of many years of discussion and debate following the general deterioration in public health and the lack of an individual ability to

pay amongst some of the population following the Second World War. The implementation of a national health service was fraught with difficulties, as at the time the health provision was fragmented. Despite this, the then Health Secretary Aneurin Bevan nationalised the health providers, forming the National Health Service (Willcocks, 1967; Webster, 2002). Talbot-Smith and Pollock (2006) proposed that the NHS was guided by three principles, those being

1. That it meets the needs of everyone.
2. That it is free at the point of delivery.
3. That it is based on clinical need, not ability to pay.

It was envisaged the NHS would have an organisational culture based on a fairness for all, i.e. 'a public service culture'. The culture of the NHS changed from the latter to a more controlled or 'hierarchy culture' during the first forty years of its existence (Bourn & Ezzamel, 1986; Davies, Nutley & Mannion, 2000; Ubius & Alas, 2009). This hierarchical culture arose from the need for the NHS to be financially viable and have a greater management control. Prior to this, the doctors had autonomy over what they spent and how they spent public money (Willcocks, 1967). The Secretary of State for Social Services commissioned an independent NHS management inquiry in 1983 which focussed upon two tasks: one being to see how NHS resources were used and controlled and so to secure the best value for money and best service for patients, the other to identify further management issues that needed to change to fulfil task one (BMJ (no author), 1983). This inquiry led to a report led by Roy Griffiths (Griffiths Report, 1983). Davies (2009) quoted Griffiths, who famously said:

> *"if Florence Nightingale were carrying her lamp through the NHS today she would be searching for people in charge"*
>
> (Davies, 2009, pg.1)

Following the Griffiths report a management culture was born, generating a concern that professional influences of doctors and nurses would be lost (Davies, 2009).

Changes to the hierarchical systems within the NHS changed the 'once payers' (the individual hospitals) into 'purchasers and providers' and the introduction of the internal market was developed (Davies, 2009). Scott et al. (2003a) recognised these changes in healthcare and suggested that in the years between the 1980s and 2000s the NHS has seen an unprecedented level of structural healthcare reforms. These reforms were in pursuit of efficiency, effectiveness and wider access, again reinforcing the shift from a public service culture to a more corporate culture.

A change in government in 1997 resulted in a change in the focus of organisational culture, moving on from the culture Griffiths created, i.e. a hierarchical culture, to that more in line with a cultural mix of 'market culture' and 'person culture'. The market culture was based around productivity and efficiency, whilst the person culture was based around the people (staff and patients) within the organisation (Brown, 1998). This change in thinking was a new direction for the Labour government of the day, who produced the document *'A First Class Service, Quality in the New NHS'* (DH, 1998).

This was the first real recognition that culture played an important role within the NHS. This change in culture was viewed as fundamental to achieving meaningful and sustainable quality improvement in the NHS. This document clearly linked culture to the people within the organisation, and highlighted the importance of the staff within the prevailing culture. It also suggested a focussed effort where it was needed to enable and empower those who work in the NHS to improve quality locally (DH, 1998). The staff within the NHS were part of the overall concept of culture on a macro level, but this document also highlighted the importance of the micro culture i.e. it considered the need to understand culture locally, and also promoted the need to celebrate a culture of innovation and success. The link between culture and performance will be discussed later in the chapter.

Culture and its importance was also identified within the *NHS Plan: A plan for Investment, a Plan for Reform* (DH, 2000b). This government document set out the changes needed for the future of the NHS within the UK. Within this document it was clear that the quality of care, patient experience and culture were interdependent on each other, bringing the 1940s NHS into the 21st century.

The DH also commissioned *Equity and Excellence: Liberating the NHS* (DH, 2010), which focussed on a commitment to a culture of evaluation and learning, and this supported the *NHS Plan* in renewing its focus on measurement and the new concept of a learning culture (DH, 2000b). To provide measurement and learning, and also to support staff, the *NHS Constitution* was developed to reinforce the fact that it remains a publicly-owned institution (DH, 2013). This document clearly identified the responsibilities of the NHS, its staff and users of the service in improving health services.

3.5 The existence of organisational culture within the NHS

There is a clear indication that a specific organisational culture has always existed in the NHS (DH 2015). To improve performance and overall patient care, this culture has to constantly adapt. Improving organisational culture in Scotland and Wales is also viewed as essential (Scottish Government, 2013; Welsh Government, 2012). Brown's (1998) concern was the lack of cultural

definition in the NHS, which he referred to as 'an embarrassment of definitional riches', suggests that the existence and measurement of a single NHS culture, may be problematic.

Scott et al. (2003a) conducted a systematic literature review of the use of quantitative measurement of organisational culture in healthcare. The objective of this review was to evaluate measurement tools that are available for research into healthcare research and the measurement of an organisation's culture, and potential for culture change. This was a large scale study drawing on a large number of electronic databases. Terms included organisational culture and culture, and the search produced 1,700 records. Using a deductive method this number reduced to eighty-four articles that reported the development or use of organisational culture assessment instruments from a quantitative paradigm. To ensure that Scott et al. (2003a) had obtained all available literature surrounding the measurement of organisational culture, they consulted thirty experts in health service policy and management research, both in the UK and USA. Of the eighty-four articles, only the literature relating to nine instruments was used as these matched the overall guiding principles of performance and culture. Later in the review, a further four instruments were included, making thirteen in total.

Some of these tools have a strong theoretical and conceptual stance, and others are more pragmatic. Also, while some tools focus on the assessment of one or more specific dimensions, others focus upon a more comprehensive range of dimensions. There appears to be differences in the potential of the instruments to explore the deeper manifestations of organisational culture.

In the work of Scott et al. (2003a), their review of relevant individual articles helped to enhance my own understanding in relation to my research question. One paper described using the Competing Values Framework (CVF) as a method of assessing the culture of an organisation. Reviewing the literature, it is apparent that the CVF tool is one of the most commonly used to assess organisational culture within the healthcare setting (Scott et al. 2003a; Quinn & Rohrbaugh, 1981; Cameron & Freeman, 1991). The CVF tool was developed primarily for a management structure, and was never intended to be used below this level (Quinn & Rohrbaugh, 1981; Cameron & Freeman, 1991). However, the CVF tool is the most influential and extensively used tool in the study of organisational culture (Yu & Wu, 2009). The original work by Quinn and Rohrbaugh (1981) was based upon three sets of competing values: first was organisational focus, with an emphasis on the wellbeing and development of the people within the organisation itself; the second was related to organisation structure, from an emphasis on stability to an emphasis on flexibility; and the third related to the organisational processes and final outcomes. From these sets of values, four effectiveness models were developed:

1. **Human Relations Model**: This places a great deal of emphasis on people and flexibility, having cohesion and morale as its means, and human resources development as its end.

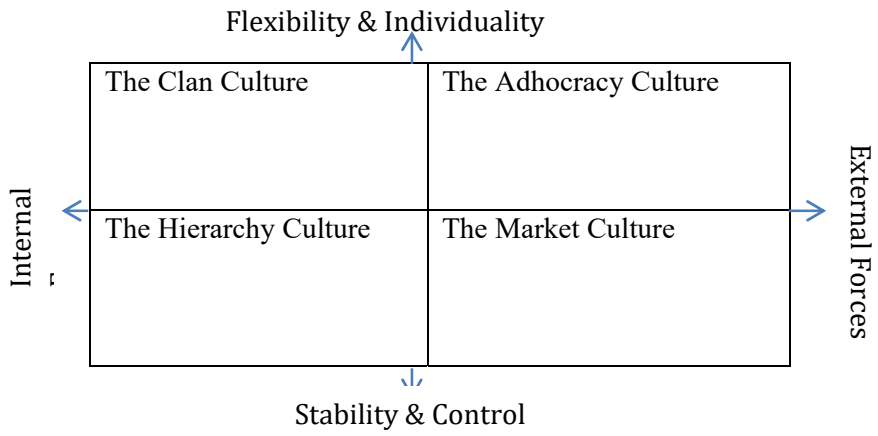
2. **Open Systems Model**: Places a great deal of emphasis on an organisation and flexibility, having flexibility and readiness as a means, and growth and resource acquisition and external support as its end.
3. **Internal Model**: Places great emphasis on people and control, information management and communication as means and stability and control as its end.
4. **Rational Model**: Places great emphasis on organisation and control, planning and goal settings as means, and productivity and efficiency as its end.

Within the original model by Quinn and Rohrbaugh (1981), culture or organisational culture was never explicitly identified. Nevertheless, there was an underlying implicit understanding of culture and its characteristics. This implicit understanding of culture identified a model of organisational culture types, those being clan, adhocracy, hierarchy and market (Quinn & Rohrbaugh, 1981; Mitroff & Kilmann, 1976; Cameron & Freeman, 1991; Jacobs, Mannion, Davies, Konteh, Walshe, 2013). The CVF uses a number of questions within a self-report questionnaire. The framework has two dimensions, a focus on internal maintenance, versus external relationships, and a focus on organic processes versus mechanistic processes. The intended purpose of this framework is to determine the organisational culture type, i.e clan, adhocracy, market and hierarchical. These are defined as:

1. **Clan culture**: is full of shared values and common goals, an atmosphere of collective and mutual help, and an emphasis on empowerment and evolvement.
2. **Adhocracy culture**: is like a temporary institution, which is dismissed whenever the organisational tasks are ended and reloaded rapidly whenever new tasks emerge. The adhocracy culture is often found in such industries as filming, consulting, space flight and software development.
3. **Market culture**: focuses on the transactions with the environment outside the organisation instead of on the internal management. The organisational goal is to earn profits through market competition.
4. **Hierarchy culture**: has clear organisational structure, standardized rules and procedures, strict control, and well-defined responsibilities.

(Yu & Wu 2009, Pg. 38)

Hooijberg and Petrock (1993) suggested that an organisation that uses the CVF framework should firstly establish which culture is dominant within their organisation. This identification of the cultures allows the leaders to assess how they can change their organisation, and also to develop action plans for this change. The organisation uses surveys of the staff and plots these on the following figure to ascertain where the employees see the culture within their organisation.



(Figure: 7 Identification of Cultures (Hooijberg & Petrock, 1993, p. 33)

Once this cultural assessment is complete, the leaders can see from the plotted figure their cultural profile, and can use this to make changes to their organisation so their desired profile matches their desired culture.

The use of the CVF model explicitly acknowledges that culture can be changed and managed, and indeed this change can be what the leaders require. The CVF model may be the most used tool to assess organisational culture from a management focus. However, it fails to consider all staffing and levels within an organisation, instead concerning itself about what leaders can do to change the culture. The CVF model makes a clear assumption that organisations can be 'boxed' into compliant labels, traits or characteristics, labelling all organisations as if all have been pre-determined. Denison and Spreitzer's (1991) research supports my analysis of the CVF model. They confirmed one reason for the confusion is the lack of agreement of the definition of organisational culture. Yu and Wu (2009) explained that the CVF model does not attempt to explore the 'panorama' of organisational culture, rather the three value dimensions. These dimensions are discussed as internal-external, control-flexibility and means-ends; this third dimension is integrated into the first two dimensions which established the CVF model.

Organisational culture is arguably extremely complex and is contextually bound to each organisation and individual context. Using a three-dimensional tool, such as CVF, may encompass the values of the organisation but fail to recognise the beliefs and assumptions of the very staff that make up that culture. Yu and Wu (2009) reinforce my analysis by suggesting that it is insufficient to measure organisational culture and its values by using three dimensions. The apparent focus of the CVF model appears to be management, effectiveness and efficiency. From a numerical statistical perspective the CVF model may be of use, however it fails to capture the unpredictability of working with patients and staff, as people are not products with predicted outcomes.

Moving away from a positivistic measurement tool to a mixed approach to gain a more holistic approach to understanding of culture within organisations, Walker, Symon and Davies (1996) suggested using the Corporate Culture Questionnaire (CCQ) and the Twenty Statements Test (TST). The CCQ uses a 21-dimensional framework to form the basis of the questionnaire. These 21

dimensions look at the performance, human resources decision making, and the relationship domains. These domains are further divided into dimensions and are answered with either a positive or negative response. This is in opposition to the TST, which reflects the social construction unique to the social unit. In Walker et al.'s (1996) study, these tools were distributed to a large number of staff within the organisation and then analysed. The results suggested that there was some convergence of the two sets of results.

The main similarities of the results came from the negative statements from the TST and the low scores of the CCQ. These similarities were based largely around staff treatment and poor morale. This study failed to explore important elements of cultural depth, and the many facets of culture. Saffold (1988) warned that studying only a limited number of dimensions fails to address the complexity and distinctiveness of culture, and misses the patterns of culture.

One assessment tool that is widely used within healthcare, and is suggested to address the complexities of culture, is the Nursing Unit Cultural Assessment Tool (NUCAT). This tool assesses 50 different cultural behaviours that have been found to reflect the cultural behaviours of staff. It uses a questionnaire that identifies the staff member's self-perceived preferred behaviours, and their perceived group typical behaviours. It reflects the importance of what the staff think of their own behaviours, and how they see the group's behaviours and the group norms as perceived by the individuals.

However, the group assumptions of the staff are potentially not considered. Seago (1997) argued that the NUCAT lacks construct validity and is therefore less reliable. This had led to variable results across different organisations. Focussing on what staff do is perhaps more concerned about climate rather than culture. This reflects my research in that although the staff discussed having a focus upon patient safety, during observations this was not evident.

Overall, the instruments explored, to some degree, the employee's perception and opinions of their working environment. Only a few examined the deeper meanings of values and beliefs that informed these views (NUCAT and TST). However, none of the measurement tools explored the meaning of organisational culture fully, leaving out important elements like assumptions that guide attitudes and behaviour, which is the very essence of culture.

Jung et al. (2007) expanded the study by Scott et al. (2003a) by including qualitative tools in an attempt to capture a more holistic view of culture. Jung et al. (2007) openly acknowledged the difficulty in analysing all the available tools due to the difficulty in obtaining the original work. They reported that some of the authors refused permission, some others did not reply to the request whilst others gave permission. Only tools from the original source were reviewed, which may have resulted in an incomplete search.

Seventy instruments and approaches for exploring and assessing organisational culture were identified and, of these, forty-eight were assessed for their strengths and weaknesses, which

included a framework for coding the data identified by the searches according to a pre-set criterion. Some confusion and overlap ensued due to the words used within the various studies, and the different focus upon different aspects i.e. leadership, structure, innovation, job performance planning, communication, outcomes, results, environment, risk taking, aggressiveness and collaboration. Jung et al. (2007) also highlighted the difficulty in applying the tools, not only from the confusion and overlap of words, but also because of the tool's intended use.

It is important that the correct tool is used in the right context (Jung et al. 2007). Jung et al. (2007) found the tools available for measuring organisational culture use both quantitative and qualitative approaches. Scott et al. (2003a) found that the quantitative approaches often left out important elements associated with measurement, such as assumptions, leaving the study and measurement of this important area somewhat lacking. In contrast, the qualitative nature of a number of the assessment tools appears to take the individual behaviours into consideration. These include using a number of different data collection methods, including observations, interviews, and discussions, which allow for the detailed and meaningful examination of underlying values, beliefs, and assumptions (Morey & Morey, 1994; Ott, 1989).

However, qualitative research on organisational culture is often time consuming and costly (Ott, 1989; Hofstede, 2001; Yauch & Steudel, 2003). It also requires sensitivity to the subtleties and complexities of life, making its design more difficult (Mishra 2001). Morey and Morey (1994) and Mishra (2001) highlighted that complexity of information provided by qualitative research can sometimes be intimidating and frustrating. Yauch and Steudel (2003) suggested that a combination of qualitative and quantitative research is needed to fully explore and measure organisational culture.

Scott et al. (2003a) highlighted the lack of an 'ideal tool' to measure organisational culture. They also argued that the ideal tool, in fact, does not exist, partly due to a lack of agreed definitions of culture. They concluded that singular attempts to define and measure organisational culture are misplaced. Instead a plurality of conceptualisations, tools and methods are more likely to offer robust, subtle and useful insights.

The Culture of Care Barometer (Rafferty, Philippou, Fitzpatrick and Ball 2015) is a recently-devised diagnostic tool used by Trusts in the NHS to determine their cultural development needs and opportunities for improvement. The tool invites employees to give Likert rating scale responses ranging from "strongly disagree" to "strongly agree", to questions about organisational culture elements such as engagement, empowerment, management and leadership, values and resources. The tool can be criticised because it does not allow for more in-depth qualitative exploration of employee perceptions and the assumptions underpinning their responses to the questions. Indeed, its authors (Rafferty et al 2015) recognise its limitations, suggesting it should be used in conjunction with other tools. This further reflects the complexity of the concept of culture and the challenge of trying to measure it.

3.6 THE USE OF NHS CULTURE IN PERFORMANCE

One of the drivers behind the need to define culture is the government's plan to improve performance through creating, managing, and changing cultures. Scott, Mannion, Davies & Marshall (2003b) proposed that performance in the NHS can be improved by changing culture, and this is based upon six consecutive assumptions:

1. The NHS and its parts have a culture.
2. The nature of this culture influences performance.
3. Culture can be changed.
4. The culture's attributes can be identified.
5. Key players can develop strategies that impact on the formation of beneficial cultures.
6. The benefits of such managed cultures will outweigh the negative consequences.

Attempting to change the culture of an organisation is a challenge (Scott et al. 2003b; Davies, et al. 2000). If the culture is the very being of an organisation, then changing it and measuring the change will be difficult. Davies et al. (2000) suggested that NHS organisations take the view that the culture is an attribute of the organisation, rather than its essence, and therefore culture can be changed and manipulated more readily.

As highlighted, one of the most significant changes to organisational culture within the NHS was the shift from a people culture developed at the inception of the NHS, to a hierarchical culture (Griffiths Report, 1983). This cultural shift saw the freedom of staff, predominantly the doctors, become limited and controlled. The changes were made in order to make the NHS a more efficient and effective service (greater performance), holding to account those who controlled the budget and who managed clinical services (Bourn & Ezzamel, 1986).

The 1980s saw the first real recognition of performance management within the NHS. Performances at that time varied greatly, and had a range of measures including, clinical processes, health outcomes, access, efficiency, productivity and employee variables. Within all of these performance measures, there is little consistency in measurement tools used (Scott et al. 2003b).

This lack of consistency of tools used to measure performance compares sharply with the work of Peters and Waterman (2004) who studied the 10 top performing organisations within the USA. They made a direct link to cultural characteristics of excellence, suggesting that productivity comes from the people, and that culture has a direct link to performance. Peters and Waterman (2004) supported the idea that the culture is made up of the people within the organisation. Mullins (2010) supported Peters and Waterman's view, suggesting culture plays an important role in effective organisational culture.

In contrast, Ashkansy et al. (2000) contradicted any findings linking organisational culture and improved performance. One reason they suggested was the lack of research about the measurement

of this relationship. They also suggested that the measurement tools which do exist tend to measure those accessible aspects of performance and culture, and not all the elements of culture, i.e. assumptions and beliefs.

Scott et al. (2003b) conducted further research focussing upon the influence of organisational culture on healthcare performance instead of just measurement. The results of their literature review identified that the ten studies that directly related to healthcare used a mixture of methodologies and employed a range of different measurement tools. Scott et al. (2003a) had identified in their original study that different tools and methodologies should be employed to gain a thorough understanding of the culture of any organisation. Using a range of different methodologies and measurement tools provides triangulation of methods, improving the quality of the research. Within the Scott et al. (2003b) study, a key article by Jackson (1997) analysed the 'did not attend' (DNA) rates within an outpatients' department. The study used both observations and telephone surveys based on a previously-used questionnaire. Within the observations, the processes of action and the attitudes of the staff and patients during one typical outpatient clinic session was examined. It was evident that just focussing on one outpatient clinic session was limited, and this had negative impacts on the usefulness of the data and conclusions drawn.

Although limited, the results of this research identified the Trust had a hierarchal culture and within the outpatient department the influence was the consultant medical staff who operated in a 'person culture' (person culture is when the individual is the central point, and the organisational structure exists only to serve that person) (Jackson, 1997). Its focus was a dysfunctional outpatients' department, with processes that did not flow, leading to the conclusion that it was the organisational culture that was at fault. Further analysis of this article demonstrates that it was the local behaviours that needed to be addressed, and subsequently managed (Jackson 1997). However, the significance of using the results from only one department is questionable when considering the influence of organisational culture on local services.

Another study focussed upon services and not the organisation as a whole (Shortell et al. 1999). This study assessed the impact of Total Quality Management (TQM) and organisational culture on endpoints of care for patients who had undergone coronary artery bypass graft surgery (CABG). This large study collected data on 3,045 patients from 16 hospitals. Staff from the 16 hospitals completed a two-part questionnaire, to assess the hospital's TQM implementation and culture. The quality aspect of the questionnaire used 58 items based upon the National Malcolm Balridge Quality Award Criteria, which had been used in successful organisations (General Accounting Office, 1991).

The TQM's main focus was on leadership, information and analysis, strategic quality planning, human resource utilisation, quality results, quality management, and customer satisfaction. The cultural aspect was measured using a 20-item instrument, used in previous studies within healthcare, which defines the beliefs, norms, values and behaviours of the members within the

organisation. The focus of the instrument for the cultural aspect was on how members approached their work and how this work was conducted. The TQM measures the management structure, and the quality outcomes of the organisation, whilst the cultural measurement focuses on the behaviour of the staff. The results of the research showed that there were differences between each of the 16 hospitals, particularly a 2 to 4-fold difference in the quality and outcomes. However, even with this in mind, it was recognised that the TQM and culture were not associated with these differences. Indeed, implementing the TQM model and a positive organisational culture had little influence on the quality and outcomes measured.

The research findings by Shortell et al. (1999) are an important reminder that organisational culture and its impact on care is difficult to measure. What is needed is a tool that can be adapted to local cultures and outcomes, exploring the micro (ward level) as well as the macro (organisational level). Indeed, Shortell et al. (1999) acknowledged this in their recommendations and suggested that what is needed is an examination of the relationship between individual professional skills, motivation, group level micro system team processes, and interventions.

Two further studies were identified by Scott et al. (2003b), both containing the measurement of organisational culture from a management and strategic perspective (Nystrom, 1993; Gerowitz, Lemieux-Charles, Heginbothan, & Johnson, 1996). Nystrom (1993) used a non-validated measurement tool looking at the norms and values of the management and strategic team. The results of this study indicated that the culture does affect the outcomes of the organisation, and that people who work in a strong culture show greater commitment and willingness to work harder. Nystrom (1993) highlighted the fact that healthcare organisations that exhibit strong cultures achieve desired outcomes for managers and other employees. However, this study focussed upon managers and executive secretaries. Arguably, the relationship between strong cultures and better performance may only be true at that level of the organisation. As such, employees at other organisational levels may not have the same commitment.

Gerowitz et al. (1996) used the Competing Values Framework (CVF), discussed earlier, to examine the role of the top management team culture in hospitals within Canada, UK and the USA. This research highlighted the differences in in-service delivery between the three countries. The UK had more of an empirical and clan culture, which Gerowitz et al. (1996) described as an internally-focussed culture that is process orientated. The clan culture focuses upon the concerns for its staff loyalty, commitment and group cohesion. The leaders of the groups are seen as mentors, who are considerate, supportive and facilitate teamwork and group interaction. The empirical culture within the UK focuses upon order, procedures and predictability, based upon reward by following the rules, and the leaders are seen as coordinators, organisers and administrators.

Within Canada, the main culture was seen to be both clan and rational. The rational culture reflects an organisation that is goal-achieving, being market-focussed and prioritising gaining superiority. Their leaders focus upon being decisive, hard drivers, and achievement-orientated. Within the

USA, the culture was seen as rational and developmental. The development culture is where people think long and short term, they have stimulating environments, and new ideas come from everywhere.

The clan cultural model within the UK can be seen to focus on the staff, creating a sense of a family environment and, as such, being a caring organisation. In contrast, the empirical cultural model reflects the executive and management team within the Trust, which is based upon order, procedures and following the rules, with the leader taking on more of a coordinator and administrator role.

Analysis of some of the research articles found by Scott et al. (2003b) showed that each study employed a different methodology and had different results and conclusions. They also all appeared to measure a different element of the culture and performance of an organisation. None of the studies identified measured the same aspect of the organisation, and the range of factors measured included staff, patients, managers, top teams, impact of quality models, work commitment, care delivery, and admissions. This indicates that a universal tool is difficult to establish.

Scott et al. (2003b) also stated that the proposition that organisational culture and healthcare performance are linked has an enduring intuitive appeal. Yet, this link is not supported by any evidence. Davies et al. (2000) explored the dearth of empirical research about organisational culture and performance and suggested that a relationship between organisational culture and its impact on organisational success or performance has not been demonstrated.

This lack of congruence between culture and performance was further supported by Denison (1984). In this influential work, Denison proposed that there is little solid evidence of the impact of an organisational culture on performance, and the evidence that does exist is not convincing. Schein (2010) concurred with this view and suggested that there needs to be further study involving a number of organisations to determine the link. This link to culture and performance was discussed by Gordon and DiTomaso (1992), who suggested that many authors have stated that there is a hypothesis that successful companies have strong cultures (Deal and Kennedy, 1982; Kilman, Saxton & Serpa, 1985; Mitroff & Kilman, 1984; Ouchi & Price, 1978; Peters and Waterman, 1982; Schein, 1985). However, these papers are mainly conceptual and anecdotal, without clear evidence-based links between either performance or culture.

The concept of organisational culture and its impact on performance within the NHS is further explored in a systematic review by Jung et al. (2007). Here, a large number of qualitative and quantitative instruments to assess organisational culture were highlighted. Only six of the tools identified directly related to healthcare, while the others related to alternate types of industry. Jung et al. (2007) stated that there is no ideal tool that exists, and the tools used in one context may not fit another.

The importance of recognising the organisational culture type was demonstrated in research by Jacobs et al. (2013) in which they used the Competing Values Framework (CVF) to measure the performance of a number of measures in English acute hospitals. The results of this research identified that those hospitals that had a clan type culture had better performance results in quality and safety, thus suggesting that culture does influence performance in this study. Yu and Wu (2009) supported this and suggested that a clan culture demands organisational commitment through a process of internal socialisation. This important message of internal socialisation reinforces the need to have all staff employed within the organisation working towards one goal, for example patient safety. Internal socialisation is needed to foster shared values and beliefs through effective communication. Helfrich et al. (2007) suggested that the CVF may be the most widely-used model to measure organisational culture within healthcare, but cautioned that this tool was only intended to be used on managers; its wider applicability was not established.

Helfinch, Mohr, Meterko, and Sales (2007) highlighted the importance of assessing the CVF instrument in each new context and with each new staff group. However, one tool cannot measure all staff views across all contexts. In addition, the CVF tool does not consider assumptions, as established earlier as being important in guiding attitudes and behaviours. Helfich et al. (2007) suggested that challenges still remain to find a tool that accurately represents all staff, incorporating their values, beliefs, attitudes, assumptions and behaviours. Despite this, using some tools could be a useful snapshot of some of the staff's views. However, the results should be used with caution.

A clear link between NHS organisational culture and performance has not been established in my literature review. Some literature suggested that organisations use culture as a dashboard to justify how well their organisation is doing, or alternatively as a scapegoat if things are not as good as they should be. One such area that is measured constantly is that of patient safety, and how organisations are developing a patient safety culture in protecting patients from harm. To measure the culture depends on how culture, measurement and performance are defined, the subject of investigation and the intended use of the results.

Coeling and Simms (1993) suggested that culture is not merely one behaviour, or a few key behaviours, but a patterns of behaviour unique to each individual group. These patterns of behaviour combine to form the group's cultural pattern. Coeling and Simms (1993) suggested that culture is like a kaleidoscope of various components, and it is how these are arranged when rotated that produces the unique pattern. Different groups behave differently, and when the members of the group change then the behaviour changes.

3.7 NHS PATIENT SAFETY CULTURE

In Chapter 2 of this thesis it was identified that patient safety is a major concern both within the NHS and healthcare worldwide. The recognition that there were safety issues with regard to medical errors and patient harm has been discussed and studied for over a century. Prior to 1999,

100 years of study surrounding harm and errors within healthcare did not identify the extent of the serious nature of poor safety within healthcare. Therefore, the recommendations made throughout this period addressed the issue only superficially, and the major implications were only recognised by a few individuals (Vincent, 2010). It was not until 1999 that further fatalities and serious injuries were investigated and publicised in the report by the Institute of Medicine (IOM) '*To Err is Human*' (Kohn, Corrigan & Donaldson, 2000). The USA and the UK are not alone when it comes to harm and deaths within healthcare. The World Health Organisation (WHO) (2009a) explored this issue of harming patients in greater detail, and proposed that safety incidents were significantly worse than previously thought. The WHO have estimated that every year, tens of millions of patients worldwide suffer disabling injuries or death due to unsafe medical care, but that this could be a significant underestimate (WHO, 2009a). Sheps and Cardiff (2011) stressed that healthcare delivery is a critical and highly dynamic process. carrying significant risk for those using it.

Stelfox, Palmisani, Scurlock, Orav and Bates (2006) conducted a systematic literature review for patient safety and medical errors between 1994 and 2004. They found 12,416 publications for review and, of these, patient safety and medical errors were the major focus for 5,514 of the publications from over 40 different countries. The greatest increase in publications followed the publication of the IOM report in 1999. Prior to this, around 59 publications per year were identified, which then tripled to around 164 publications per year after the report (Stelfox et al. 2006). It can be therefore argued that the increase in publications surrounding patient safety and medical errors represented the increased consideration given to the issue following the IOM report. Stelfox et al. (2006) suggested that the safety conversation in healthcare sciences literature has progressed from being the subject of occasional publications to being a serious dedicated focus on safety.

Longo, Hewett, and Schubert (2012) used a survey methodology to assess patient safety systems implemented since the release of the IOM reports. They used a 91-item comprehensive questionnaire. Longo et al. (2012) explained that the survey instrument used was developed from six focus groups that identified a comprehensive list of patient safety systems that should be found in a hospital. Following these focus groups, the 91-item survey tool was produced. The survey was used in a number of hospitals and repeated to identify any variables between the two timeframes. The response rates from the two surveys were 76.8% (n=126) for the first survey and 78% for the second survey (n=128). This very good response rate supported the view that most hospitals conformed to some of the recommendations, particularly those on patient safety, from the IOM report. These included the use of patient safety plans, policies, programmes, safety committees, and patient safety rounds. However, there was considerable variation in influence on hospital leadership and the environment. This variation showed some hospitals had implemented the IOM recommendations, whilst others had not, and quality suffered as a result. In real terms, there have

been lessons learnt and some conformity to the IOM recommendations. However, a number of changes have not been recognised. As a result, Longo et al. (2012, p. 2863) asked:

> *"Must we wait another decade to be safer in our health system?"*

Longo et al. (2012) suggested that the change to a safer system of care is far too slow. However, research from Stelfox et al. (2006), which was conducted prior to the study by Longo et al. (2012), suggested that real improvement had been made in response to the IOM report, and a turnaround in thinking was occurring. This thinking supported a different view on safety, moving away from dispensing blame to improving systems. It promoted a fair blame culture and focussed upon how and why mistakes happen, rather than singling out one person to blame in a punitive way. With this new focus, there was a change in the direction of the research and, as such, studies began to concentrate more on interventions to improve patient safety.

Sheps and Cardiff (2011) mirrored the feelings of Longo et al. (2012) in that they asked for a patient safety wakeup call. They proposed that after a decade of intense effort, patient harm was still a problem and a challenge in healthcare. This challenge within healthcare has existed the last 100 years, and thus a complete solution with be difficult and time consuming to identify (Vincent, 2010). Although much literature focuses upon patient safety, this concept is still difficult to address. For example, it took nearly 60 years for the aviation industry to become ultra-safe. One reason why healthcare is so far behind other industries is in part due to the failure to recognise the dynamics involved in safety (Sheps & Cardiff, 2011).

Thus far, safety within healthcare has been highlighted as a major concern not only in the UK but worldwide. However, learning from the patient harm incidents has led to a plethora of literature about patient safety, much of this building on the IOM report's analysis of the failures within healthcare (Kohn et al. 2000), and also guidance by the Department of Health (DH, 2000a). What is important to recognise is that organisational culture impacts on safety culture. This idea draws attention to the difficulty in defining culture, as evidenced throughout this thesis.

Hellings, Schrooten, Klazinga, and Vleugels (2010) proposed that assessing a hospital's patient safety culture is a challenge. As with organisational culture, there are two approaches to this topic, each of which take different elements into consideration, qualitative and quantitative approaches. Hellings et al. (2010) supported this and suggested that there is no clear consensus of which method is best to use in investigating safety culture in a specific healthcare context. The Health Foundation (2011) discussed the difficulties in recommending one tool to measure safety culture due to the lack of available research.

One tool recognised by the NPSA is the Manchester Patient Safety Framework (MaPSaF). This tool was developed in the UK by the National Primary Care Research Development Centre and

Manchester University School of Psychology Sciences. The initial function of this tool was to help primary care organisations assess their safety culture. This tool was then further developed to include a number NHS different organisations, including those providing acute care.

Parker et al. (2008) suggested that the MaPSaF focuses on 9 dimensions of patient safety:

1. Overall commitment to quality.
2. Priority given to patient safety.
3. Perceptions of the causes of patient safety incidents and their identification.
4. Investigating patient safety incidents.
5. Organisational learning following a patient safety incident.
6. Communication about safety issues.
7. Personnel management and safety issues.
8. Staff education and training about safety issues.
9. Team working around safety issues.

Parker (2009) conducted a research study looking at the MaPSaF in a primary care setting. He used interviews in an attempt to develop a description of a Primary Care Trust in terms of the above 9 dimensions of patient safety, and at each level of the five levels of safety culture. These levels are:

1. Level 1: Pathological. Why do we need to waste our time on risk management and safety issues?
2. Level 2: Reactive. We take risk seriously and do something every time we have an incident.
3. Level 3: Calculative. We have systems in place to manage all likely risks.
4. Level 4: Proactive. We are always on the alert thinking of risks that might emerge.
5. Level 5: Generative. Risk management is an integral part of everything we do.

Parker and Hudson (2001, p. 5,124)

Following on from the previous research and the need for validity, Parker (2009) conducted 14 focus groups with 33 staff to explore opinions of the MaPSaF, and to assess its face validity, utility and potential usefulness. They suggested this framework was best used in a workshop to raise awareness of the safety culture within the different organisations, and to allow managers to highlight areas of strengths and weaknesses in their safety culture to help target improvement plans. The MaPSaF tool appears to provide not just a diagnostic tool, but to also help in the identification of areas of improvement which, in turn, allows the staff to identify the areas of concern.

The Health Foundation (2011) collated a number of studies from a worldwide perspective, including more than 33,000 pieces of research, then reducing this down to 100 studies for synthesis. The overall results showed problems in the usefulness of certain tools. This was due to the large range of healthcare contexts in which the tools were used. One area of grave concern to

me was that the Health Foundation (2011) found that most of the available studies were largely descriptive in nature, and focussed on testing the tool in one particular context, rather than a comparison between tools in different contexts.

One tool highlighted within this study was the Manchester Patient Safety Culture Assessment Tool (MPSCAT), which is promoted by the NPSA. An interesting aspect of interpretation by the Health Foundation is that they perceive this as a culture assessment tool, rather than a safety framework. This tool is used widely by NHS organisations and was developed from literature reviews and expert input.

The change in focus to culture-centric from framework-centric is highlighted in MPSCAT's 10 dimensions:

1. Continuous improvement.
2. Priority given to safety.
3. Systems errors and individual responsibility.
4. Recording incidents.
5. Evaluating incidents.
6. Learning and effecting change.
7. Communication.
8. Personnel management.
9. Staff education.
10. Teamwork.

This tool originally had 9 dimensions, however the Health Foundation (2011) added 'evaluating incidents' as a tenth dimension without explanation. Although this tenth dimension is undoubtedly important, there is a question as to the validity of this current tool due to this addition (Health Foundation, 2011). Concerns exist about this tool based around the lack of published work on its use. Although Trusts do use this tool anecdotally, the Health Foundation have produced no related research to support it.

Hellings et al. (2010) identified another tool which is widely used in healthcare. They researched a number of public and private hospitals in Belgium using questionnaires. They found that hospitals had a number of choices when it came to the type of questionnaire used, but decided on the use of the Hospital Survey on Patient Safety Culture (HSOPSC) due to its systematic testing of internal structure. The questionnaire was then translated into Dutch, which brings the concern of the accuracy of the dimensions when translated. However, Hellings et al. (2007) gave reassurance that validation and revalidation was conducted on the results of the translation. The questionnaire was replicated twice. The time difference between the two questionnaires is difficult to judge from the details in the article, but all questionnaires were returned. Hellings et al. (2007) analysed the data,

and found that ten patient safety culture dimensions and two outcome measures were evident. However, it is difficult to ascertain how the authors labelled the cultural dimensions and outcome measures, whether these were known published dimensions, or what the authors felt were safety dimensions. Singla et al. (2006) reported in their literature review of patient safety and culture that one of the difficulties in using safety culture dimensions is that not everyone agrees to what they are and what questions are to be asked. However, it does appear from Singla et al.'s (2006) research that a development of a consensus of culture dimensions exists.

The research by Hellings et al. (2007) showed interesting results across the hospitals, demonstrating poor compliance with patient safety. The overall support for patient safety compliance from the management was 35%, meaning 65% of the management teams did not fully support patient safety compliance on a day-to-day basis. There was a 36% non-punitive response to error, but what happened to those staff who made an error was not addressed is unclear. Other results indicated concerns about transfers and transitions to other areas within the hospital (scored 36%), staffing (scored 38%), and teamwork across the hospital (scored 40%). Hellings et al. (2007) noted the following within the teamwork dimensions: poor coordination between staff; things falling between the cracks when transferring patients; staff worried about mistakes being kept on their personal file; staff working in a crisis mode, trying to do too much too quickly; and hospital management who seemingly were only interested in patient safety if there was a major incident.

Following on from their study, Hellings et al. (2010) conducted another piece of research using the same measurement tool, i.e. the HSOPSC, but this time using 12 dimensions. Again it was unclear where these 12 dimensions evolved from. However, clear research questions were asked, unlike the first study. The research was based upon the measurement of patient safety culture, so the research questions were:

1. How can hospital patient cultures be improved?
2. What can we learn after the intervention period?

The questionnaires were again sent out in two different time periods, and to the same hospitals as the first research. Overall, the research found significant improvements to nearly all the dimensions. The greatest positive response was the managers' attitude. This clearly demonstrated that the first study potentially positively influenced a change in attitudes towards patient safety. The other dimensions of teamwork, hospital transfers and transitions, and non-punitive response to errors and staff still remained poor, and even regressed to a certain degree. Although Belgium's healthcare system may be different to that of the UK, the study shows that improvements were made, which is important. It might be assumed that if the managers' attitudes improved towards patient safety concerns, then their new positive attitude would influence the responses of others to patient safety concerns.

The HSOPSC is based upon the American Hospital Survey on Patient Safety Culture measurement tool, and has the following 12 dimensions:

1. Overall perceptions of safety (outcome dimension).
2. Frequency of error reporting (outcome dimension).
3. Supervisor/manager expectations and actions promoting patient safety.
4. Organisational learning and continuous improvement.
5. Teamwork within units.
6. Communication openness.
7. Feedback and communication about error.
8. Non-punitive response to error.
9. Staffing.
10. Hospital management support for patient safety.
11. Teamwork across hospital units.
12. Hospital handovers and transitions.

(Waterson, Griffiths, Stride, Murphy, & Hignett, 2010, p. 4)

Concerns over measurement tools used for safety culture persist, including concerns over the HSOPSC due to the tool being continuously used and adapted, making comparative results difficult to achieve. Sarac, Flin, Mearns, and Jackson (2011) maintained that the HSOPSC is one of the few tools that has reference to a theoretical framework, and has had its psychometric properties assessed. Looking at a number of measurement tools of a safety culture, Scott et al. (2003a,b), Flin, Mearns, O'Connor, and Bryden (2000), Singer, Gaba, and Geppert (2003), and Nieva and Sorra (2006) all showed that the tools are varied, and measure a myriad of different factors. However, using dimensions that are not universally agreed as a base for the questions and analysis could lead to a misrepresentation of results. Most tools produce a generalist view point, but all fail to address all aspects of culture (Singla et al. 2006).

A large number of tools to measure safety culture have been developed and used within the USA. Despite this, Sarac et al. (2011) conducted a study within the UK using a number of Scottish hospitals to investigate the psychometric properties of the HSOPSC tool. The hospitals were selected by the Health Board responsible for that hospital. Sarac et al. (2011) used the HSOPSC due to its extensive use within the USA and its rigorous design. Some adaptations were needed to the questions within the HSOPSC for Scottish research, as has been the case within a number of European studies conducted in Norway, England, Netherlands, Belgium and Switzerland (Olsen, 2008; Helings et al. 2007; Waterson et al. 2010; Pfeiffer & Manser, 2010). Staff in the hospitals were interviewed to check for the usability of the questionnaire. After checking, one amendment was made, which was the term ‘event’ being changed to ‘incident’. The questions were the same as the original questionnaire, with the addition of three new outcomes, measured by 12 items. It is interesting to note that the reason why this tool was used was that it was the most rigorously designed and extensively used, but was then changed by the research team without further testing or validation. The sample was a large number of healthcare staff, made up of 1,969 drawn from seven acute Trusts, with a 22% response rate. This poor response rate could be significant in the

overall findings, impacting on the usability of the measurement tool. Further studies are needed to measure the safety culture within the identified Trusts.

Most of the research relating to measuring culture appears to be based around the tools themselves and whether or not they are appropriate and have the validity to measure what they are supposed to measure. There has been no research found that produces usable methods to measure, change, or enhance the safety culture. Addressing this need to have a tool that helps measure patient safety culture was reinforced by the Council of Europe (2006) who proposed a recommendation that governments need to develop a coherent and comprehensive patient safety framework.

This framework's objectives were to help promote:

1. Promote a culture of safety at all levels of healthcare.
2. Take a proactive and preventive approach in designing health systems for patient safety.
3. Make patient safety a leadership and management priority.
4. Emphasise the importance of learning from patient-safety incidents.

(Council of Europe, 2006)

As already discussed, trying to find a framework is very difficult. One reason is that a safety culture appears to be directly linked to, and influenced by, the organisational culture. Taylor (2010 p.199) discussed the very definition of safety culture. He suggested that safety culture definition was:

1. An assembly of characteristics and attitudes of the organisation and individuals.
2. An organisation's values and behaviours modelled by the leaders and internalised by its members.
3. The product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour.
4. Where people question old assumptions.
5. A pattern of basic assumptions, referring to the pattern of organisational behaviours derived from the values and behaviours which management and staff share.

Taylor (2010) went on to suggest that to measure a safety culture directly is not possible. The reason being that the safety culture is deep seated in the organisational or individual beliefs, and so cannot be measured. Consequently, research may focus on the wrong aspects of culture by choosing those it can measure.

Taylor (2010) suggested what we should be measuring is the characteristics that are common to a safety culture:

1. Safety is a clearly recognised value.
2. Leadership for safety is clear.

3. Accountability for safety is clear.
4. Safety is integrated into all activities.
5. Safety is learning-driven.

Taylor (2010, p. 132)

When the characteristics of a safety culture are explored, then culture may be the wrong terminology to use, as research suggests culture is the beliefs, values, behaviours, attitudes and assumptions of individuals.

In an attempt to understand these characteristics and their link to leadership, Sammer, Lykens, Singh, Mains, and Lackan (2010) conducted a comprehensive review of the safety culture literature. Although this was a US-led study, it still encompassed a large amount of literature worldwide. They found 200 scholarly journal articles which met their inclusion criteria of English language, humans, and years 1999 – 2007. From these 200 articles, they narrowed the field down to just 38 studies, with the main criteria for the reduction being US studies alone. This narrowing is unfortunate in that the USA and UK often share the lessons learnt from the world of research, for example the IOM (Kohn et al. 2000). The study found that a broad range of cultural properties existed, and these were organised into seven categories, some of which could be defined as subcultures:

1. Leadership.
2. Teamwork.
3. Evidence based.
4. Communication.
5. Learning.
6. Just.
7. Patient centred.

Sammer et al. (2010) found that a safety culture begins with leadership, and particularly that engaged leaders are critical to an organisation's success as they drive the culture. Not only did Sammer et al. (2010) and Yates et al. (2005) associate the critical component of leadership to safety culture, but also Blake, Kohler, Rask, Davis and Nayler (2006) and Taylor (2010) identified that leadership is one of the most significant facilitators for establishing and promoting a culture of safety. One of the articles referred to by Sammer et al. (2010) focussed on putting safety at the core (Ballard, 2006). This article provided a useful insight into how a religious healthcare organisation identified the problems they had with safety, and through developments in five key elements managed to transform their own safety culture:

1. Leadership. A strong and accountable leadership will be indispensable, leaders working together to create a safety environment that has a clear message, 'do no harm'
2. Reporting systems. To be able to function better as a team, and through encouragement and support be able to report adverse events and near misses.
3. Measure 'what matters', or what is important to improve the culture. Instead of measuring things that affect the budget, measure what affects patient safety.
4. Best practices. Develop best practices both at the local and national level.
5. Structure, safety, service and quality are bound together. The importance of safety needs to be reflected in the organisation's structure and agendas.

These five elements bring to the forefront the importance of leadership. Ballard (2006) highlighted the need for the leader to create a 'just culture'. This 'just culture' provides a blame-free environment in which it is understood that most errors are the result of inadequate processes. Acknowledging that people make mistakes, Ballard (2006) discussed 'blameworthy' occurrences as acts that involve alcohol or substance misuse on the part of the care provider i.e. acts committed by a person who consciously acts unsafely. McCarthy and Blumenthal (2006) analysed a safety culture from case studies of different organisations. They highlighted that no healthcare organisation can offer an ideal model that other organisations can use to achieve a safety culture. They described that organisational leaders determine their own objectives, reinforcing the lack of an ideal model to measure culture. Reason (1997) suggested that each organisation's leaders should think about the five attributes for a safety culture:

1. An informed culture. Those who manage and operate the system have to have current knowledge concerning human, technical organisational and environmental factors that determine the safety systems as the whole.
2. A reporting culture. An organisational climate in which people are prepared to report their errors and near misses.
3. A just culture. An atmosphere of trust, where people are encouraged, even rewarded, for providing essential safety-related information. However, people need to be clear about where the line is drawn between acceptable and unacceptable behaviour.
4. A flexible culture. Adapting effectively to changing demands.
5. A learning culture. The willingness and the competence to draw the right conclusions.

The five attributes above can, as McCarthy and Blumenthal (2006) have suggested, help to rectify system 'blindness' by providing a means to detect, eliminate or mitigate system vulnerabilities that could harm patients. Whittington and Cohen (2004) support firstly the need for a 'just culture' to promote reporting of errors, so that people would be free from blame, and normal human errors were no longer punished. This rather simplistic view on human error and punishment does not

address the issue of how many times a human can make an error. If the systems in place promote error-free practice, and the human still makes an error, then perhaps the systems need to be challenged.

3.8 Leadership and culture

Within the previous two chapters it has been argued that changing or creating a culture, whether it is organisational, safety, learning, or just, is difficult within healthcare. Successive governments have suggested that culture can be created, manipulated and changed to ensure safe, efficient and effective care for the users of the service (Health Care Commission, 2009; DH, 2000a; DH, 2001; NPSA, 2004; NAGSPE, 2013; Francis Report, 2013). *The NHS Plan* (DH 2000b) provided a strategy for major changes in the NHS, touching on the need for major cultural changes. For this, they identified that a leadership academy for health would be created, allowing the new NHS to have first class leaders at all levels. To deliver this radical change programme and create the new safer cultures, new clinical leaders were introduced at all levels within the NHS. Building this safer culture depends on strong leadership, and leadership from the top of an organisation with clarity of vision and clear policies in relation to safety (NPSA, 2004).

The NPSA (2004) identified that good leadership is needed to establish a clear and strong focus on patient safety throughout an organisation. Although efforts should be focussed upon leadership at the top of the organisation, they suggest the need for leadership at every level within the organisation to drive safety throughout the organisation. NAGSPE (2013) also highlighted the need for leaders within the NHS to be present and visible, and have first-hand knowledge of the reality of the system at the front line. However, very top leaders may be out of touch with what is happening at the patient/staff interface.

'*Seven Steps to Patient Safety'* (NPSA, 2004) clearly identified that the top leaders should be kept up to date with and have the ability to listen to what's going on. It is important to recognise that having leaders at every level would enable a much more fluid system, so that a clear consistent message of safety permeates throughout the organisation. This focus upon top leaders (executive team) and the poor focus upon leaders at all levels, has been questioned by the leadership academy in that they have provided a healthcare leadership model which will help those who work in health or care to become better leaders, whether they hold a formal leadership responsibility or not (NHS Leadership Academy, 2013).

This leadership model outlines nine leadership dimensions:

1. Inspiring shared purpose.
2. Leading with care.
3. Evaluating information.
4. Connecting our service.

5. Sharing the vision.
6. Engaging the team.
7. Holding to account.
8. Developing capacity.
9. Influencing for results.

This evidenced-based model enables the leader to understand how their leadership behaviours affect the culture, climate, individuals and teamwork. It reflects the values of the NHS, effective leadership and learning (NHS, 2013). The importance of leadership at all levels was also recognised by NAGSPE (2013) in that what is important is that leaders need to shift their behaviour from one that supports increased risks, and so making healthcare less safe, to that of leadership behaviour that reduces risk and makes healthcare more safe.

Shifting leadership behaviours need to be at all levels within the organisations. This was a finding of investigations into several of the failing hospitals (Francis, 2013; Health Care Commission, 2009). The recommendations highlighted that leadership is pivotal for a culture of safety. Sovie (1993) proposed that it is the primary responsibility of hospital leadership to assure that the organisation and its members provide high quality of care and services. Sovie (1993) further suggested that a positive hospital culture is critical to accomplishing these objectives. Kabcenell and Luther (2012) mirrored Sovie's work in that they suggested that leaders at all levels have q crucial role in changing behaviours and cultures. To change the behaviours and cultures requires the leaders to set the vision, establish the rules, model behaviour and build the support systems.

Schein (2010) supported the link between leadership and culture and made a bold statement in that he proposed that culture creation and management are the essence of leadership, and that leadership and culture are interrelated. Schein (2010) suggested the creation of culture begins with leaders imposing their own values and assumptions on a group, and these become mainstream, thus creating a culture. Avolio and Bass (1995) studied how leadership and leadership behaviour impact on the staff and found that with consistent leadership and behaviour, the behaviour of the staff will change and become the norm. Avolio and Bass (1995), like Schein (2010), proposed that if a leader shows consistent patterns of behaviour, then this behaviour will become embedded into the group's culture. Bass and Avolio (1994) suggested that there is a constant interplay between culture and leadership, and leaders create an environment for the development of the culture. If leadership approaches create the culture, then the culture arguably holds the organisation together (Bass & Avoilo, 1994).

When leadership creates a culture, and this culture is constant for future groups or teams, it is perhaps more likely to become the 'norm'. However, this creation of culture takes time to embed into the organisation (Schein 2010). The leader needs the ability to step outside the culture and start evolutionary change processes, create new norms, and develop a new culture. Changing an organisation's culture happens slowly, typically taking around eight to ten years. This work begins

with creating new experiences and routines that are critical to performance (norms) (Kabcenell & Luther, 2012). If cultures need to be created and/or changed then this takes time; the new rules and assumptions take time to become adopted within the group. However, this argument is questionable. If culture change takes time, with changes in policy, governments, and differing focuses due to targets etc., then the new norms may not have the time to become embedded, leaving instability within the organisation. Halligan (2007) supported this view of leadership and culture, suggesting that transforming the NHS is not about financial, structural or technical factors, it is about custom, tradition and convention (the culture).

Trying to influence an organisational culture without authentically dealing with leadership and the workforce is problematic (Halligan, 2007). Walshe and Boaden (2006) stated that one of the characteristics of a positive safety culture is assertive leadership, and the creation of this is an overall executive responsibility (Health & Safety Executive, 2005; Leape & Berwick, 2000; Carol, Rudolph & Hatakenaka, 2002; Kuhn & Youngberg 2002; Nieva & Sorra, 2003; Singer et al, 2003; Westrum, 2004). Walshe and Boaden (2006) also stated that although the fate of the organisation is in the hands of the executive leader, this person does not always have to be the driver of change. Taylor (2010) supported this need to have senior leadership, and that the leadership should be clear, visible and committed to safety.

The Institute of Medicine (IOM) (Kohn, Corrigan & Donaldson, 2000) made a number of recommendations following their investigations into the high mortality rates within the USA. Recommendation four proposes that a national commitment to achieve a threshold improvement in patient safety is needed. This will require strong leadership, committed to the protection of patient safety. Leape and Berwick (2005) discussed that, since the publication of *To Err is Human* (Kohn et al. 2000), healthcare leaders have learned a great deal about safety that they did not know in 1999. However, this has taken some time to develop. Building a culture of safety remains a challenge. Leape and Berwick (2005) also suggested that creating cultures of safety requires major changes in behaviour. This focus upon just changing behaviours deviates from culture in its true form. Schein (2010) and Taylor (2010) discussed the issue of culture having a number of different elements, i.e. values, beliefs, assumptions, attitudes and artefacts, of which behaviour is only one. Moving the focus from observing culture as a whole to observing the culture as behaviour, may be the way in which patient safety behaviour can be changed.

McFadden, Henagan and Gowen (2009) supported this behavioural viewpoint and recognised that highly reliability organisations who make less errors, are linked to that of senior leadership's behaviour and attitudes. Again this is moving the focus of organisational culture on a macro level to that of a more micro level, via a focus upon leadership behaviours and attitudes. McFadden et al. (2009) further suggested that the senior leaders need to care about patient safety. These charismatic leaders need to create and foster a culture of safety, which includes making safety a top priority.

3.9 Conclusion

This chapter has presented a literature review which provides the background to this thesis. The literature review has identified that the Government of 2015 accepted that organisational culture exists and that adapting certain cultures will allow the NHS to perform with greater efficiency towards patient safety. This belief was based upon being able to measure the organisational culture using a variety of tools. However, as indicated, the tools available are limited in some contexts and that local adaptations will be needed. The following chapter sets out the design of the research undertaken to address the research question in the context of existing knowledge.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter outlines the foundations of this research from a methodological perspective. It begins by providing the rationale for a methodology that explores social contexts and social interactions from the perspective of the participants. It provides a rationale for naturalistic inquiry as the chosen methodology. This chapter then provides the details of the research process undertaken, and steps taken to maximise trustworthiness.

4.2 RESEARCH DESIGN

Earlier in this thesis it was explained that understanding the concept of culture is difficult. Williams (1976) proposed that culture can be seen as the entire way of life, activities, beliefs and customs of individual people, a group, or society. He suggested that organisational culture is a social construction of individuals within the organisation and, therefore, any research question would have to focus upon the staff themselves, their behaviours, attitudes and beliefs. The nature of organisational culture takes into account the whole organisation. This is reflected in the Seven Steps to Patient Safety (NPSA, 2004), in that all staff should have an understanding of the organisational culture in which they work; it should be congruent throughout the organisation.

This is important as shared understanding and ownership is thought to be an essential component of producing both top-down and bottom-up accountability for patient safety. This shared understanding can be seen as a permeation of the spread, interpretation and influence of attitudes, beliefs, assumptions and behaviours running within and through the organisation. As discussed earlier, congruent understanding of organisational culture is vital in ensuring that each member of the organisation shares a common goal and vision, and when no-one is looking their behaviour remains patient-safety focussed (NPSA, 2004). The following question was developed to encompass a 'whole' view of the relationship between organisational culture and patient safety and how organisational culture flows or 'permeates' through each layer of the organisation:

'How do top down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust?'

Within this question the following sub questions are embedded:

1. How is organisational culture understood throughout the organisation? Do all staff from the Chief Executive to the ward team have the same understanding?
2. What safety initiatives have been conceived by the executive team, and how have these been communicated throughout the organisation?
3. How were the safety initiatives introduced to the ward? Were these understood, and how have they been implemented?

4. Does the executive team's conception of safety initiatives align with ward staff's implementation of them?

Sub question one was used to gain an understanding of the staffs' perception of the organisational culture within a single NHS Foundation Trust. It was envisaged that any areas of shared perceptions would be identified, as would any areas of disagreement, and information elicited would be used in future research.

Sub question two helped to identify important patient safety measures and how these were communicated throughout the organisation.

Sub question three identified how the safety initiatives have been perceived by the ward staff, and how they have been implemented within the ward patient/staff interface.

Sub question four was used to identify any areas of misaligned communication.

Each element of culture and patient safety was therefore explored to provide an improved understanding of culture and its effects upon patient safety.

4.3 Research context

It is important at this point to understand the context in which this research was conducted. The Trust used for this study is one of the country's top performing NHS Trusts, covering a large geographical area within England. The Trust provides acute, community and social care services to approximately 665,000 in-patient, out-patient, accident and emergency, and community patients of all age groups within the population. The Trust's performance standards at the time of the study were excellent: 98% of patients attending an appointment rated the Trust as excellent, very good or good; 95% of patients attending an appointment would recommend the Trust; 94% of patients staying overnight rated the Trust's care as excellent, very good or good; 89% of patients staying overnight would recommend the Trust; and 92% of patients attending the accident and emergency departments felt listened to and treated with respect. It was rated as one of the top 5 in the country for cancer care, and named in the top 40 hospitals within England. The Trust has invested heavily to improve their hospitals, providing greater medical cover for the patients. It had achieved the highest standards when being assessed by independent regulators, such as Monitor, the Care Quality Commission and the NHS Litigation Authority. The Trust was led by the Chief Executive Officer (CEO), who had a long serving career within the NHS and was the CEO for a number of years. Supporting the CEO was the Director of Nursing (DoN), who also had a long history of service within the NHS, and had been the DoN for a number of years within the same Trust. This long-term leadership provided stability and strategic direction from the executive team.

The executive team were supported by a definitive management structure. The management layer used for this study was middle management, represented by modern matrons. The role of the

modern matrons was recognised as instrumental to patient safety, and a responsibility to improve delivery of patient care (NHS Plan, DH, 2000b). Within the Trust, the Modern Matrons are responsible for managing a number of wards, as well as having overall responsibility for the Key Performance Indicators (KPIs) and the Commissioning for Quality and Innovation (CQUIN) targets. The wards included in this research were labelled ward A and ward B to aid anonymity. Ward A was an acute 30-bedded cardiology ward, admitting patients who have suffered some form of cardiac event, such as a myocardial infarction and heart arrhythmias. This ward was staffed to a ratio of 1:6, meaning that for every 6 patients there is a registered member of staff during the day. During the night, the ratio is 1:15. The ward had a mixture of side rooms and six-bedded bays, for both male and female patients. There was a ward manager, two ward sisters and a number of junior grade staff nurses, as well as a number of health care assistants (HCAs). Ward B was a 36-bedded care of the elderly ward, admitting elderly patients with mainly medical problems. The ratio is 1:6 on a day, and 1:15 on a night. The ward had many side rooms and open six-bedded bays. Due to the complexity of many of the patient's needs, the ward employed a number of both registered and non-registered staff to care for 'special patients'. This required one member of staff to closely observe a patient who has extra needs, both physical and/or psychological.

4.4 METHODOLOGY

The term 'methodology' means how to proceed from findings of empirical research to making inferences about the truth (Perri & Bellamy, 2012). This is supported by Clough and Nutbrown (2012) who suggested that methodology provides the reasons for using a particular research recipe, and asks why rather than how. The methodology for this study focussed upon the people working within an NHS organisation. However, the focus was multifaceted, in that to understand the permeation of safety initiatives, and organisational culture and patient safety, it was important to analyse the journey of information and explore how this permeated throughout the many layers of an organisation, and what effect it had on the staff at every level. It was important that this study focussed upon a methodology that enabled the exploration of the social context in which staff operated, its social construction and its development. The methodology's focus was non-positivistic, involving the exploration of people's behaviour in a naturalistic, context-bound environment.

Polit and Beck (2004) suggested that positivist approaches are often named modernist, to emphasise rational and scientific thinking, often referred to as logical positivism. Polit and Beck (2004) went on to suggest that within the positivist paradigm, assumptions are made that nature is basically ordered and regular, and that an objective reality exists independent of human observation. Green and Thorogood (2014) took this further by suggesting that a positivist philosophy is one that assumes that there is a stable reality, separate from human understandings of that reality, and which can be measured using surveys and experimental research, employing objective, deductive reasoning that controls the study.

Others argue that a positivist approach to social research is limited (Jupp, 2009; Polit & Beck, 2004). Hennink, Hutter and Bailey (2011) supported this criticism of the positivist paradigm by suggesting that positivism objectively measures what essentially separates the researcher from the researched, and fails to acknowledge the interactive and co-constructive nature of data collection with human beings.

In direct contrast to positivism, the non-positivist approach reflects the natural setting in that it looks at reality from the perspective of the creators of that reality, the people themselves i.e. their social construction. This creation of reality of the individual can be labelled constructivism. A constructivist paradigm is concerned with how the people construct their own reality. This important element of reality construction was highlighted by Hardy, Gregory and Ramjeet (2009), who discussed constructivism and how the people convey their experiences to others (construct meaning).

The experiences of reality and interpretations of that reality is a subjective process which is socially constructed, as opposed to objective as in the positivist world (Green & Thorogood, 2014). This subjective reality from a constructivist paradigm dictates that reality is formed from the experiences of the people within the social context, and discounts any phenomenon outside this context (Lincoln & Guba, 1985). Within the NHS Foundation Trust, each staff member construct their own meaning from their personal and professional experiences, therefore constructing and 'adding to' the organisational culture. Wenger (2008) suggested that people within a social setting are interdependent and, thus, share a culture. Nevertheless, producing congruence of meaning and understanding of this shared culture, and taking into account that each person has their own individual culture, presents a challenge. A methodology that exploited the social construction of reality within a context-bound organisation was required. Naturalistic inquiry (NI) was chosen (Polit & Beck, 2004) as a methodology that emphasised the inherent complexity of humans, and their ability to shape and create their own experiences (Erlandson, Harris, Skipper, & Allen, 1993). Guba (1978) suggested that naturalistic inquiry is an alternative mode of inquiry by its relative position along two dimensions. The first dimension is that of the degree of manipulation of conditions antecedent to the inquiry, and the second is the degree of constraint imposed on outputs by subjects involved in the inquiry. NI uses the investigator's inductive abilities to 'sift' through information, as insights are then gained, and new questions emerge (Polit and Beck 2004).

Prior to deciding on NI, other methodologies were considered. The first alternative methodology considered was ethnography. Parahoo (2014) explains that ethnography, like NI, focuses upon the natural environment. Within this the researcher is interested in how the behaviours of individuals is influenced by the culture in which they exist. This study had multiple layers of the organisation to examine, as well as different teams. The need to explore lots of different settings in detail would have made an ethnographic approach too complex within the scope of this study. It is also almost impossible for a lone researcher to become embedded into the culture at executive, senior and

middle management, and ward level. Phenomenology was also considered. Phenomenologists study the everyday experiences of individuals and the meanings they attach to that experience (Depoy & Gitlin, 1998). Streubert and Carpenter (2011) further suggested that phenomenology is concerned with the life experiences of the person, their happiness, fears, commitments and the meaning of stress. The aim of my study did require a focus on individuals. However it also aimed to study organisational processes and contexts, drawing on data from sources other than the participants. Therefore phenomenology was also discounted. Finally, grounded theory was considered (Glaser & Strauss, 1967). This is best described as the systematic discovery of theory from the data of social research (Depoy & Gitlin, 1998) or a study of social processes and social structures (Polit & Beck, 2004). Although interactive processes between individuals in an organisational context were an important focus for the study, a research approach was needed that could capture other factors within the organisational environment influencing the culture beyond the perceptions and interactions of individuals.

The decision was made to use NI as a way of studying the participants, and the organisational systems and its culture, as it allows a more holistic approach than the other approaches may have been able to do.

4.5 METHODS

Within naturalistic inquiry it is possible to use other qualitative methods (Lincoln & Guba, 1985). For this research, case study was used as a method. Yin (2009) proposed that case studies can be used as a methodology. Moreover, within this study the case study was used as Erlandson et al. (1993) suggested, as a method within the naturalistic paradigm.

Yin (2009, p. 18) defined a case study as:

> "An empirical inquiry that… investigates a contemporary phenomenon in depth within its real-life context, specifically when the boundaries between phenomenon and context are not exactly evident."

To address the research question it was important to understand the real-life phenomenon within the chosen context, an NHS Trust. The context was complex, with different hospitals, specialities, departments, and a wide range of staff within each area.

Yin (2009) suggested case studies are ideal when the phenomenon and context are blurred. Depoy and Gitlin (1998) highlighted the confusion and the debate that surrounds case studies as an appropriate method. It is often assumed that case study is a design in which a single subject (or case) is investigated. However, Depoy and Gitlin (1998) suggested that case studies can investigate multiple units or persons, and that a phenomenon may consist of a single subject, single part, or many sub parts. Polit and Beck (2004) suggested that case studies are an in-depth investigation of a small number of entities. However, within this research the entities in question were teams within

an NHS Foundation Trust. Polit and Beck (2004) suggested that the entity can be an individual, family, group, institution, community, or other social units. The case study method facilitated the exploration of the social context and social construction at the macro (organisation), meso (management) and micro (ward) levels. Yin (2009) supported the idea that case studies can be used in this context and suggested that case studies have been common research methods in psychology, sociology, political science, anthropology etc., and thus are well suited within the social context of this study.

A case study approach could help to enhance the understanding of the holistic nature of culture, and could add depth to the analysis of how culture permeates through an organisation. In this study, this was achieved by using teams as the cases and tracking how they implement and disseminate information through the various levels within the organisation. Erlandson et al. (1993) developed this understanding further, and proposed that using case studies:

1. Build upon the reader's tacit knowledge by presenting lifelike descriptions that allow the reader to experience the context.
2. Allow for the demonstration of the interplay between the inquirer and respondents.
3. Provide the opportunity to probe for internal consistency.
4. Provide a grounded assessment of context by communicating information that is fundamental to a particular setting being studied.

Using the teams as cases helped to ensure that the research remained contextualised to the areas of the organisation being studied, as the teams chosen remained fairly constant throughout the research. The case study focuses around 'why' individuals think, behave, or develop, as opposed to 'what' his or her status or progress is. Stake (1995) took this idea further and suggested researchers seek to understand, hear stories from, and enter into the world of people to identify how they function in their everyday pursuits. Polit and Beck (2004) suggested that case studies often relate to past experiences and situational factors relevant to the problem being examined. Case study, according to Yin (2009) and Stake (1995), can be used for both qualitative and quantitative research, and cannot be purely described as either qualitative or quantitative, but exploratory, descriptive, or explanatory methods.

Stake (1995) identified that case study research can be categorised into three distinct cases. The 'intrinsic' case study is chosen when we have an intrinsic interest in one particular case and the need to develop a greater in-depth understanding of that case. The 'instrumental' case study is appropriate when we need a general understanding, or need to be provided with information. The third is 'collective' case studies, where a number of differing cases are studied to provide a broader theoretical understanding of a particular inquiry. This research into organisational culture uses the collective case study method as a framework to help investigate the research question. The

collective case study method did not isolate the individuals from their normal life situation because they were studied within their natural work setting i.e. the Trust (Swanborn, 2010).

This study used three cases, each case being formulated around a tier of the organisation i.e. the executive team (Case 1), the management team (Case 2) and two ward teams (Case 3). Yin (2009) suggested using case studies in this manner can lead to a definitional drift i.e. confusion over the boundaries of each case, leading to inaccurate representation of the data obtained from each case. Recognising the possibility of the drift was important, but using this three-case method enhanced the analysis through illuminating similarities, differences and contradictions, and allowed for complex, casual links to become apparent and explained (Yin, 2009).

4.6 Access and gatekeeping

The NHS Foundation Trust used as a research site had strict access permissions prior to access. These included a number of steps that needed to be followed in a linear manner:

1. Gain university Ethics Committee approval.
2. Discuss research with the Director of Nursing (DoN).
3. Gain NHS Research and Development Department (R&D) permission.
4. Obtain a research passport and identification card.
5. Discuss and gain permission from the clinical matrons.
6. Gain permission from each of the sample population.

Ethical approval was delayed due to minor amendments requested, largely to do with the observation process. Following amendments, the necessary permission was gained (appendix 1).

The Director of Nursing (DoN) at the Trust was supportive of the research and agreed for me to use the NHS Trust as the research site. The DoN identified modern matrons to act as gatekeepers. Creswell (2007) suggested that the gatekeeper is the initial contact for the investigator, and leads the investigator to the participants. This rather simplistic view of the gatekeepers is supported by Green and Thorogood (2014), they also warned that the gatekeepers are those who control the access to the fieldwork site or to the participants.

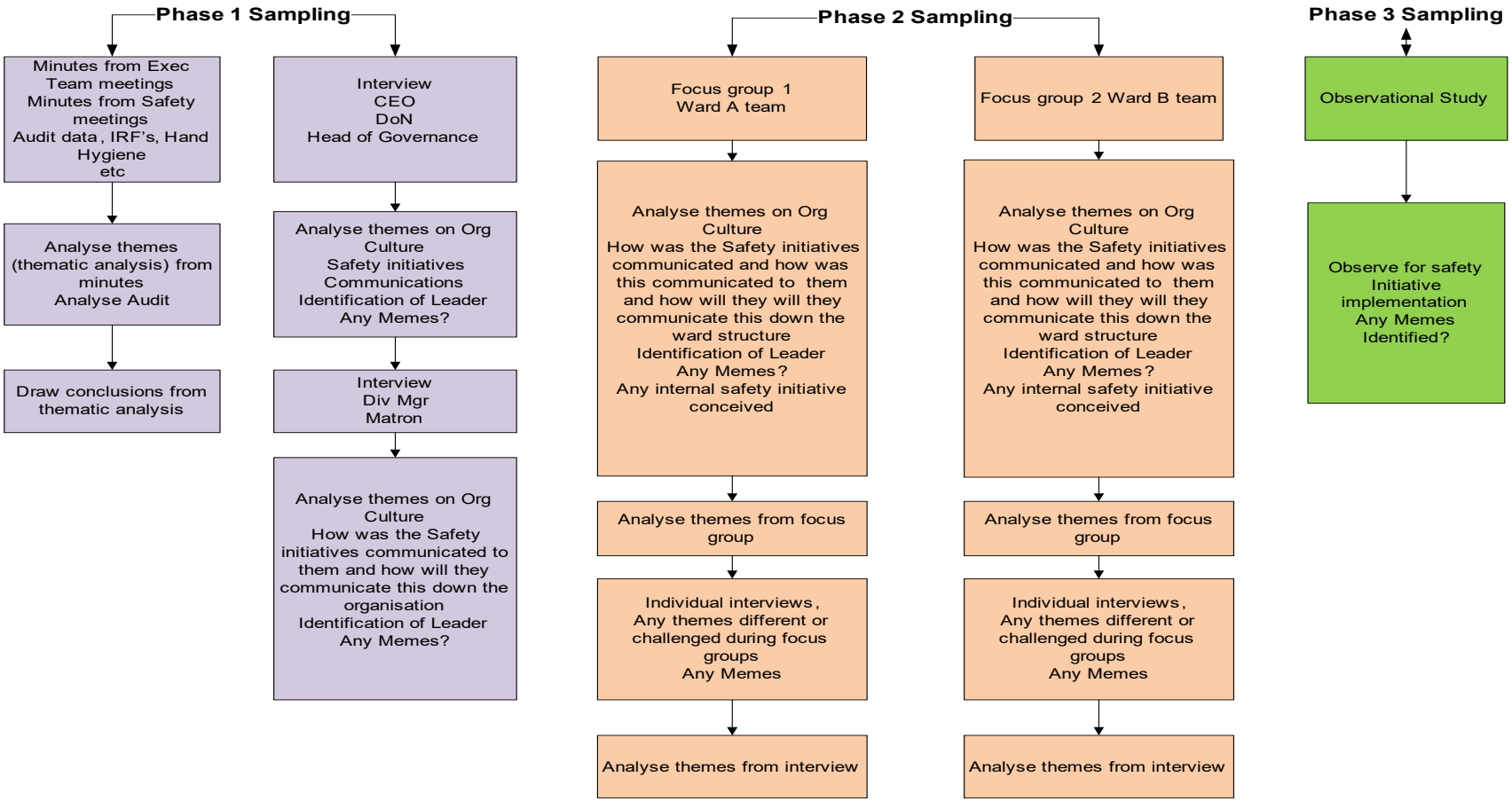
Permission was granted by the Trust's R&D Department. The issue of the passport and identification card was simply an administrative process and, once issued, gatekeepers were contacted; one chief matron and two modern matrons. Two wards were identified for the study. Both were in the same business unit but had different specialities. The matrons offered to hand out the initial contact forms asking ward staff to contact me if they were willing in order to receive further information regarding the research. There was also a need to discuss the research with the ward managers to ensure that their consent was gained to access to the ward team. The data collection was divided into three distinct phases.

Phase 1 of the research consisted of interviews with the Chief Executive, Director of Nursing, matrons and management team. Access to the staff was sometimes difficult. Staff were often called away during the interviews or did not turn up due to work pressures. In comparison, analysis of the executive meetings was quite straightforward, as the DoN provided copies of each month's minutes. These minutes were also in the public domain on their Trust's website. The ward governance meeting analysis was more difficult to access and analyse, as some of these were handwritten, some had been lost, and the meetings themselves were sporadic. Overall, however, it was possible to obtain a good overview of the discussions that had taken place.

Phase 2 involved undertaking individual interviews and focus groups with the ward staff. This again proved problematic. Multiple visits were made in an attempt to interview the staff, but these were often not fruitful, as staff were regularly unavailable.

Phase 3 Permission was gained at the beginning of a duty shift to observe the handover and the care delivery. The staff did appear to be a little suspicious at the start of the observations, but they soon grew accustomed to my presence.

Figure: 8 A pictorial representation of the 3 phases identifying each stage of the data collection.



4.7 Ethical issues and issues relating to participation

As stated, permission was gained from both the university ethics committee, and the Trust's R&D Department. The Trust's R&D Department and the gatekeepers agreed for me to approach the staff in writing. The staff were sent an invitation and an expression of interest letter to raise awareness of the research. These were sent to the executive (appendix 2), management (appendix 3) and ward teams (appendix 4). The interest letter asked the staff if they would like further information about the study. Staff interested in participating, returned the letter to me to express this.

In addition to the letter, the participants were provided with a copy of the research information sheet (appendices 5, 6, 7). Verbal explanation of the research was also provided, and I answered any questions that arose. On meeting the staff, they indicated that they were interested in taking part in the research. The participants who agreed to take part in the research were asked to sign a consent form (appendices, 8, 9, 10, 11). Participants were provided with a copy of the information sheet to retain for their information. This sheet detailed how the participant could withdraw from the study and also provided my contact details.

The participants were informed they could withdraw from the study at any time, and that if they did withdraw this would not affect their relationship with me, their colleagues, or other participants. It was also agreed that any withdrawal would not affect patient care. On withdrawal, any data collected relating to any individual would be destroyed through crosscut shredding and treated as confidential waste. However, if the participants granted permission for me to use any data collected prior to their withdrawal, this would be included in the analysis. All participants were provided with a unique identifier to preserve anonymity. This was generated in the presence of the participant, and used throughout the study. There were two lists generated for the study. List 1 had the participant's name, ward, role and unique identifier recorded on it, and list 2 only had the unique identifier and no other identifying data. It was stored in a locked filing cabinet in my office, to which only I had access.

Due to the fact that only one Chief Executive and Director of Nursing were employed within the Trust is was noted that they may be identifiable. This was explained to the participants and within the study information sheet. However, when referring to data collected during this phase, a generic term of 'executive team' was used. No other participants were identified in any reports, presentations, or papers produced by me.

All data generated i.e. tapes, minutes, transcripts, discussions, and written observations, were stored securely in a locked filing cabinet until the research had been completed. Once the thesis was written, all recorded data was destroyed. All documents, transcripts and written observations will be retained in a locked filing cabinet for 1 year post completion of the Doctorate, then crosscut shredded and disposed of as confidential waste. Any computer-generated information was

protected on the university's secured staff drive. This was password protected, and no personal data was stored on the computer drive.

All interviews and observational studies were undertaken within the chosen hospital, so that the staff remained in their own familiar environment. There was, however, a risk that some staff members may have become upset/angry during the interview/observational sessions. This did not happen. As a registered nurse, any issues would have been discussed with the participant. Assurances were gained from the occupational health department from the chosen hospital that they would have staff available to help the upset/angry staff member, if issues could not have been resolved during the discussions with me. Staff members were provided with contact numbers for the occupational health department prior to the start of any interviews/focus groups.

The issue of observation raises ethical issues. Non-participant observation was used. This has been criticised somewhat as it can be seen a covert method of data collection. However, this study used non-participatory observation as an overt data collection tool, as all staff were aware of my intensions. It was important to meet all staff that were likely to be observed. This included a meeting where the participants were provided with an information sheet which detailed my actions. The participants (staff within the Trust) were asked to sign the consent form.

The consent process took into consideration the four basic elements of informed consent (Polit & Beck, 2004, p. 151):

1. All relevant aspects of what is to occur and what might occur should be explained to the participants.
2. The participants should be able to understand this information.
3. The participants should be competent to make mature judgements.
4. The agreement to participate should be voluntary and free from coercion.

The participants were informed that they had the right to ask if all or certain elements of the observation could be omitted from the field notes. Any patient data, including gender, care delivery, location, bay number name, hospital number etc. were not recorded. Only the staff involved were recorded using their unique identifier number during periods of observations.

Field notes were used to record the observation of any/all of the safety initiatives implemented upon the wards. The ward staff handover was also observed. This was an important element of the observation to determine if the safety initiatives were discussed, what importance, if any, was placed upon them and also to determine areas of individual responsibility. It was identified that using patient's names and personal information during handover was acceptable, but this was not recorded in any field notes to maintain confidentially.

During the observations the staff were informed that my role was as a non-participant observer, but they were reminded that I was also a registered nurse, and thus regulated by the Nursing and

Midwifery Council's (NMC) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives* (2008). Within the Code, numbered sections clearly identified that:

> "32. You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk
>
> 33. You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards
>
> 34. You must report your concerns in writing if problems in the environment of care are putting people at risk"

Participants were advised that anything arising during the research that infringed the Code would be followed up immediately. The NMC's *Guidance for Nurses and Midwives: Raising and Escalating Concerns* (2010) was followed.

4.8 POPULATION AND SAMPLING

This study used a purposive sample for all data generation of this research. Polit and Beck (2004) proposed that this type of sample is based upon the belief that the investigator's knowledge about the population is important. Depoy and Gitlin (1998) supported this assertion and went on to suggest that purposive sampling involves the deliberate selection of individuals by the investigator. Erlandson et al. (1993) suggested that purposive sampling is central to naturalistic research and the use of the 'human instrument' (i.e. the investigator) in data collection, as this allows the researcher to increase the range of data exposed, and maximises the researcher's ability to identify emerging themes. This view was supported by Lincoln and Guba (1985), who outlined that this type of sample relies on the researcher being able to interact with the sample within the natural setting.

Lincoln and Guba (1985) supported the need for purposive sampling within the NI paradigm by highlighting how the investigator is likely to eschew many of the traditional sampling methods, as purposive sampling will allow the uncovering of an array of multiple realties and maximise the ability to become immersed in the data. Creswell (2007) agreed that purposive sampling allows the investigator to select the individuals and sites for the study, because they can purposefully inform an understanding of the research problem. Initial consideration included what to study and whom. These questions are central to purposive sampling within naturalistic research (Elandson et al. 1993; Creswell, 2007). Lincoln and Guba (1985) suggested that it is important to be focussed on what to study. Choosing this type of sampling therefore requires interaction between the sample and the investigator. This requires the investigator to be 'steeped' in the details of the inquiry, requiring a level of mature judgement that is only achieved by continuous interaction. There was a need to understand the scope of the social context, and how people from all levels of the

organisation view patient safety and organisational culture, in order to effectively evaluate congruence of information that is transmitted from board to ward, and ward to board. To understand this complexity, the selection of the correct sample was pivotal, and therefore it was important to return to the original sub questions:

Sub question one helped to gain an understanding of the staff's perception of the organisational culture within a single NHS Foundation Trust. It was envisaged that any areas of shared perceptions would be identified, as would any areas of disagreement, and the information elicited will be used in future research. The sample used ensured that the perceptions of organisational culture from the Chief Executive down through the organisational layers to the healthcare assistant on the ward were identified.

Sub question two identified important patient safety measures and how these are communicated throughout the organisation.

Sub question three identified how the safety initiatives were perceived by the ward staff, and how they have been implemented in the ward 'patient/staff interface'.

Sub question four identified any areas of misaligned communication.

Information elicited from the sub questions directed the sample chosen, alongside the fact that each layer of the organisation required representation and investigation to gain broad insights into that particular NHS Trust. The sample therefore consisted of a cross section of staff members in an attempt to generate data from board to ward. As already identified two wards were used. To aid anonymity, these were labelled ward A and ward B. This did not correspond to actual ward numbers/letters that are used within the NHS Trust setting.

The sample consisted of:

1x Chief Executive Officer

1x Director of Nursing

3x Modern Matrons

1x Directorate Manager

Ward A

1x Ward Manager

1x Ward Sister

1x Staff Nurse

1x Health Care Assistant Band 3

1x Health Care Assistant Band 2

Ward B

1x Ward Manager

1x Ward Sister

1x Staff Nurse

1x Health Care Assistant Band 3

1x Health Care Assistant Band 2

Total population n=16

Each level of the organisation was included through the executive, management, and nursing teams including the health care assistants on the ward. This facilitated generation of an understanding of the individuals' perceptions of culture and the flow of information from board to ward. Two wards were sampled in case study 3. This was to reduce too much emphasis on any particular speciality.

The overall aim of the thesis was to provide a nursing perspective on the research questions by focusing upon the ward nursing staff and the hierarchical leadership structure that influenced their practice. Huber (2013) suggested that nursing is seen as a unique profession whose primary focus is in caring, giving, and managing the care the clients need, 24 hours a day. Although studying medical staff may have added a different perspective, the care they deliver in a ward setting is often episodic and instrumental in nature, as they are not based there all of the time. This study explored a nursing perspective, therefore no medical staff were included in the sample.

As part of the sampling strategy a number of safety initiatives were identified through the Trust Annual Report 2011/2012, and by the CEO during the interview process. The identified safety initiatives were falls, medication errors, infections, recognising the sick patient, and pressure sores. These initiatives were confirmed during the interviews, within the observations, and through analysis of secondary data. Each stage of the data collection looked at these five safety initiatives.

4.9 DATA COLLECTION

Data collection utilised a number of methods: individual interviews; focus groups; analysis of minutes from the executive board meetings; and ward governance meetings (secondary data), as well as observational studies.

The data collection was divided into three related but distinct phases

Phase 1. Retrospective analysis of the minutes from the executive team meetings, and interviews with the executive and management team.

Phase 2. Focus groups and individual interviews from the ward teams A and B.

Phase 3. Observational study of the implemented safety initiatives.

Phase 1 The Chief Executive, Director of Nursing, and matron and management team were interviewed using semi-structured interview questions in accordance with the interview schedule (appendices 12, 13). These interviews were used to gain an understanding of their perception of the organisational culture. This information was then used to compare the perceptions of organisational culture throughout the organisation. Information was also generated about how the safety initiative was communicated to management, and how they, in turn, communicated this to the ward staff. This information was used to elicit information about their own organisational thinking about safety initiatives, how these were communicated to them, and how they implemented the initiative. In addition, the minutes produced from the executive board meetings and ward governance meetings were analysed to identify if they have been informed/updated about the external/internally derived safety initiatives.

Phase 2 The staff participated in individual interviews. This included the ward manager, ward sister, staff nurse and two health care assistants of differing grades. During these individual interviews, the staff were asked the same questions in accordance with the interview schedule (appendix 14). The individual interviews allowed the development of a greater understanding of the staff's perceptions of their own organisational culture and how information flows down to them from the executive and management team. From the individual interviews, more probing questions were developed to identify how individuals on the ward work within a team, and how this team approach affects patient safety. These probe questions were then asked during the focus group interviews. The same staff participated in the focus group. The individual interviews were commenced prior to the focus groups to elicit the unbiased view of the staff. It was felt that the senior staff of the ward may influence the staff during the focus groups as some of the participants were very junior. During these focus groups, staff were asked questions in accordance with the interview schedule for the focus group (appendix 15). The ward team were asked if they had identified any safety initiatives, and how this was communicated back up to the executive and management team.

Phase 3 This was made up of a non-participant observational study. This facilitated observations of the staff and the implementation of the safety initiatives first hand. No patients, carers or next of kin were studied. Field notes were developed about the safety initiatives, and how these were communicated during shifts / handovers. The observational studies followed an observational schedule and protocol. This allowed a consistent approach to observations (appendices, 16, 17). The approach above required an in-depth analysis of how any safety initiatives were communicated

from board to ward and ward to board, from initial conceptualisation through to implementation. Team minutes (ward-based and executive team meeting minutes) were analysed to examine any patient safety initiative.

Interviews

Erlandson et al. (1993) suggested that interviews within NI should take the form of dialogue or interaction. This semi-structured method of interviewing allows the reconstruction of the past, the interpretation of the present and prediction the future (Lincoln & Guba, 1985). Depoy and Gitlin (1998) supported this and suggested that non-structured interviews are primarily used within naturalistic research which uses probing questions to obtain information. Conducting semi-structured interviews facilitated a holistic view of the staff perception of their organisational culture and information flow, allowing some basic structure to the question. Interviewing is not without its problems. Cresswell (2007) highlighted the challenges of the mechanics of interviewing. These include interviewee behaviour and outbursts, as well as the challenges of obtaining the interviews due to time constraints, and the physical location i.e. equipment, rooms etc. This was the reality experienced during data collection. Lack of office/interview space, people cancelling and work pressures all interrupted the interview schedule. Hennick et al. (2011) supported Cresswell (2007) when they suggested that the interviewer needs skills to establish a rapport with the interviewee. Using the interviewing skills developed during my professional nursing career, rapport with the staff was evidently established when participants visibly physically relaxed during the interview. This was achieved by using humour and empathy, and by listening to the staff and to what they had to say. The staff knew they were being listened to for their own perspectives, and they were being allowed to tell their 'story' using their own experiences and opinions. One method which aided this relaxation was my ability to react to the interviewee and rephrase questions so they understood what the question was. Hennick et al. (2011) stated this takes great skill in knowing when to react and when to listen. Streubert and Carpenter (2011) suggested that the preparation for interviewing starts before the interview takes place, in that consideration is given not only to the physical location and questions to be asked, but also the social and cultural context. They proposed that interviewers come with histories, cultural value systems, and expectations of both the interviewer and the interviewee. A rapport with the participants was also established as they knew I had extensive nursing experience and a shared professional interest with them and their work.

Focus Group Interviews

Following the individual interviews, the ward staff participated in a series of focus groups. These focus groups explored the staff's perceptions of the organisation. This was used in cross case comparison alongside the perceptions of the executive and management teams. A focus group is a

particular group interview intended to exploit group dynamics. They are aimed at promoting self-disclosure among participants (Streubert & Carpenter, 2011). Focus groups are naturalistic in design, and use small groups to facilitate data collection (Depoy & Gitlin, 1998). The focus group used the same members of the purposive sample that had individual interviews i.e. ward members. Using the same sample is supported by Polit and Beck (2004), who promoted the use of purposive sampling within focus groups but went further by suggesting that the focus group needs to be comfortable, and that people need to feel at ease. One reason for the choice of the sample was to ensure that the staff felt more at ease, expressing their views by having a similar background with other group members. Parahoo (2014) supported the use of focus groups and suggested that the participants may provide great depth of information due to the social nature of the groups. The focus group allowed me to gain a greater understanding of the staff's feelings and opinions as they appeared to relax quickly with their peers, and they had already formed a relationship with me.

Parahoo (2014) highlighted a potential problematic aspect of focus groups: internal conflict. However, within these focus groups there did not appear to be any conflict. One reason may have been due to the fact that the ward manager was a member of the group. Grbich (2003) warned that some people can dominate the group, and some may not contribute well in social situations. It was anticipated that this may occur, and the 'corporate' response to my questions rather than individual or group views may be given, due to the ward manager being present. This did occur initially to some extent. The staff kept looking at the manager before they answered, but with encouragement the staff did open up to me and discuss what they truly felt. The ward manager was open with her responses, and some very honest opinions were communicated to me and the rest of the group. This then had the effect of 'allowing' the staff to be more open. The focus group discussion was important to allow me to explore the ward team in a social situation. This did happen, and some very detailed data was gained from this experience.

Observations

To capture the social context of this research, non-structured, non-participant observation was also used as a data collection tool. Marshall and Rossman (1989) suggested that observations are the systematic description of events, behaviours and artefacts in the social setting. Erlandson et al. (1993) supported this and suggested that observations allow the discovery of the "here and now" via the five human senses. Lincoln and Guba (1985) proposed that observation allows the researcher to understand motives, beliefs, concerns, interests, unconscious behaviours and customs. It allows the world as the participants see it to be observed, in their own terms, live in their time frames, and to grasp the culture in its own natural, ongoing environment. Depoy and Gitlin (1998) suggested that non-participatory observation can be used to obtain an understanding of a natural context without the influence of the observer. It was therefore important to be seen as an observer, with little influence on the staff on the ward.

Cohen, Manion and Morrison (2001) supported the concept of not interfering and went on to suggest that the non-participatory observer stands aloof from the group activities they are investigating and eschews group membership. This was very much the case within the research as it was important to just watch and listen. However, questions were asked to clarify what was being observed. This was important as this type of observation helps to explore the meanings of a social context (Cohen et al. 2001). At first it was important for me to become immersed in the context. Lincoln and Guba (1985) called this period defocusing and immersion which allows the investigator to develop their tacit knowledge of the situation and develop some sense of the salient aspects. Defocusing allowed facilitated listening to what was being discussed, as well as the ability to watch what was happening within the context.

My insider view as a registered nurse allowed me to focus on patient safety and interpret the social construction of practice related to this (Reed & Proctor, 1995). The non-structured element of the observations was extremely important to understand the relationships, behaviour and interactions of the participants in their natural context. Punch (2001) highlighted the importance of non-structured observations within a naturalistic paradigm. He suggested that structured observations tend to follow the positivist approach with pre-planned observation schedules. A patient safety focus provided key areas to explore. This was informal, but gave some structure to the field notes.

The observational periods focussed on ward A and B, over a two-week period. The following table highlights the observational contact time.

Table 4: Observational Studies

Day		Early Handover	Lunch Handover	Night Handover
1, 2, 3, 4, 5	Ward A	Yes	Yes	Yes
6, 7, 8, 9, 10	Ward B	Yes	Yes	Yes

Table 4 shows that the observational contact time was restricted to two weeks. Each ward handover was observed, as well as allocation of patients to the teams, and limited routine ward care. This observation of the care was discussed and consented to by the staff on the assurance that any closed curtains would not be opened to observe direct or personal care. Similarly, there would be no disclosure of patient information. Each ward was observed for one week, providing 5 contact days per ward. This facilitated observation continuity of the staff handovers and basic care provided from one shift to another. Erlandson et al. (1993) proposed that observations are only one element of data collection. The observer is there to observe daily activity and see the operational meaning of what they have seen. These observational periods allowed me to see the current context of practice for the participants. There is much debate on the length of time needed to be spent in an area for observations. Parahoo (2006) argued that with non-structured observations the choice between a large or small amount of time in the observed area is down to the investigator. Lincoln and Guba (1985) proposed that what is important within NI is that the here and now is reflected. As Lincoln and Guba (1985) went on to suggest, the best predictor of an organisation's or community's behaviour in the future is its current behaviour. This limited period of time spent observing the two wards may have led me to miss some practice. However, data gathering was a useful addition to the study.

Hennick et al. (2011) proposed that whilst observations are a vital method to provide context and explanations of behaviour, recording field notes can be cumbersome and be subjective. Depoy and Gitlin (1998) recognised the subjectivity of observations, and that the observer should conform to the rules of watching, listening and recording. Polit and Beck (2004) acknowledged the potential for observer bias, and stated that whilst this cannot be completely removed it can be minimised through careful recording of data and training. It was important to capture the essence of my observations in real time, and so a Dictaphone was used to record the field notes. The recording took place in a private room at convenient times on the ward to maintain confidentiality. These times were chosen when staff were conducting personal care behind bed curtains. No patient details were recorded.

Secondary data

Within this study, data was collected from two secondary sources: the minutes of the executive and ward team governance meetings. This was an important aspect of the triangulation of data collection, as it helped provide documented evidence of the safety initiatives being communicated within the meetings. Yin (2009) suggested that including multiple sources of evidence allows a much broader range of issues to be addressed, and the development of 'converging lines of inquiry'.

The label of 'secondary data' may appear to give it less importance than other data. Erlandson et al. (1993) defended this type of data and suggested that the use of this secondary data can be similar to that of interviews and observations. In support of the importance of secondary data, Cohen et al. (2001) suggested that it should not be minimalized, as it can contribute significantly to the research. The use of this type of data is important and adds 'value' to this study.

There are limitations to secondary data collection using the minutes of the meetings discussed. The first limitation was confidentiality. The Trust was reluctant to provide copies of the minutes. This issue was discussed with the executive and ward teams and they were reassured that the documents would remain confidential and no identifiable data would be used. A further issue was the accuracy of the data. The dates of the meetings appeared to be irregular, particularly the ward governance meetings. To try and resolve this issue, one year's worth of minutes were analysed. This then appeared to balance out the irregularities.

Sarantakos (1993) highlighted a number of limitations with secondary data collection. He suggested that some of the data may be out of date or incomplete and that documents may be biased as they only represent one view. However, within the executive and ward meetings there were a number of staff who participated in the discussions, limiting the potential of bias.

To gain an oversight of the research phases, a pictorial view of the process can be found in Figure 9.

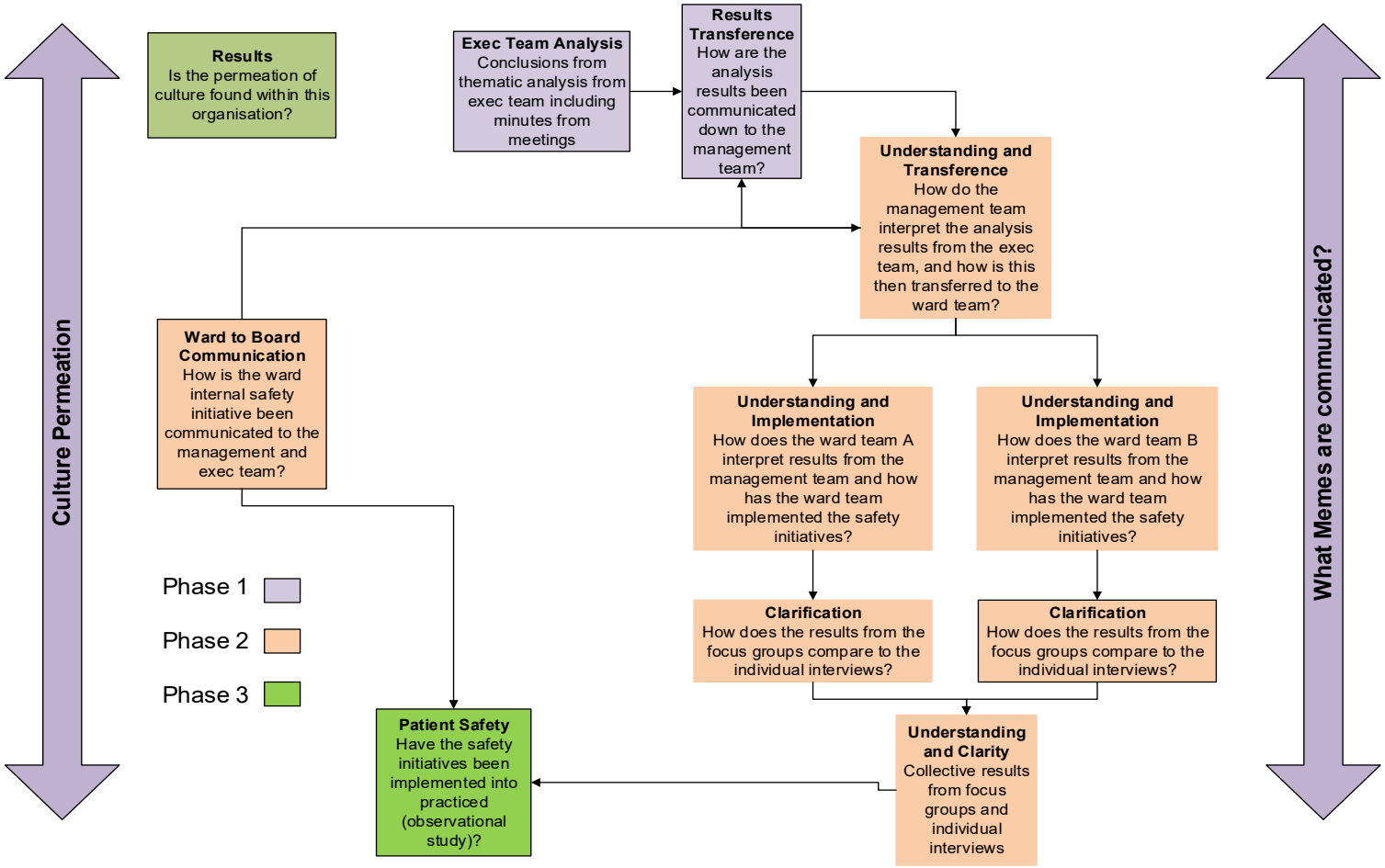


Figure 9: A pictorial guide to the research phases and the questions considered

4.10 DATA ANALYSIS

Data analysis within a NI paradigm represents a dynamic logical process (Depoy & Gitlin, 1998). However, this logical process does not mean that data analysis is linear. It is creative, flexible and sometimes appears chaotic. This aspect of data analysis is in keeping with the interpretive nature of this study, and the need to understand, explain, and interpret the human experiences of the participants (Hennik et al. 2011). In support of this, Polit and Beck (2004) suggested that data collection and analysis are carried out simultaneously. As discussed within this chapter, several data collection tools were used to capture the human experiences and to explore the breadth of permeation of culture through various layers of the organisation. These were individual interviews, focus groups, observations and minutes from the executive and ward governance meetings. The data were analysed qualitatively as a set, drawing out key issues of relevance to the research question.

The individual interviews and the focus groups were transcribed verbatim. Hennick et al. (2011) suggested that this is a written record of the interview and that verbatim transcription creates a very detailed record of the words used, and the voice of the participant, providing a more detailed analysis to be defined. This verbatim transcription represented the interview in detail, including coughs, pauses, laughs and non-lexical utterances. This enabled a better recollection of the interview and supported the interpretation of what was said and in what context. Observation field notes were also transcribed verbatim. The minutes from both the executive and wards were already in plain text and used as such to facilitate thematic analysis.

All of the data collected were analysed using thematic content analysis to construct categories. Erlandson et al. (1993) and Lincoln and Guba (1985) supported the view that what is important in data analysis is to use a systematic approach. This adds structure and provides a framework to the data analysis. To provide the structure to the analysis, an eight-step approach to this stage was used (Tesch, 1990). The eight steps by Tesch (1990) are the most common approach to data analysis within qualitative research (Green & Thorogood, 2014). This method was used for the individual, focus group interviews, secondary data and observations. There was a large amount of raw data to analyse, but to help visualise, organise and develop the categories, MindGenius Education 4 was used.

An illustration of the data analysis process undertaken is provided below to facilitate an audit trail of thematic analysis decision making. One transcript from the individual interviews was used as an example to demonstrate the eight-step approach (Tesch, 1990) used for all data (appendix 18). Step 1, involved reading the transcript whilst listening to the

actual interview to gain a 'feel' for the participant's intentions; an important step to ensure the personal nature, intonation and focus of what was discussed was not lost. At first nothing was documented. It was important to just listen and read in order to absorb the situation. Further listening to the recording and reading of the transcript was undertaken and marginal notes were made on the transcript to help focus and clarify my thoughts and gain a preliminary understanding of what was being discussed (appendix 19). Miles and Huberman (1984) described this as an important method as notes, basic codes and ideas within the margins of the page, or 'marginal remarks', are identified. This allows focus and prevents distraction.

Within step 2, MindGenius Education 4 was used to map a general overview of the marginal notes made. At this stage, these were just general points and initial developments of thoughts on how the participant discussed each topic. MindGenius Education 4 was used as more of a notepad to record this important step. The following text demonstrates step 2. An example of the transcript extract is found below to illuminate in detail the process undertaken. Each individual line was numbered for this approach so the process could be audited, but also to ensure clarity and ease of retrieval. This was to prove valuable at this early stage due to the large amount of data to analyse. It can be seen that participant 1 (P1) discussed a culture as a topic, but again this was just to gain an insight:

> *The Trust has a pretty vibrant, positive and patient focussed culture line 26* ***(P1)***
>
> *A culture of people wanting to do their best improve things, try to get to a position where they are happy for their families to be treated here line 27-29* ***(P1)***
>
> *If staff see a problem sort it out, let's not make a big thing of it, just sort it out line 29-30* ***(P1)***
>
> ***(P1)*** *leads the culture line 63* ***(P1)***
>
> ***(P1)*** *sets the tone, the team, exec team, the board have to be clear, all the clinical leaders be clear that they are seen as a visible manifestation of the culture line 63-65*

Further initial analysis using a technique of cutting and pasting the important topics from the transcript was undertaken with 'post-its' to highlight areas of interest. These were then transferred to flip chart paper to gain a visual overview of what was discussed. This step was described by Strauss and Corbin (1998) as open coding, where concepts are identified. This type of coding is normally found within grounded theory methodology, but within this study it proved to be a useful way to help structure the data analysis.

Step 3 generated a general list of the topics identified in step 2. An example of the topics found through the initial analysis and connections made to similar topics is found in figure

10. This process of generating lists was conducted for each of the participant interviews, observations, and analysis of the minutes.

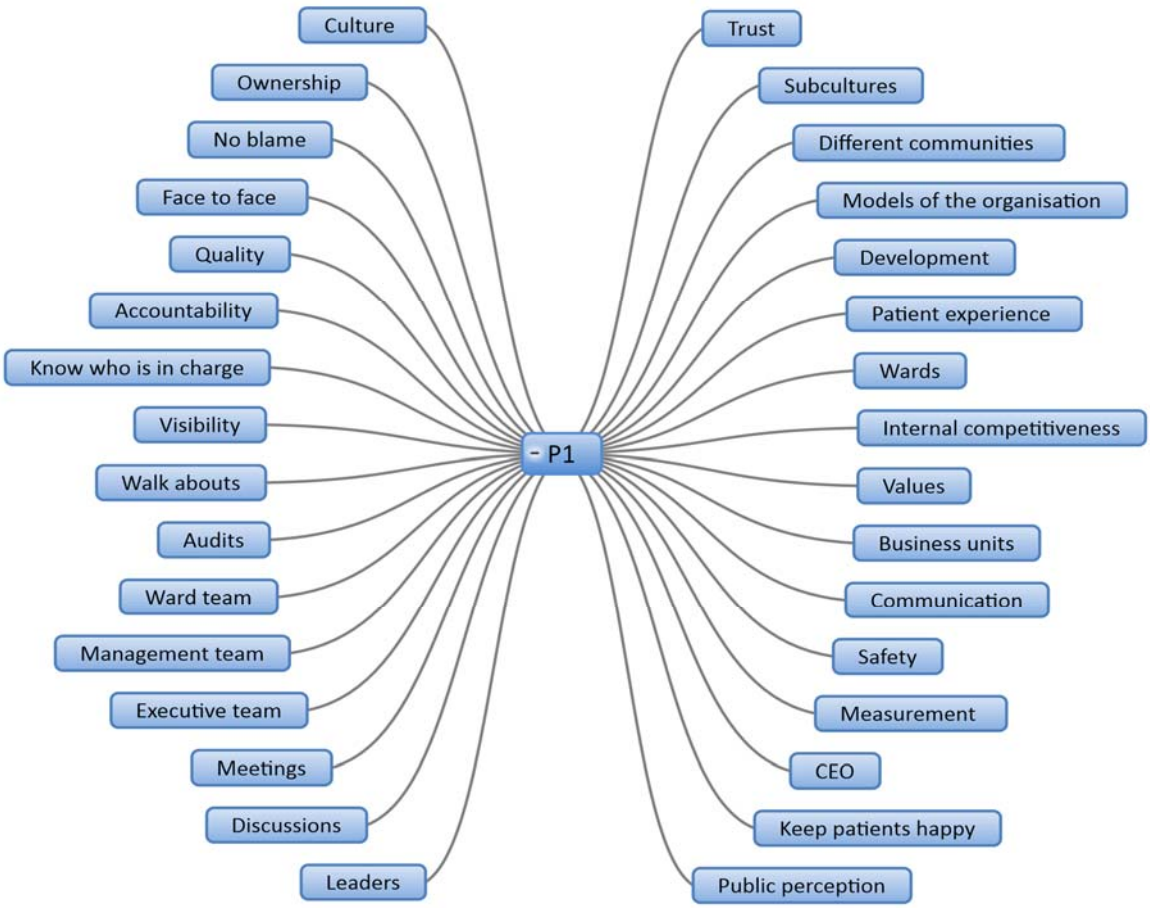


Figure: 10 List Generation

In Figure 10, the list of general topics can be seen. This included all the relevant topics discussed by P1 as generated from the transcription (appendix 19). There is an example of the transcribed text, including the line numbers, found in table 5.

Overall Culture Trust has a pretty vibrant, positive and patient focussed culture 26 A culture of people wanting to do their best improve things, try to get to a position where they are happy for their families to be treated here 27-29 If staff see a problem sort it out, let's not make a big thing of it, just sort it out 29-30	*Internal competitiveness* One ward competes against another, around patient satisfaction 101-103 Competitiveness shouldn't be a negative thing 109 Clinical staff are generally quite competitive, the key is to have pride in what you are doing and if pride can be channelled positively is a good thing 113-115
Discussions Information flows: Performance, quality and patient experience go through the system and internal com's in briefings, and press releases, CEO does notes to staff and all that 147-149 Stuff out of the board just helps to confirm there's consistency, there's a connection 154-155 Information does not flow from exec team to ward team in a timely manner 166	*Proof of audits* Loads of Auditing 208 Engagement when things are important 209 Measure, measure and measure 210 CEO walks around scratching and sniffing and listening 212 CEO cannot rely on one measurement tool but needs to see the data and walk around's 213-214 Hand hygiene cannula care, commode compliance is generally ninety-eight percent and above 221-222

Table 5: Topic Generation

Within table 5, initial general topic names are shown. These initial names changed several times in an attempt to reflect an accurate picture of the data obtained.

In step 4, new flip charts were used to gain a 'clean sheet' of ideas using the topics found. The topics were then assigned basic codes, via more descriptive words of the topic that came from some of the discussions from the participant. For example with Participant 1 some topics included: organisational culture; internal competiveness; discussions; and proof of audits.

Steps 5 and 6 involved interpreting topics and collating them into overarching themes that gave more meaning to patterns in the data. Any data that did not 'fit' into any identified theme was not deleted, as it may have proved important at a later date. This data was placed into a new theme named 'misalliances'. This important step was described in grounded theory terms by Strauss and Corbin (1998) as axial coding; processes of relating categories and sub categories, and making connections between the categories. Although my study was

not a grounded theory study, the process of examining and re-examining the data was similar.

Once the above 6 steps were completed for each of the interviews, focus groups, minutes and observational studies, all the topics with their codes were combined into themes. During steps 7 and 8 all themes were re-analysed, and placed on new flip chart paper, and also MindGenius Education 4 was used to help structure the further analysis. Each of the interviews, including the focus groups, were then analysed as per case. As discussed earlier in this thesis, the cases represented the executive, management, and the ward teams. The individual interviews and focus groups were analysed with the combined topics, which helped to develop case themes. An overview of this process is found in appendix 21. From the analysis of the data from all cases it became apparent that themes existed from the combination of all the themes. These themes were then subject to further analysis using the data within the themes. Using this technique, seven themes emerged. These were: cultural consistency; safety initiatives and focus; communication; measurement; development; leading and shaping; and communities of practice.

Table 6 provides details of the themes that were produced from all the data analysis. Also, it gives examples of the topics that generated the themes.

Cultural consistency ➢ Led by CEO ➢ Vibrant ➢ Positive ➢ Patient focussed ➢ Value driven ➢ Consistent culture ➢ No blame ➢ Open culture ➢ Team culture ➢ Learning culture ➢ Culture ➢ Culture different but patients' wouldn't notice ➢ Sub cultures allowed but policed ➢ Happy patients come before everything ➢ Patients are at the heart of everything we do	***Leading and shaping*** ➢ Clear leadership ➢ Permeation of leadership ➢ Visible leadership ➢ Poor team approach to management ➢ Management and senior nurse presence
Development ➢ Leadership development ➢ Clinical development ➢ Equal opportunities for staff ➢ Staff are informed, trained and developed	***Communities of practice*** ➢ Staff are team people ➢ Know their roles ➢ Staff are encouraged to share information
Communication	***Measurement***

➢ Poor consistency of information from board to ward ➢ Poor flow of information ➢ Prioritisation of information is needed ➢ Staff get good flows of information ➢ Meetings need to be face to face ➢ Improvement is needed for all staff to understand the information ➢ Reduction in communication barriers	➢ Audits ➢ Measure, measure, measure ➢ CEO walks around, scratching, sniffing and listening ➢ Multi approach to measurement, not reliant on one tool ➢ Very high compliance rate with audits i.e. hand hygiene, cannula care, commode ➢ Audits and measurement of quality ➢
Safety initiatives and focus ➢ Is led by exec team ➢ Team thinking ➢ Multi-level teams working as one ➢ Safety priorities: ➢ Falls ➢ Medication safety ➢ Deteriorating patient ➢ Pressure sores ➢ CDiff ➢ Infections ➢ Group thinking on patient safety days ➢ All staff involved in learning around safety initiatives ➢ Lessons are learnt from incidents	

Table 6: Theme details

From the data analysis and the development of the seven themes, the information elicited from the data represented an accurate reflection of what was recorded and the intent of the participants. A question could be raised at this point as to why manual data handling was used and not an electronic method. Electronic data handling tools have been developed and available from the 1980s, becoming more refined and helpful. Their purpose is to follow an assigned code or label to segments of text from the research (Cresswell, 2007). Depoy and Gitlin (1998) suggested that the naturalistic investigator can find computerised programmes helpful in data analysis, but warned that these systems can never replace the analytical and interpretive processes that an investigator can bring. During the data collection phase, many challenges were faced. These included time restrictions due to my full-time teaching commitment. When analysing the data there was a need to own the whole process, and become immersed in the subject. Creswell (2007) linked this ownership to developing a distance from the investigator to the data. Erlandson et al. (1983) suggested that data analysis relies on the expertise of the investigator, their intuition and their tacit knowledge. Concerns have been raised in the use of computerised programmes in that it turns a cognitive process into a mechanical and technical activity (Polit & Beck, 2004). There is much evidence to suggest that the computerised programme can take out the long arduous task of data analysis to a certain extent. One advantage is the computer can deal with a large amount

of information and data input. On reflection computerised programmes could have potentially saved time. However, the techniques and process used in my study were accurate and robust, despite not using an electronic tool.

4.11 Trustworthiness

The research design as discussed earlier used naturalistic inquiry as the methodology. This interpretive, constructive paradigm allowed the exploration of phenomena in its own context, observing behaviours, interactions and communication between individuals within and between levels of an organisation. It was therefore important that this method was used throughout the research to ensure a consistent approach and help ensure that this research was trustworthy. Trustworthiness refers to the degree to which readers of the research are convinced of its value and findings (Lincoln & Guba, 1985).

Streubert and Carpenter (2011) used rigor as a definition of trustworthiness in research. They suggested that rigor is demonstrated through the researcher's attention to, and confirmation of, information discovery. The goal of rigor is to accurately represent the study participants' experiences.

Lincoln and Guba (1985) proposed that qualitative research should be judged using credibility, transferability, dependability, and confirmability, instead of positivistic terms. Erlandson et al. (1983) linked rigor to human knowledge by suggesting that if the intellectual inquiry is to have an impact on human knowledge, it needs to guarantee some measure of credibility. Lincoln and Guba (1985) stated that credibility has several major components that can be applied to qualitative research. In relational to this study, the components were as follows:

Prolonged engagement provided the foundation for credibility, in that the culture of the organisation and the social context were learnt over an extended time (Erlandson et al. 1993). This prolonged engagement helped reverse any distortion within the observations due to the Hawthorn effect. Over time, distortions were potentially reduced as the participants got used to my presence and trusted me in the context. This prolonged time period allowed confirmation of the observations and clarity of any misquoted information or incorrect observations. Parahoo (2006) also warned of the dangers of spending too little time in the observational setting and that with unstructured observations the researcher can choose to spend a little/large amount of time within the research context, 'seeking out' the truth wherever they find it. There was difficulty experienced with prolonged engagement, as observations proved to be time consuming and intrusive in the clinical setting. In the main, only short interactions were observed, and this facilitated an understanding of how the safety initiatives were communicated and practiced.

Persistent observation is discussed by Polit and Beck (2004) as concerning the salience of the data being gathered and recorded. This aspect focuses upon the characteristics or aspects of a situation or a conversation that are relevant to the study. Holloway and Wheeler (2002) supported the suggestions of Polit and Beck, explaining that persistent observation concerns situations that are studied for enough time to allow for selectivity of what is most relevant and representative to the issues being examined. Lincoln and Guba (1985) summed up this definition of persistent observation by stating that it adds to the dimension of salience to what otherwise appears to be little more than mindless immersion. Arguably the constructivist investigator needs to spend time within the context to see what is going on (prolonged engagement) but also to provide more depth to the observations (persistent observation) (Lincoln & Guba, 1985) One of the difficulties with persistent observation is that, not unlike prolonged engagement, it is time consuming. Shorter interactions with staff were invaluable for observing the specific safety aspects of relevance.

Triangulation is the use of different approaches and methods in collecting data to strengthen the credibility of the study (Holloway & Wheeler, 2002). Parahoo (2006) explained that triangulation is a way of combining more than one method in the same study. To gain a holistic view of the nature of organisational culture, a triangulation of methods was used. Erlandson et al. (1993) supported this view when they suggested that the best way to elicit the various and divergent constructions of reality is to collect information about different events and relationships from different points of view. Denzin (1989) confirmed this and suggested that triangulation has four different modes: using multiple and different sources, different methods, use of different investigators, and different theories. The different data collection methods utilised in this study facilitated this approach to triangulation. This type of methodological triangulation allowed clarity of more than one individual reality. This naturalistic constructivist paradigm in my study was concerned with how the people construct their own realities. This important element of reality construction was highlighted by Hardy et al. (2009). However, viewing one individual would not provide the main picture needed to address my research question. There was a need to understand multiple realities from various people throughout the organisation.

Peer debriefing is an important step in the credibility assurance. There are several purposes to peer debriefing: keeping the investigator honest; exposing them to searching questions; asking questions that the researcher might otherwise avoid; exploring methodological next steps with an non-biased person; and acting as listeners for personal catharsis (Lincoln & Guba, 1985). Peer debriefing can also help to focus the researcher (Erlandson et al. 1993). Depoy and Gitlin (1998) suggested that peer debriefing can also help the researcher to review their audit trail by randomly selecting data to code and compare with the researcher, and also by checking the interpretation the researcher has

developed from the data. Often, when people are immersed in the data for so long they can take some of the results for granted, and so lose rich data and its interpretation. However, it is hoped that with peer debriefing, this deviation will be reduced. Peer debriefing was conducted with the support of two colleagues who were asked to analyse a portion of data for discussion. In the main, colleagues supported my interpretation and gave feedback on any anomalies which were identified.

Negative case analysis was used to refine my interpretations. This included cases that appeared to disconfirm my developing understanding that were explored until I was confident that all cases were accounted for (Polit & Beck, 2004; Erlandson et al. 1993). Examples of its use in my study are evident in the discussion chapter, adding to the credibility of my study.

Referential adequacy is concerned with data being related and interpreted to the context, thus providing a holistic view of that context (Erlandson et al. 1993). Lincoln and Guba (1985) suggested that at one time referential adequacy only included video recordings to capture real-life episodes, but it is now suggested that documents, photographs etc. can be used to demonstrate the real life of the participants. A number of data collection methods were used, including interviews, focus groups and analysis of secondary data, and this helped to ensure that the referential adequacy of my study reflected a holistic view of the participants' multiple, socially constructed realties.

Member checking involves taking the findings back to the participants and providing an opportunity to confirm/refute interpretations (Green & Thorogood, 2014). Grbich (2003) suggested that member checking can be conducted within a focus group situation, where data is presented back to the participants. Punch (2001) suggested that member checking is not always required. The participants in my study listened back to some of their comments from the individual interview in order to clarify meanings. However, no systematic member checking took place. Attempts were made to revisit some of the participants within the Trust. However, these were largely unsuccessful due to staff's time limitations, their workload, difficulties for me gaining access to the wards and changes to ward staff. However, as identified, peer debriefing was used to enhance credibility.

Transferability concerns how the findings of the research can be transferred from the research sample or a population to the whole group (Holloway & Wheeler, 2002). As my research was contextually bound, and the realities of the individuals of that context could only relate to the findings of that area within the time frame of the data collection, transferability is limited to some degree. Erlandson et al. (1995) suggested contextual and reality construction changes over time. Lincoln and Guba (1985) suggested transferability of the results of a NI study is held with the reader of the research and not the investigator. To

allow the reader to identify transferability, a detailed thick description of the context is required which includes the sounds, sights, descriptions, and relationships within that context (see discussion earlier in this chapter).

Dependability relies on the researcher to provide evidence that if the study was to be replicated with the same or similar respondents, and the same or similar context, then similar results would be produced. However, as discussed above, the context, the people and relationships change, and so the variance will change. Consequently, the naturalist researcher does not look for invariance (what has changed), but trackable variance (how and what things changed) (Erlandson et al. 1993; Guba & Lincoln, 1989). Trackable variance can only be achieved through a dependability audit, in that an external person can see the processes that were undertaken. This includes data collection, interview transcripts, data reduction, analysis of data and outcomes, all documentation, and a running account of the processes. The peer debriefing contributed to this.

Confirmability is concerned with the product as a result of the data. The naturalistic researcher is transparent about the influence of the data to facilitate audit. A diary of my thoughts, suggestions, actions, and detailed records of each stage provides this.

4.12 CHAPTER SUMMARY

This chapter has provided an overview of the methodology and methods used within this research. Using a naturalistic inquiry methodology allowed me to obtain a contextually-bound picture of the aspects of the organisation that helped and/or hindered patient safety. Using a triangulation of data collection methods enabled a holistic exploration of the organisation. Combining all three methods provided a unique insight into the workings of the organisation, particularly in relation to patient safety and how related information flows and is interpreted from one level to the next. This chapter has presented a critique of the trustworthiness of this study. The following chapter presents the findings.

CHAPTER 5 RESULTS

5.1 INTRODUCTION

As identified in the previous chapter, to understand how the safety initiatives permeated through this organisation, a triangulation of data collection methods was undertaken. From the data analysis, seven themes which promoted and allowed permeation of safety concerns through the organisational culture were identified. These were: *cultural consistency; safety initiatives and focus; communication; measurement; development; leading and shaping; and communities of practice.* The results of the data analysis of the seven categories will be presented in this chapter. Firstly, this chapter shows that permeation can be achieved by mapping the journey of a successful initiative and how this flows from board to ward. Secondly, it discusses how unsuccessful permeation results in the poor flow of information. During the interviews, one of the executive members identified five safety initiatives as the priorities within the Trust, those being, falls, medications, infections, recognising the sick patient, and pressure sores. These safety initiatives mirrored those of the Safety First Campaign by the NPSA (2015), and were further recognised by the HSCIC (2015). To demonstrate the permeation of these initiatives through the organisation's culture, two of the five initiatives are used as an illustration in this thesis. One displays successful permeation of the initiative, and the other shows unsuccessful permeation.

5.2 CULTURAL PERMEATION (RESULTS IN CONTEXT)

To show the successful permeation of a patient safety initiative, falls was chosen. Falls was the only priority that demonstrated a consistent application and communication throughout the layers of the organisation. During the interviews, the staff discussed safety initiatives, and falls was clearly identified as the main initiative that the staff focussed upon. This was true from the executive team, through the organisational layers, to the lower grade staff on the wards. Due to the fact that falls was so energetically identified by all staff, it provided the clearest representation of successful permeation. In contrast to this, recognising the sick patient was used as an example of unsuccessful permeation. This appeared to only flow one layer down from the executive team. During the data collection, only the executive and one staff member from the management team identified recognising the sick patient as a patient safety priority. None of the other staff members highlighted this, and so this provided an excellent example of unsuccessful permeation. The following safety flow grid maps the journey of the two initiatives through each layer of the organisation.

Table 7: The Journey of two safety initiatives.

Initiatives	Executive Team	Mgt Team	Ward A Senior Staff	Ward A Middle Grade Staff	Ward A Lower Grade Staff	Ward B Senior Staff	Ward B Middle Grade Staff	Ward B Lower Grade Staff
Falls	X	X	X	X	X	X	X	X
Recognising the sick patient	X	X						

The falls initiative was recognised equally by both executive team members and ward staff. Conversely, recognition of the sick patient was only discussed by one of them within the interviews. Both the executive team members emphasised the importance of falls when asked about the safety initiatives by stating:

"…the big things we are focussed on at the minute are falls …and recognition of the sick patient and then doing something about it, all the early warning stuff, they are the biggies for us. Probably the one that has the most focus at the minute is falls..." (ExT 1, Line 185-189)

The other executive member reinforced this by stating:

"…falls is one of them absolutely falls and there are a huge amount of falls" (ExT 2, line 427-429)

In support of the falls initiative, the executive team stated that there was a huge emphasis on staff awareness and focus surrounding falls. They stated:

"...the one that has the most focus at the minute is falls" (ExT 1, line 188-189)

The focus around falls was initiated from concerns that the number of patients falling was becoming a major problem. The executive team stated:

"…there was a big problem around falls…" (ExT 2, line 471)

The problem of falls was highlighted in this Trust's annual quality report, in that the number of incidents involving serious harm from falls had risen from 27 to 61 in one year. The Trust had concluded that this rise was due to improved reporting. The identification of this significant concern led to raised awareness throughout the organisation, and led to further training for the staff. The executive team stated:

"…we have raised awareness, we've trained, we've done loads of training" (ExT 2, Line 491)

This raised awareness was reinforced by the creation and introduction of 'at risk from falls markers'. These were in two forms, one being yellow falling star paper stickers for notes etc., and the other magnetic yellow falling stars for the patient information board, each highlighting a patient at risk from falls. The executive team stated:

"…we've got the little yellow star, the yellow stars are on the medication sheet …and on the patient information board so we can just put the magnet down if somebody is at risk of falling [Yellow star]" (ExT 2, Line 492-493)

Not only were risk assessments, risk markers and falls care plans used, but also practical steps in falls prevention were taken. One such step was the introduction of a slipper swap. If the patients come into hospital without safe slippers, the ward team would swap these for a safer pair (with the patient's consent). There were also a number of other initiatives surrounding bed and chair sensors. These alerted staff if a patient left the safety of their chair or bed. One local initiative was a yellow wristband. These were placed upon patients who had more than one fall, and this was stated by the executive team:

"we've had swap the slipper, we've had chair sensors, the bed sensors… we put yellow wristbands on for patients who have had more than one fall" (ExT 2, line 494-497)

It appeared that the focus placed upon falls by the executive team had been a major driver which had ensured that all staff were aware of the issue. The safety flow grid discussed earlier reflected the consistent flow of the falls initiative from board to ward.

The management team also highlighted that falls were a major priority for the Trust. As reported within their quality report, various comments had been made by the management team, one of which was:

"…falls is huge because we've got lots and lots of older people with falls" (Mgt T 4, line 215)

The management team recognised falls as a major initiative and stated that there was a large amount of work going on in this area:

"there's lots and lots of work going on around any theme, any aspect of keeping the patient safe" (Mgt T 4, line 217-218)

It was very clear in the falls journey that two senior teams were committed to the prevention of falls. Those were the executive and management team. This is reflected in the safety flow grid. The falls journey on the wards will now be shown.

Ward A highlighted that falls were a priority within the Trust:

"…falls is a big issue… but getting better" (Ward A, S/S 7, line 679-680)

The issue of reducing patient falls was highlighted in the same interview. The ward senior staff member stated that:

"our falls, we're getting better with our falls because documentation and that was poor when I got here and you can never stop people from falling no matter how much people shout at you because your patients are falling over, we get all the falls who come here because anybody with a cardiac arrhythmia who has a fall comes to this ward so our falls are high compared to other departments" (Ward A, S/S 7, line 772-776)

This acknowledgement of the high falls rate was identified by one of the lower grade staff, who appeared to take the high incidents of falls seriously when she stated that:

"oh the falls on here is just horrendous… they just happen it's like the worst Trust and its really embarrassing and I'm thinking God how's that happened because it's not like we're like neglecting the patients" (Wd A, LGS 12, line 503-514)

On ward B, the focus around falls was emphasized further by the ward senior team when they stated:

"…falls is huge in the Trust, there's a special falls group, there's falls nurses, there's falls doctor, there's a fall, clinic, thousands of falls paperwork, prevention of falls care plans, there's falls referral care plans. Now if someone falls more than twice you've got to do a cause analysis obviously falls is a massive thing" (Wd B, S/S 19, line 367-371)

The middle grade staff on ward B supported the views of the senior staff in saying that falls were a priority. They stated:

"falls I think is a major thing on this ward at the moment" (Wd B, MGS 14, line 355)

The recognition that falls is a major initiative on the ward was once again identified by the lower grade staff, and this was quite clearly the first thing they identified. One lower grade staff member stated:

"falls, because we get a lot of patients in with falls… I think the main thing on here is falls" (Wd B, LGS 17, line 533-538)

Again the other lower grade staff member on ward B supported this view:

"they will be falls, falls itself, falls… safety wise preventing falls takes up a huge part" (Wd B, LGS 16, line 383 & 392)

From the focus group, the collective acknowledgment was that the main priority was falls. They discussed this in the following statement:

"falls, its inevitably falls, it's always falls" (Wd B, FG, line 531-537)

It could have been interpreted from this statement that the staff were overly familiar with hearing' about falls, making this a more inconsequential importance. Nevertheless, all staff agreed that falls was an issue and it was recognised as the main priority for both the Trust and the ward. Training around falls was taken seriously by the executive team they stated:

"…we have raised awareness, we've trained, we've done loads of training" (ExT 2, line 491)

Support for staff about falls appeared to be quite robust. The staff on ward B suggested that they have study days on falls, and falls awareness. The senior staff on ward B stated:

"we've all got to go on a falls away day and we've all got to do the falls training" (Wd B, S/S 19, line 451-452)

This awareness ran throughout ward B, as a lower grade staff member stated:

"we get a specialist falls nurse who comes down… and I did a course" (Wd B, LGS 17, line 556 & 558)

This specialist nurse was also mentioned on ward A by the senior staff when they stated:

"…the falls team are coming around and spending half a day on each ward" (Wd A, S/S 7, line 811-812)

However, no other members on ward A stated that they had specialist or general training on falls, only the senior staff member.

Within the ward area, patients at risk from falls, and indeed those who have had a fall, were clearly identified within the handover sheet and also via the use of the patient information board and yellow star falls stickers. One lower grade staff member, when asked about falls, stated:

"it's all over the handover sheet, everybody who's had falls, it's on the handover sheet. We update the board on an evening so if the falls… we take the stickers off the board… we've got stickers to go on the front of the files for them, on the front of the medication file to show that these people are at risk from falls. So everybody should know" (Ward B, LGS 17, line 585-590)

The use of handovers to discuss falls was also reinforced by another lower grade staff member. She stated:

"it's always raised when someone has had a fall" (Ward B, LGS 14, line 371-372)

It is interesting to note it was only the two lower grade staff members on ward B who identified that falls were discussed within the handover. During the observational studies, falls were addressed at times, but when a repeated faller was identified on the patient information board this was not passed on verbally to the ward staff. I observed:

"on the board they had certainly one patient who was a repeated faller, but again that wasn't transferred during the handover it was on the board and was on the communication sheet" (Wd A Obs, line 261-263)

Although the information was on the board and communication sheet, all staff were also made aware of this verbally, instead of trying to read about the repeated faller. This verbal

reinforcement within the handover was later highlighted by me when I noted that the repeated faller had fallen once again:

"the staff nurse did kind of highlight that one patient had fallen. This was on the board this morning but wasn't discussed this morning. This gentleman went onto fall later on this morning" (Wd A Obs, line 297-299)

Had this gentleman's risk of falling been discussed verbally in the morning handover, and staff made aware, then he may not have fallen. Although the faller was identified, no reason for the fall was given. This then does not allow the staff to be cautious of future events.

Ward B had similar issues with verbal handovers. During observation it was clear the staff had a distinct lack of awareness of both potential and actual fallers:

"during the handover there was no discussion at all about falls or had anyone had fallen or was at risk from falling, what their fall status was overnight" (Wd B Obs, line 30-32)

And the lack of awareness of falls was evident:

"I felt that a distinct lack of awareness concerning falls issues, and on the board there was no marker, I know they have yellow falls stars but that wasn't actually against any patient's name" (Ward B Obs, line 37-40)

During other observations, there remained a lack of awareness surrounding falls. The staff relied on the handover sheets to read about their patients. However, one staff nurse lost her handover sheet, relying on memory to handover the patients at a subsequent shift change over:

"one staff nurse said she lost her handover sheet so a lot of the handover was based on her memory of the patient during the night which was extremely poor in that she couldn't remember a huge amount" (Wd B Obs, line 59-61)

This apparent lack of communication regarding falls was influenced by the staff on duty. On one ward, one of the senior staff on the ward provided a very comprehensive handover to her staff:

"one of the sisters fed back on the handover it was extremely comprehensive… a lot of the patient falls and that they were addressed this time identifying that the patient who had falls, identifying patients who were a little wobbly on their feet" (Wd B Obs, line 198-199 & 205-207)

Although the staff identified falls as the main priority on the ward, and some staff did recognise the importance of the issue of falls, verbal communication of this during the handovers was poor, and dependent on who was handing the patients over.

The results from the minutes of the executive and ward governance team meetings did support, to a degree, that falls was the main priority. Communication surrounding the issue of falls was evident within the executive meeting minutes. Falls were discussed in a number

of the monthly meetings, and in one meeting it was stated that the falls data was to be presented on a quarterly basis. In contrast, within the ward governance meetings, falls were only discussed in two of the monthly meetings for a whole year.

This lack of discussion within the ward meetings did not reflect the staffs' ability to raise falls as the major concern. The staff did have regular meetings with the management, as identified within the communication element of this chapter.

It is shown within this chapter that consistent communication from the board to the ward resulted in all staff being aware of the importance of falls, and it was this effective communication and reinforcement that allowed all staff to have this shared value.

There are some inconsistencies regarding falls, as although staff discussed falls as a major Trust initiative in the interviews, they did not always demonstrate this initiative within practice.

When this reinforcement was not provided, then unsuccessful permeation resulted. To demonstrate this unsuccessful permeation, recognising the sick patient was chosen, this being one of the five initiatives from the executive team. The safety flow grid (table 3) at the beginning of this chapter showed that recognising the sick patient did not appear to flow from board to ward. It only permeated one level down, and even this single layer permeation was problematic. The management team as a collective did see the recognition of the sick patient as an issue, and it was communicated in the variety of ways such as:

"deteriorating patient" (Mgt T 18, line 238), "keeping the patient safe" (Mgt T 16, line 218), "surviving sepsis" (Mgt T 3, line 159) .

One of the management team did not identify the sick patient as a priority. She focused on many other issues, but not the sick patient. It was noted that only one member of the management team focussed specifically on the deteriorating patient. There appeared to be a lack of recognition of the issue at the executive level, where only one team member identified this as a priority. The other executive member did not mention this.

This lack of clarity was also reflected one layer down from the executive team in the management team. The ward teams did not acknowledge the issue of the recognition of the sick patient, as this was not mentioned in any of the interviews or focus groups. During the observations, it was noted that the National Early Warning Scores (NEWS) were not passed onto the next shift. On one observation there was an NEWS of 4, which relates to a patient at risk:

"the NEWS on the boards ranged between 0 – 4 and when they went through the handover to the early staff a NEWS of 4 wasn't actually identified as an issue to be handed over to the next shift" (Wd B Obs, line 45-46)

The NEWS score directly relates to the patient's blood pressure, respiratory rate, heart rate and oxygen saturations. Each observation is measured and scored numerically. The score is associated with a response which helps guide the practitioner on further actions. A score of four could be seen as a patient deterioration.

The incidents of the sick patient ranged from deteriorating with melaena (blood within the faeces) to one patient who had not passed urine for 16-20 hours (which could be a symptom of renal failure, dehydration, blocked catheter, etc). These were not communicated well within the handover.

From the analysis of the executive team's meeting minutes, the recognition of the sick patient was not identified. Conversely, NEWS was identified as a monthly agenda item in the ward clinical governance meetings, but no action plan was provided to me on how many of the issues with implementation were being addressed.

How permeation can be successful (falls), and unsuccessful (recognising the sick patient), has been illustrated using examples from the data. The initiatives are measured using Commissioning for Quality and Innovation (CQUIN) targets. It appeared that those interviews that included measurement (such as falls) were more likely to be successfully permeated throughout the organisation. If not measured (such as recognizing the sick patient) then permeation was not identified at different organisational levels.

Each of the seven themes that are important for successful permeation are presented below. Examples of successful permeation, i.e. falls, and unsuccessful permeation, i.e. recognising the sick patient, are used to demonstrate how each of the seven themes facilitated better contribution to the permeation of organisational culture.

5.3 Cultural consistency

The executive team recognised that organisational culture does exist. They talked about this fluently and with conviction, and had an ability to relate this to their organisation. One member of the executive team explained that organisational culture within the Trust is:

> ***"a pretty vibrant, positive, a patient focussed culture. What we've been trying to do is build a culture about people wanting to do their best, improve things, try and get to a position where they are happy for their family to be treated here, and increasingly if they see a problem sort it out, let's not make a big thing of it, just sort it out" (ExT 1 lines 26-30)***

This statement identified that the staff are central to care delivery and improvement. This was reinforced by the following statement:

> ***"It's a culture of not being frightened to own up to mistakes, not frightened to ask questions, not frightened to give an honest and fair opinion" (ExT 2, lines 50-51)***

The view of the organisational culture of the executive team was reflected in the management team's opinion. They identified that the Trust had a target-driven, open and fair, no-blame culture. They viewed culture as forward thinking and inclusive, believing that they involved ground level staff in a lot of decisions:

"it's a fairly modern open relaxed culture" (Mgt T3, line 68)

The management team took the concept of culture further by linking this to patients and staff. This perception of organisational culture was generally consistent throughout the management team. One management team member suggested that:

"it's very much committed to do the best for patients, but not only support patients but support staff to be able to have the resources to provide that, I feel that they take patient care really seriously" (***Mgt T4, line 56-58)***

There were some differing views from the management team. Some thought the culture was the same throughout the whole of the organisation but others stated that culture did not flow through all the levels:

"I can't say hand on heart that the culture filters down to all levels of the organisation because there's probably a number of people who just come in, and do their job and they go home and they're not really that connected with it all" (Mgt T 18, line 71-74)

The executive team and management team appeared to have the same overall concepts of their organisational culture, providing congruence of meaning. However, the executive team did recognise that each area does 'feel different' but there was a consistent message.

"Probably no matter where you go in the organisation, if you ask them anything to do with patient safety or the commitment, or how "…NHS Foundation Trust" works you will probably get the same answer, probably not in the same words depending on which level you actually spoke to, but you would get that theme to come out to say that it is a '…Trust way, everyone works together, we do it because we like to succeed we do it best for patients, if your patients' are happy, the staff are happy" (ExT 2, line 40-45)

This consistent message of commitment to patients did tend to reflect the ward staff's views of the organisational culture also. Nonetheless, this was not always viewed as positive:

"it's all about public perceptions, nobody cares whether it's the right thing or the wrong thing, it's all about public perceptions… it's to make the public think we're great" (Wd B, S/S 19 line 89-98)

The ward staff generally linked organisational culture to the culture of the ward. The ward staff, certainly the middle and lower grade ward staff, struggled with the term organisational culture, even after explanation. The ward staff could not conceptualise the macro level of organisational culture. They could conceptualise the micro level, as this was what they could see and feel: the ward itself. However, the consistent message from the ward staff was that

the overall organisational culture had nothing to do with them. This did not affect them; it was very much the ward culture that was their main focus:

"as for the organisation itself I generally don't have much dealing with it behind ward level" (***Wd B, LGS 16, line 96)***

The lower-grade staff on the ward found the ward culture a friendly place to work. They felt valued:

"on a ward level I am happy, we've got a new boss… she's wonderful and she's young and she listens to you, that's excellent, I like that, I'm valued, I love being a valued member of the staff" (Wd B, LGS 17, line 207-214)

However, taken away from this micro level and the micro culture on that ward, the staff's perspective of the culture within the organisation reflected that of an uncaring Trust,

"on a Trust level, I think they would replace you without thinking twice… I don't think they value people as much as… I think they value their managers and their sister's and their staff nurses but not the health carers, not the domestics" (Wd B, LGS 17, line 218-224)

The statement above involving the care of the staff within the organisation was also reflected in statements from the senior members of staff on the ward. They stated:

"I think they like to think that staff are at the centre of the organisation but they will cut staff short at any time to please relatives" (*Wd B, FG, line 50-51)*

This undermining of staff was identified by a senior staff member who stated that the Trust move staff from one ward to another to appease relatives. Consequently, this left other wards short at times. There did appear to be some incongruence between the overall organisational cultural view, and that of the ward.

The executive team were asked about subcultures, their existence, and their influence on patient care:

"we've probably got lots of little subcultures as well, all the sites feel slightly different" (ExT 1, line 41-42)

This acknowledgement of the existence of subcultures was something that had been embraced. One member of the executive team did say that the Trust did spend a lot of time trying to have one uniform culture.

"when I took over myself, thinking well actually there's value in having your own nuances, there's a reason it's there, as long as it's not damaging or harmful or contradictory to where you're trying to get overall" (ExT 1, line 98-100)

Following this change of thinking, the executive member also promoted this idea of sub-cultures:

"I think having a bit of local flavour is not a bad thing" (ExT 1, line 100-101)

The executive team had different viewpoints and beliefs about subcultures. One other member of the executive team described subcultures in a negative sense. When asked about the existence of subcultures they replied:

" I think there is probably a bit of that it doesn't come to the surface very often… but when it does it usually is a result of a grievance, somebody's felt like they haven't been dealt with fairly and that will filter its way up" (ExT 2, line 172-174)

Again, when the executive member was asked whether the subcultures were healthy she replied:

"I think in some respects it is healthy, because if they have taken the opportunity to raise a grievance, they've not been frightened to raise their grievance and have their say"(ExT 2, line 186-188)

The management team again had differing viewpoints on subcultures. One manager suggested that:

"we are all in the same… I feel we have all got the same philosophy and go around patients and patient care" (Mgt T 4, line 101-102)

This response suggested a belief that there are no subcultures, and only one overall culture that focuses on patients and patients care. One other manager viewed subcultures to be a natural entity and suggested that:

"I think they do but I think some of it is a positive, because I think some of the subcultures exist because the socialisation of the work is very different to other specialities so I don't see it as being a particularly bad thing, as long as it doesn't dwell on some of the negative" (Mgt T 3, line 89-92)

One of the senior staff on ward A also linked subcultures with negative connotations. She associated subcultures with cliques. She stated:

"I think there's three separate cliques in this department, I'm not in any of them, I don't want to be, I don't like cliques so I find it really difficult, they're very quick to try and get you into trouble (Wd A, S/S 7, line 287-289)

The focus group on ward A revealed that there was an acknowledgment that subcultures do exist, but this was linked to friendship groups. Upon being asked if this is good or bad:

"it's a really positive thing if those people are working together but then if you've got a mix, sometimes it can have an effect on the atmosphere" (Wd A, FG, line 158-159)

Ward B acknowledged that they did indeed have negative subcultures. However, since a new manager had been employed, the subcultures did not exist in a negative way.

There did appear to be congruence that organisational culture did exist. When this was linked to the permeation of the falls initiative, a flow from board to ward was evident. Conversely, recognising the sick patient, as a safety initiative, did not permeate lower than the management team.

5.4 Safety initiatives and focus

The executive team linked the organisational culture with the existence of a safety culture. This safety culture encouraged staff to not be afraid to own up to their mistakes. The executive team recognised that people make mistakes and they can learn from this. This view was supported by the management team, who also felt that there was a culture that was committed to doing the best for patients, and this was driven around high standards of care.

This was further discussed by the management team when they stated that the organisation wanted to deliver the best care it could, in the safest of environments for the patient, and that patient safety is:

> ***"not resting on their laurels, always looking to improve but having patient safety at the sort of core of everything that we do" (Mgt T 18, line 44-46)***

This was also reflected by the ward and senior level staff. They agreed the Trust aimed to provide outstanding quality nursing care. This was contradicted to some extent by the senior ward team, who suggested that the Trust disregard patient cares at times due to resource issues. The ward team saw the Trust as a very financially-driven organisation which was involved in efficiency savings. The staff suggested that there was not enough staff to deliver the outstanding nursing care they aspired to deliver.

The management team stated that the staff were supported to deliver the best possible care, and that when extra staff were needed, they were supplied to ensure patient safety.

There was a very strong emphasis on patient quality:

> ***"when you hear the CEO speaking it'll be all… its all-around patient safety, you know quality can't be compromised" (Mgt T 18, line 67-69)***

This important message reflected the executive team's statements, in that:

> ***"we have to make savings but the quality has to be maintained and actually improved, so it's doing more with less" (Mgt T 18, line 70-71)***

To ensure that safety was a priority, the CEO stated that:

> ***"we've got a lot of management presence and more importantly senior nurse presence, so we've got Matrons on nights and weekends etc" (ExT 1, line 228-230).***

This did appear to be about just making sure they were doing more with less. This was reflected in the care delivery by both ward senior and middle grade staff. One of the lower

grade staff felt she had little time to spend with patients. This member of staff wanted the executive team to come down to the ward and see how the ward staff actually worked, whilst being short staffed, and with such a heavy workload. The staff member went on to state that the Trust did not listen, or help staff deliver patient care.

This request for the executive team to witness was also made by another lower grade staff member. They stated they did not see the executive team and they should come down and see how they work a little bit more, perhaps spending half a day on the ward.

Lack of resources and staff issues did not appear to be taken into consideration by the executive team. They stated that patient views come first. Despite this, the ward staff felt that the Trust's culture was based around public perception.

One of the executive members stated:

"you've got to make the patient happy at the end of the day" (ExT 2, line 56-57)

This 'making the patient happy' was a recurrent theme from both management and the ward staff, but this can affect the patient's safety. There were concerns surrounding a patient's clinical need for treatment and what the patient's family requested, as where these were in conflict, the family need was listened to rather than the clinical need:

"the family went on and on about it so they just put one up, (Intravenous Infusion) ***oh it keeps the family happy" (Wd B, S/S 19, line 101-102)***

The need to keep the patient's family happy was reinforced within the focus group by an example of compliance to a family request. They discussed an incident where relatives wanted some intravenous fluid for their loved one. The staff explained there was no clinical indication or need for this, however the views of the family superseded the clinical judgment of the staff:

"Basically it is anything to avoid a complaint so the likes if we kept going and saying, no, no no we're not going to give them fluids, they will make a complaint, it will have to go further and then they just want to avoid that so it's easier just to give in" (Wd B, FG, 19, line 77-80)

The need to keep the patient and public happy was discussed at various times throughout the ward staff interviews. Indeed, the executive team stated that all the focus was on quality patient experience. The analysis of the data demonstrates that patient safety was a major concern to all the staff within the organisation, although priorities were often different. The executive team identified five initiatives, these being falls, medications, infections, recognising the sick patient and pressure sores. The reason for just focusing on these was identified by one of the executive team:

"I think what's hard though for people to just filter out all the things and what's actually important. We need to work hard all the time, these are just the things to focus on cos the system will tell everyone there are thousands of things to do all the time" (ExT 1, line 196-199)

The five initiatives would allow the staff more focus, filtering out all the unimportant issues. However, just one layer down, the management team identified thirteen initiatives. This was discussed in the individual interviews with the management team. The ward staff felt there were too many safety initiatives. Again this was reflected in the executive team's comments concerning the thousands of potential priorities. Despite the focus, even the management initiatives were received differently throughout the ward teams.

The highest priority was given to falls. This was identified from the executive team through the organisational layers to the lower grade staff on both wards. This demonstrated that congruence of information was achievable when the whole team was focused upon one issue, and that there was investment in the issue. The next priority was infections. This included Clostridium Difficile (C-Diff) and Meticillin-Resistant Staphylococcus Aureusis (MRSA).

It can be seen that this initiative was congruent within all the layers up until it reached the lower grade staff on both the wards. The lower grade staff did not highlight infection or infection control within the individual interviews, and it was only identified in the focus groups. This was only discussed when the senior grades had identified infections as a priority, and as a result the lower grade staff recognised this. Acknowledgement of other initiatives was inconsistent. The safety flow grid below (table 4) shows that falls flowed through all the layers, and infections also passed through all the layers, except lower grade staff on both wards.

Table 8 The flow of safety initiatives through the organisation

Initiatives	Executive Team	Mgt Team	Ward A Senior Staff	Ward A Middle Grade Staff	Ward A Lower Grade Staff	Ward B Senior Staff	Ward B Middle Grade Staff	Ward B Lower Grade Staff
Falls	X	X	X	X	X	X	X	X
Medications	X	X						
Infection	X	X	X	X		X	X	
Recognising the sick patient	X	X						
Pressure sores	X	X				X		

Slips, trips		X		X				
Moving and handling					X			
VTE		X						
Safeguarding		X						
Dementia, Delirium		X	X					
Patient Safety		X	X	X			X	
Privacy and dignity		X						
Maintaining health and well-being for staff		X						
Intentional rounding			X		X	X		
Complaints			X					
Nutrition		X				X		

The Trust held what they called 'safety days', where representatives from all staff teams come together, from the directors to the health care assistants. The teams then explore different safety initiatives:

"whole teams come in, block out a day an so go to… 'a local venue' with the team there will be sixty seventy people there and what's that's all about is them identifying what their safety priorities would be" (ExT 1, line 238-240)

One of the executive team also confirmed that the safety days occured with whole teams:

"the health care staff actually come to a patient safety day and they come as part of a team, they come up with a project and then they feedback the next time they go" (ExT 2, line 378-380)

The patient safety days were not highlighted by the staff during the interviews with staff on Ward B. However, on Ward A the senior staff did discuss the safety days:

"I went to the first patient safety day that they held, the Trust and you had to come up with an idea to improve patient safety at ward level" (Wd A, S/S 7, line 637-639)

The patient safety days were not discussed by any other member of the Ward A team, with the exception of a lower grade staff member. However, this was not discussed in detail and was really only a passing comment as she stated that the ward was just far too busy.

Not all the managers believed that the safety initiatives were working:

"I think there is a long way to go with falls, it's hugely complex… I think there's been lots of initiatives introduced but I'm not 100% sure what if any is making a difference" (Mgt T 3, line 211-214)

A number of observations on both wards were conducted. During the handover, falls was not mentioned:

"during the hand over there was no discussion at all about falls or about anyone had anyone had fallen or was anyone at risk from falling or what their falls status was… a distinct lack of awareness of falls and on the board their fallen star markers were not associated with any patients" (Wd B Obs, line 30-40)

This lack of awareness was on both wards, but when a senior staff member handed over on Ward B she provided in-depth information of patients' falls status and who was at risk. The staff did take this on board, although this was only provided by the one senior staff member.

There was a repeated faller on ward A. There was a falling star against their name, but again this was not discussed during the handover. The patient was identified on the handover sheet, but it was not subsequently discussed. During the morning I noticed a falling star, meaning a patient must have fallen. This was not discussed during the handover. Returning to listen to the lunchtime handover, this patient had once again fallen.

During the observational period there was a distinct lack of hand hygiene:

"wandering around the ward really I see that hand hygiene again is really poor, going from one patient to the next without gelling, without washing their hands, however they did use aprons most of the time" (Ward A Obs, line 312-314)

One worrying area was when a patient was barrier nursed, and needed moving up the bed:

"two physiotherapists came in, put gloves on and the staff nurse did as well, but they didn't wash their hands prior to putting the gloves on or anything or after they actually lifted the patient" (Ward A Obs, line 316-319)

This lack of hand hygiene was further apparent when a middle grade staff member was inserting a cannula into a patient's hand:

"on the night shift I was watching a staff nurse who didn't wear gloves or use an apron and I didn't see her wash her hands, …a no touch technique was not used, she kept tapping the vein to try and bring it up but didn't re-clean after that… when she finished the procedure I didn't see her gel her hands at the patient's bedside" (Ward B Obs, line 13-19)

During the ward observation there was a genuine lack of awareness of patient safety:

"on handover for the late shift one of the newly qualified staff nurses had said that one of the patients had not P'ud (passed urine) ***overnight, and she was too busy and she hadn't checked it that morning so potentially that could have been 16-20 hours without the patient passing urine" (Ward B Obs, line 162-164)***

Again, later in that day, this patient who had not passed urine was discussed once again by the middle grade staff member:

> ***"that patient who said hadn't P'ud*** (passed urine) ***last night they didn't have time to check him this morning and again the staff nurse had said will you make sure he has peed as he hasn't they hadn't noticed it on the afternoon so that's probably nearly 24 hours potentially that this patient hadn't peed" (Ward B Obs, line 211-215)***

> ***"the sister said that she couldn't find the medicine kardex for one of the patients at tea time and still couldn't so they withheld the medications for tea time, and justifying that he probably wouldn't take them anyway… the sister identified that a patient had a penicillin allergy which was the first time I had heard that today" (Ward B Obs, line 200-211)***

There appeared to be an apathy surrounding patient safety and communication issues. The above statements were not the only incidents. In conclusion, the staff were very much aware of the falls initiative. This was demonstrated throughout all the layers of the organisation. All the staff identified this during the interviews, but during the observations this was not seen as a priority for discussion. This did demonstrate that all staff had been communicated to about falls. There was a great emphasis from the executive and management team about this issue.

This was not the case for initiatives such as the recognition of the sick patient. The staff appeared to be unaware of this from the hierarchy, and there appeared to be no emphasis on this issue.

5.5 COMMUNICATION

The Trust operated what the executive team called a devolved system built on autonomous 'business units'. Each speciality is its own business unit, and each business unit has its own finance, management and human resources people. They are run as separate divisions or self-contained units. Each business unit has:

> ***"its own board with the exec director and a business unit clinical director" (Mgt T 18, line 572-573)***

One of the executive team confirmed the difficulty with information flow through the business units by stating:

> ***"so a lot of what goes on in the board, other than you know we have a got a broad quality strategy, how we are doing on performance and quality and patient experience, that goes through the system and in internal communication, in the briefings and the press releases, I do notes to staff and all that. I think the staff see all that" (ExT 1, line 145-150)***

The other executive team member confirmed this information flow, and stated that she has team briefings which happen each month. This was then cascaded down to heads of department. The heads of department would then cascade this down to the whole team

within two days. The team briefings were face-to-face with staff. One of the executive team members was adamant that staff should function as a team and talk to each other:

"we're just going through a process of encouraging everybody to make sure you actually take the opportunity to sit down as a team, do as much face to face as possible, don't rely on email, don't reply on written team briefs" (ExT 1, line 173-176)

The other executive team member reiterated this view about the importance of face-to-face communication, and added that it is a good time to answer questions and think about the terminology that is used. One of the executive team members discussed forums like the Senior Nurses Forum. More information is cascaded down to the staff on the wards from meetings such as this.

The management team stated that they received information passed down to them from various meetings, emails, and some face-to-face discussions. This was then passed down to the ward team through face-to-face communication, and also when minutes of meetings etc. were posted on the wards. The ward staff agreed that information did come from emails, newsletters and meetings, but one senior member of staff on the wards did not think the information got passed down well, as she stated:

"we get a lot of emails, I mean I was off yesterday and the day before as my days off and I came back to 52 emails today, most of which I delete because I will only read the ones I have to properly action. So that information gets lost. I have a matron but by the time it gets to her it's like Chinese whispers you know, so I don't get accurate information I actually get and then I've got to relay to the team and I will relay it to the team that I see, say today and then you just forget and that's honest" (Wd B, S/S 19, line 264-270)

The senior ward staff acknowledged that they do have face-to-face meetings with the matron. She also stated that she attended the heads of department meetings, and ward manager away days, but issues were still not getting discussed. The information flow could be improved, but the senior ward staff did still receive paper based communication.

Often, time constraints hindered important information being passed down from senior staff members. One senior staff member on the ward acknowledged these constraints and the difficulty in reading and disseminating important information to her team. One example she gave to highlight this problem was important information about preparation for the Quality Care Commission inspection. She stated:

"what to be expected from the CQC, like I'm on a 12 hour shift today, I haven't got time to read that, I certainly don't have time to tell the girls about it. So that will just like go in the bin in the next day or two and then what to expect from the CQC will not be there" (Wd B, 19, line 291-296)

The ward managers did hold meetings with their staff. Ward A held two meetings; one a clinical governance meeting and also occasional ward staff meetings, agand information was

cascaded down at each. It was noted that information from the top-down was poorly communicated:

"I would say top down communication isn't very good, they don't speak to the little people much" (Wd A, S/S 7, line 99-101)

"I think from the top down it's not cascaded very well, it's like you've got to do this, you've got to do that you've got to do the other, we want it done by now, you know do it by end of week or else sort of thing" (Wd A, S/S 7, line 507-509)

Ward B senior staff confirmed this finding by stating:

"I think everything's always in a rushed manner, it's always dead on target time, you know you maybe get told on a Monday, right you've got to have all your CQUIN targets by the end of the week and then like the OSM's, (Operational Service Managers) ***the people that you've never seen before, the next minute they're around checking your folders, you know like who are you, you know in your suit" (Wd B, S/S 19, line 309-313)***

Again this emphasis on last minute actions was reaffirmed by the senior staff on ward A:

"I think some of it is last minute.com when you just get told you've got to do this, urgent emails that come through" (Wd A, S/S 7, line 571-572)

The executive team were aware of the time it takes for information to be cascaded down. When asked about the information flow and whether it is timely, one of the executive members replied:

"No probably not, we are still working really hard on that, we cover two and a half thousand square miles, it has always been one of our weaknesses and just the distortion by time it flows through, you know how the message can be completely different" (ExT 1, line 166-168)

The other executive team member agreed and stated:

"I think it could be improved and you're absolutely right in the way they would understand it" (ExT 2, line 293-294)

This question of understanding also came from the senior staff on the ward. The ward managers have to ensure that information gets passed down to the team and it is their job to ensure it is in an understandable format.

One area of communication that the executive team appeared to praise was that they walk around the wards, both during the day and at night, often unannounced. The executive team member stated:

"Yeah I just turn up, I don't like doing planned stuff. The team do the Institute for Health Improvement checklists things as a team, I just turn up on site, paddle round, speak to people, the girls organise them in a more structured way, I don't like them to be just like a royal visit and we just walk and have a chat" (ExT 1, line 56-59)

The staff on the ward had mixed views about these visits. The ward manager on ward B stated she had never seen the Director of Nursing, and suggested:

"I've never met the Director of Nursing. I wouldn't know if he walked in now, never seen him" (Wd B, S/S 19, line 329-330)

The ward senior staff member on ward B had met the CEO on his visits, although the other senior staff member on ward A had only met the CEO once in 20 years. She had met the DoN, but only on a personal level, not while she was walking around the wards. The executive visits appeared to be quite sporadic. Different staff members identified that the executive team did visit the wards. One staff member stated:

I'm quite lucky because I actually know who they are and they have been on the ward, one only this week… it's not every week, and it's not every month" (Wd B, S/S 13, line 264-266)

All the ward teams acknowledged that information comes down to them from their ward managers or the matron. This was done in a variety of forms, from emails to face-to-face communication. Once again it was recognised that it is the rushed nature of the communication that is problematic. A staff nurse asked about the speed of information communicated to him replied:

"I think it's too quickly really… because we've just started one task then there's another one to come out" (Wd A, MGS 9, line 236-240)

It appeared that information did get to the ward staff but in a rushed way, and the change process was too quick.

From data in executive team board meeting minutes it was clear that very little filters down to ward-level meetings. Within the meetings, various items were discussed and action plans devolved down to the individual teams. Each month there appeared to be consistent discussions and reports surrounding slips, trips and falls, serious untoward incidents, infection rates, and surgical site infections. However, pressure ulcer rates had only been discussed once in the year. There appeared to be a distinct lack of action plans developed and followed up following the meetings.

The minutes from the ward governance meetings showed regular topics. These included the ward audits about NEWS, Malnutrition Universal Screening Tool (MUST), hand hygiene, cannula, commode use and falls care plan audits. Each month, incident reporting forms were discussed, as well as serious untoward incidents, and at times action plans were developed. However, it appeared there was no review from past action plans. One or two of the topics discussed at the executive meeting had been identified on the ward meeting minutes, those being harm rates and staff development. Yet, the terminology relating to harm rates appeared to be inconsistent. The wards used 'patients at risk' and the executive team used the term 'harm rates', which arguably have the same meaning. Staff development was clearly identified within both meetings as a priority, but no action plans could be identified. The executive team highlighted clostridium difficile (C Diff) a number of times, and highlighted

that they had breached the national target for this. This was not clearly communicated to the ward staff and the staff remained unaware of this concern. This was also the case for the MRSA infection. The ward had one incident within a six-month period. An action plan was developed, but again this was not passed down at the ward meeting.

5.6 Measurement

Measurement within the Trust comes from audits. When asked about whether the safety initiatives had been taken on board, one of the executive team members replied:

"we've got loads of auditing processes going on as well to demonstrate that they are, so when we decide something is very important there's loads of engagement that goes on and we measure and measure and measure which always gives us comfort that we are actually doing what works and the way I work is I take all those facts and data but then I'll go and take a walk around scratch and sniff and listen and it's a combination of those things that gets me to the point of thinking yeh I think we are doing that well, you can't rely on one or the other themselves" (Ex T 1, line 208-214)

The executive team believed that their audits on hand hygiene, cannula care, and commode cleaning compliance were generally 98%, and one of the executive team members thought that level represented the optimal achievement possible. The executive team were asked whether all the staff comply twenty-four hours per day:

"We have a very visible person who is responsible for the safety of that site and making sure we all know if we've got a bit fragile somewhere and that its dealt with properly" (Ex T 1, line 230-232)

The senior staff on Ward A saw the audits as the most important determinate of patient care, not the actual care itself:

"when they come around to and audit our notes and files if we haven't got something filled in we're seen to be failing even though the patient care has been fantastic on that shift or that week because some boxes aren't ticked we're failing" (Wd A, S/S 7, line 207-210)

This idea that audits were more important than the care delivered was supported by the Senior Staff on Ward B:

"we clean our commodes after every… after everything, commodes are always clean as they should be but on a Tuesday we have to submit an audit, for whatever reasons audit was forgotten to be submitted so on a Thursday afternoon myself, as the ward manager, the person who didn't submit the audit, whatever staff nurse was on shift, the matron, we've all got to go to the DoN which is fine but I was the other qualified on the ward so it meant the ward was left two patients to one qualified, while I went to explain why a commode audit wasn't filled in" (Wd B, S/S 19, line 234-241)

This senior staff member supported the use of audits and understood their importance, however:

"I agree audits are great and they're great at flagging things up, I'm not saying we shouldn't be auditing, you know I'm not old fashioned like that, of course we should

be auditing but its common sense, there seems to be no common sense" (Wd B, S/S 19, line 246-248)

When staff were auditing, the results were not always genuine. When a lower grade staff member was asked if the audits were done perfectly they responded:

"to be honest no… they don't get done perfectly, results do get fabricated because of targets… it's the commode audits, generally it's the commode audits and as a ward we didn't meet our audit, we need to improve but then it goes back to above that we're perfect. So yes we're not telling them the truth but that's something we need to improve on" (Wd B, LGS 16, line 344-360)

Being honest may not be the best policy, as a staff member on Ward A stated:

"if your score isn't 100% on that then the matron comes down straight away and says why is this not happening, and it's kind of perceived as a bad thing that someone has maybe not washed their hands but you're trying to be honest as you can on the audit, if you're not honest and you score 100% then you don't get hassle from management" (Wd A, S/S 8, line 490-494)

The falls care plans were audited, but this was not discussed during the interviews. However, the NEWS audit was highlighted. It was interesting that falls was a major initiative that flowed throughout the organisation, but the audit itself was not discussed. Conversely, the NEWS was not identified within the Trust as a major initiative, but the results of the audits were discussed.

5.7 Development

Staff development within the Trust was prioritised by the executive team as a way of improving the patient experience. One of the executive team stated:

"lots of leadership development, lots of clinical development in lots of areas and all that's about, really all that focus is about quality patient experience, doing your level best" (ExT 1, line 46-47)

The other member of the executive team appeared to agree with this statement, and stated:

"keeping your staff informed, trained and developed well makes your job a lot easier" (ExT 2, line 352)

The training and development provided was seen as reactive as it was provided in response to problems identified on the ward, for example respiratory problems. This training included both qualified staff and health care assistants:

"we had a couple of issues of incidents that happened on one of the respiratory wards and funny enough the other side had exactly the same issue and we put money together. We put in a bid together and got some funding for respiratory essentials and it was for all qualified staff to attend, three days off the belt then an OSCE and multiple choice afterwards. I had a plan that if people didn't actually get there we would support them, then what about the actual health cares they were one of three at night… right so do the health cares and I tell you what they just think they're the bees knees" (ExT 2, line 388-394)

There was also other training, such as that provided for incident reporting form completion, C-Diff pathway, falls, etc. The Trust also held cross-site education involving many staff. From the evidence above it can be seen that the executive team take training and development seriously, supporting the staff to attend training events. Data suggested that, for the management team, development and education were implicit rather than explicit. The senior staff on the ward discussed the problems surrounding lack of staff and time as a barrier to education:

"we need to have more ward managers or the sisters as supervisory and not part of the clinical team because you can't do… you can't do teaching, training" (Wd B, S/S 6, line 326-328)

The middle grade staff on the wards did not comment on development, but the health care assistants did raise concerns on both wards:

"I don't think that they put you on enough courses, we could go a lot further on this ward, the healthcare's but the Trust won't put the money into it" (Wd B, LGS 17, line 146-148)

This lower grade staff member health care assistant stated that she thought the qualified nurses took priority and were more valued:

"I think they value their managers and their sisters and their staff nurses but not the healthcares not the domestics" (Wd B, LGS 17, line 223-224)

These issues, concerning development and education, did not appear to reflect the views of the executive team:

"lots of clinical development in lots of areas and all that's about, really all that focus is about quality patient experience, doing your level best" (ExT 1, line 46-47)

"keeping your staff informed, trained and developed well makes your job a lot easier" (ExT 2, line 352)

The training and development that occurred appeared to be hindered by the lack of investment and lack of staff to enable staff time to attend training. It can be seen from the executive team interviews that recognising the sick patient was identified (the respiratory patient) as an important issues, and actions were taken to educate the staff. However, this was not discussed by the ward staff during the interviews.

5.8 Leading and shaping

The question of leadership and culture was raised by one member of the executive team (CEO) who stated:

"I think I set the tone, I think I have to set the tone, the exec team, the board have to be clear, all the clinical leaders be clear that they are seen as a visible manifestation of the culture" (ExT 1, line 63-65)

This executive member went on to say:

" I've got a set of values, which flow through, onto all the stuff that's written in the organisation. But I would say, where I would like to be is that every member of staff should be able to say they know what makes me tick" (Ex T 1, line 120-122)

The other executive member supported this concept and stated:

"he's an ordinary lad, was born and bred in the north east, he tells people there is no airs or graces about him" (ExT 2, line 112-113)

The leadership within the Trust that came from the executive team appeared to be led by lateral leadership and:

"you work on the ground when you have to, and you do things so if you have to go on a ward and the patients about to stumble you go and help the patient, if you are on call you go out and help them make beds" (ExT 2, line 114-116)

One of the executive members challenged the visibility of the executive team and their decision to help on the wards by stating:

"people maybe say well you know we're very much hands on, is that a good thing or a bad thing. But the fact that you can go along the corridor and the domestics know you" (ExT 2, line 129-130)

This executive member acknowledged that the executive team are strategic thinkers, and they do strategic things, but she stated that it is not about that:

"we are always looking to improve our services, but equally we don't forget where we've come from" (ExT 2, line 134-136)

Data suggested that from a senior leadership perspective the executive team lead the whole organisation, and this is then devolved to each business unit, which has its own senior leaders that sit on the executive board. This structure provided a strategic vision from the very top, which then flowed down through each business unit.

The management team saw that leadership of the Trust comes from the CEO:

"I think it is very important that the leadership for this organisation comes from the chief exec and his exec team … the director of nursing medical director and the chief exec are seen as pivotal individuals. The non-execs that also sit on the board are then part of the business units as well, so they cascade that behaviour down, but particularly our chief exec's very visible and a very good role model and a very good leader and I think that a lot of his behaviour certainly permeates through the whole organisation" (MgT 3, line 71-77)

Some of the management team saw leadership as a hierarchal structure:

"we've got the chief exec at the top, and then to our exec nurse, then our executive managers, and then it comes down to our operational managers, and then to the matron, and the matrons are actually more on a level with the wards and the areas that they cover" (Mgt T 5, line 116-122)

One of the management team only saw leadership from the matron and her superiors, but not the ward team. This apparent lack of leadership recognition was reflected in a rotation enforced by the management team on a senior staff member to another hospital within the same Trust. When asked the reason for this move she replied:

"to shake it up a bit, I don't know why they did that because it's just made both sides very unhappy" (Mgt T 7, line 363-364)

This move of the senior staff member proved 'unsettling' for her and her leadership behaviour. This she felt reflected on the ward dynamics, making the team frustrated. The senior staff member linked this move to the inconsistent approach of the management team. The relationship between the senior member and the management team suffered as a consequence, leading to inconsistent leadership and relationship breakdown. The leadership on ward B appeared to have changed, as a new manager had been employed. The staff stated:

"I think things run a lot smoother when the ward manager is here purely because you know you've got her back up" (Wd B, MGS 5, line 387-388)

Again, leadership was identified as an important element. They commented on the new ward manager:

"shes wonderful… she listens to you, that's excellent. I'm valued, I love being valued" (Wd B, LGS 17, line 212-213)

On ward A, the staff identified that they also have a new manager, and they commented that she was really nice and approachable. Consequently, this staff member did view the happiness on the ward as being dependant on who is on duty:

"I think it's a happy ward. Not every day is the same though; it all depends on who is here" (Wd A, LGS 11, line 178-179)

However, this acceptance on the ward was not viewed as the same by the ward manager:

"the senior staff don't support me at all, in fact they try to obstruct what I am doing" (Wd A, S/S 7, line 299-300)

This apparent lack of respect for the ward manager was not reflected in any of the interviews with the lower grade staff.

5.9 Communities of practice

The communities of practice within this organisation are split between several sites. Within each site the specialities are split into different business units, and these business units act as separate units managed with a specific team. One of the executive team members discussed how the culture felt within communities of practice:

"if you do walk into each site and talk to staff you do feel differences because they are embedded in their own little communities that in themselves are different" (ExT 1, line 43-45)

The other executive team member linked this with culture and stated it is the accent of the organisation. She went onto explain that the whole organisation works together:

"everyone works together, we do it because we like to succeed, we do it best for patients, if the patients are happy, the staff are happy" (ExT 2, line 43-45)

One of the executive members stated that the organisation used internal competitiveness; one ward against another:

"it's not a bad thing to think I want to get better than them… as long as it doesn't turn into a negative thing" (ExT 1, line 103-109)

This competitiveness was turned into a positive experience:

"clinical staff are generally quite competitive as well, I think the key is you have to have pride in what you are doing and if that pride can be channelled positively it is a good thing" (ExT 1, line 113-115)

Competitiveness was not reflected in the ward staff interviews. The view, as explained above, from the executive team portrays a community of competitive, happy teams that strive to succeed. Conversely, this explicit explanation of the teams does not reflect the reality for staff on the wards.

Although one ward manager was new, the staff appeared quite happy with their new manager, and they stated:

"she's wonderful… she listens to you, that's excellent. I'm valued, I love being valued" (Wd B, LGS 17, line 212-213)

"I think it's a happy ward. Not every day is the same though; it all depends on who is here" (Wd A, LGS 11, line 178-179)

On Ward A, the senior staff member discussed conflict on the ward. This appeared to stem from one staff member, who was previously the ward manager, so some conflict arose from that.

There was also conflict within the ward teams. There appeared to be three different cliques, and again the new manager was attempting to change practice for the better:

"I've got people here who are in senior roles who are so against me because I've come as their manager and they think they're better than me and could do the job better that me, so it's difficult" (Mgt T 7, line 472-474)

5.10 Chapter Summary

This chapter has provided a unique insight into the perceptions of staff within an NHS Trust. Within the data analysis there was evidence of seven themes that reflected the staff's perception of the organisational culture. These were cultural consistency, safety initiatives and focus, communication, measurement, development, leading and shaping, and communities of practice. These seven themes were important elements of the organisational culture, as perceived by staff. To identify if organisational culture permeated throughout the Trust, two of the five safety initiatives identified by the executive team provided an illustration of permeation, these being falls and recognising the sick patient. It was shown that with investment from all staff, permeation of culture is possible. In contrast, without that investment, then permeation is incomplete. Within the 'results in context' section, permeation was demonstrated using falls as a safety theme that successfully permeated throughout the whole of the organisation, and recognising the sick patient as the failure to permeate. The issue of falls was seen as a priority through all the layers of the organisation, and staff investment was measured by the workload of the ward, patient dependency and results of the Key Performance Indicators (KPIs). The recognising the sick patient did not appear to have the same measurement and was not seen as a priority. It is interesting to note the lack of clarity within the five safety themes in that just one layer down' most of the management team added to the list of initiatives, and also the ward staff added to this list. Consequently, none of the five initiatives permeated down to the ward except for falls. This does show that with substantial investment permeation is possible, but needs this investment by all staff, including clear lines of communication at all levels.

This chapter has highlighted examples and occurrences of permeation without fully exploring the nature of permeation. The following chapter provides an analysis of the concept of permeation in this study context.

CHAPTER 6 CONCEPTUAL ANALYSIS OF PERMEATION

6.1 INTRODUCTION

Given the central role of permeation and the lack of published work in this area it is important to provide an analysis of this concept. This chapter provides an analysis of the concept of permeation and discusses the relationship between permeation and diffusion. Supporting literature is used, alongside dictionary definitions and my own research, in an attempt to gain a better understanding of this concept. This chapter highlights a number of steps that could facilitate permeation within the Trust.

6.2 PERMEATION AND DIFFUSION

As already identified, there is some debate about the terminology of permeation as it applies to the movement of information within an organisation. Many definitions of this term exist from science (Murata et al, 2000) but very few exist within an organisation. Permeation is often implicit rather than explicit. Although permeation is discussed, a definitive definition is difficult to determine (Maier & Brandl, 2008; Dasgupta, 1997). Maier and Brandl (2008) came close to a definition, suggesting that when practices become natural and everywhere then this can be seen as a process of permeation. A dictionary definition suggests permeation means:

> "…to penetrate or spread throughout something"
>
> (Collins English Dictionary, 2009, p. 558).

In the case of my study the 'something' is the Trust and its employees as an organisation.

In relation to permeation, Beswick (2013) used the analogy of a 'cup of tea', suggesting the flavour permeates throughout the drink. Beswick (2013) went on to link permeation and innovation, suggesting that in order to fully implement innovation and change, everyone and every process of relevance needs to be infused with the essence of innovation. This infusion of essence and the 'cup of tea' analogy could be linked to this study in that there is a requirement for staff at all levels in the organisation to be aware of the safety priorities, and to value safe care.

Chapter five demonstrated that permeation of patient safety initiatives throughout the organisation can be successful, but that this is a complex process. For successful permeation there needs to be an environment that allows clear communication with each team member and for the communication to be understood by all. This needs to be linked to the core values, purpose and strategy of the organisation. The term permeation is sometimes used synonymously with the term diffusion (Collins, 2009), although the latter is also difficult to define other than in a scientific context. Rogers (1995) identified diffusion as a process of

communication through differing channels and, over time, in a social system. Diffusion can be directly related to the Trust as a social system, in that different channels were used to communicate safety priorities through to each individual within the different layers of the organisation. Permeation and diffusion are therefore similar concepts, and both have relevance for my study. However, Rogers (1995) further clarified that the outcome of diffusion is to change the structure and function of the social system, whereas permeation is simply about communicating the information.

In order to provide a structure in which diffusion occurs, Rogers (1995) suggested there needs to be:

1. **The innovation itself:** It should be a new idea as perceived by the staff or social group. However, it can be an old idea reinvented.
2. **Communication channels:** The process in which the staff and social groups share information and reach a shared understanding.
3. **Time:** How long it takes for diffusion and change to occur.
4. **Social systems:** The amount of staff and social systems who are engaged in a common goal.

Rogers (1995) went on to suggest that to implement any innovation the organisation should follow a 5-stage process which allows the individual to change over time through actions and decisions. The five stages are:

1. Knowledge: Occurs when the individual is exposed to the innovation and gains an understanding of this.
2. Persuasion: Occurs when a favourable or unfavourable attitude is formed towards the innovation.
3. Decision: This occurs when the individual engages in either acceptance or rejection of the innovation.
4. Implementation: Occurs when the individual puts the innovation to use.
5. Confirmation: Occurs when the individual seeks reinforcement of an innovation or decision already made, or reveres that decision.

It can be seen that an understanding of the 5 stages could help to ensure that innovation (safety initiatives) was implemented across the Trust. Maier and Brandl (2008) suggested that diffusion starts with permeation, and that permeation encompasses diffusion. Dasgupta (1997) also supported the link between permeation and diffusion by suggesting that diffusion is a collective process involving introduction, assimilation and permeation of information throughout an organisation. Indeed, if the definitions of permeation and

diffusion were to be examined it could be seen that they both present the process of spreading information (Rogers, 1995; Collings, 2009; Dasgupta, 1997).

Permeation in the context of this study is the process of spreading information throughout an organisation, by ensuring that each level of that organisation has effective communication on how the innovation can be initiated as a result of permeation. The results here also indicate there appeared to be a need for congruence of message and effective leadership.

Diffusion is arguably the method of delivering the innovation or information involved in change so staff can implement the fundamentals of what is being permeated. Maier and Brandl (2008) appeared to support this by suggesting that diffusion is the application to an increasing number of organisational problems. Green (2004) also supported these views and suggested that diffusion is an attempt to translate the adoption of practices by different organisations. Maier and Brandl (2008) suggested that there are different 'states' of permeation, in that practices have to be institutionalised within the organisation and their diffusion. Green (2004) defined institutionalised practices as the degree to which practices are taken for granted, and diffusion is the attempt to translate the adoption of practices.

Thus, diffusion is clearly concerned with change of practice and how this fits within an organisation. Innovation and permeation are concerned with the flow of information to support the diffusion. My reflections and thoughts are supported by Rogers (1995), who considered both the individual and the social group, and how individuals react to implementation of an innovation. Figure: 11 presents Rogers' (1995) bell curve of individuals and their responses to the innovation.

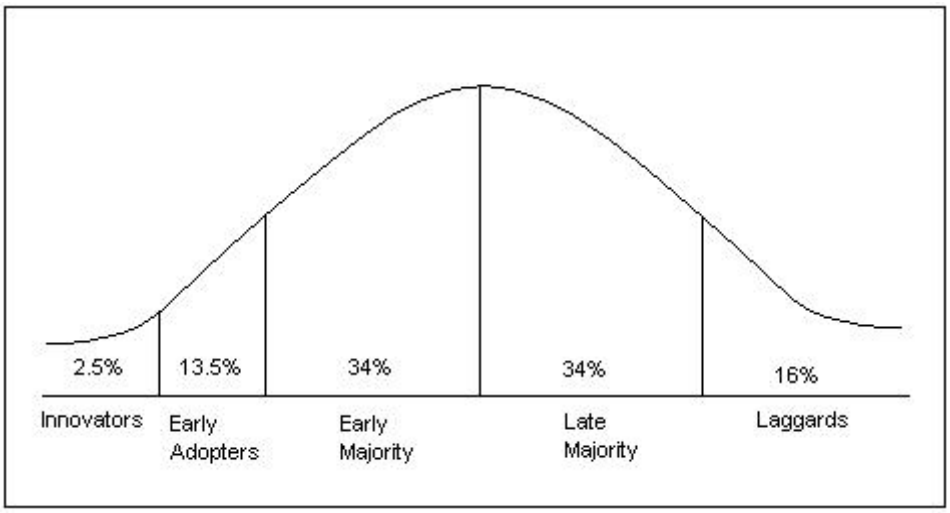


Figure 11: Adopter Categorization on the Basis of Innovativeness (Rogers, 1995, p. 262)

Rogers (1995) focussed more upon individuals, as the bell curve above suggests, and not on organisations, whilst also suggesting that the adoption of innovation relies on individuals who are:

1. **The innovators:** Venturesome and have an interest in generating new ideas.
2. **Early adopters:** A more integrated part of the local social system. Early adopters have the greatest number of opinion leaders. They serve as a role model for others and quickly accept and promote an innovation.
3. **Early Majority:** These adopt new ideas. They provide interconnectedness of the interpersonal networks. They follow an innovation rather than lead it.
4. **Late Majority:** These will adopt the innovation at a later stage. The adoption can be from social pressure from peers.
5. **Laggards:** These are the last in the social system to adopt an innovation. They tend to be suspicious of innovation.

The individual focus of innovation using diffusion is clear but, as already discussed, Durkheim (1961), Tylor (1871) and Weber (1930) supported the views that the 'individual' is unimportant within a culture, and the focus is more on groups and the members of a society as a collective. Rogers (1995) did acknowledge that organisations are more complex in adopting innovation, and it is this complex nature of organisations that would benefit from permeation.

Within the Trust it was important that permeation was identified, ensuring the safety initiatives flowed from board to ward. The permeation within this study was about action, not just a theoretical concept. Successful permeation is when action occurs, i.e. with the falls, and unsuccessful permeation, i.e. recognising the sick patient, is when no action occurs. Permeation needs to be led by committed leaders who enable the actions. Hansson and Klefjo (2003) supported this view. They discussed the idea of leaders as enablers of communication, and this has strong links to permeation. Within the Trust it was crucial to ensure that the leaders had an understanding of how permeation occurs from board to ward. It can be seen that the safety initiatives from the executive teams were a new focus for the Trust, and an understanding of these initiatives by all staff was a necessity. These new ideas needed to be permeated throughout the organisation by consistent communication led by the leaders of the Trust.

The information about the safety initiatives within the Trust may eventually permeate, but only in a multitude of ways, concentrations and perceived importance. Conversely, with clear consistent leadership, permeation may spread evenly, and all areas of practice would get the same message and then concentrate on implementation in the same way. This could lead to what O'Neill, Pouder and Bucchholtz (1998) and Abrahamson and Rosenkopf (1993)

called a bandwagon effect. Bandwagons are diffusion processes where adopters choose an innovation that most people follow once the relevant information has permeated through the organisation.

6.3 A Conceptual Analysis of Permeation

Concept analysis has been used extensively both within philosophy and nursing (Rogers, 2000). A criticism of concept analysis is the nature of concepts, as being theory formed or theory forming (Morse, 1995). Walker and Avant (2011) suggested concepts are the building blocks of theory that can be developed prior to theorising. However, others have suggested concepts are theory already formed (Rogers, 1989; 2000; Paley, 1996). More recently, it has been suggested that either perspective could be taken, and that concept analysis can be either examining concepts as theory, or to produce theory (Risjord, 2008). Concept analysis was developed by Wilson (1963) and first used in nursing in the 1980s (Morse, Hupcey, Mitcham, & Lenz, 1996). Wilson (1963;1969) developed an 1- step process to identify what he called essential features of a specific concept (Duncan, Duff-Cloutier & Bailey, 2007). The development of Wilson's work was adapted by Walker and Avant (2011) and applied to the discipline of nursing. Their process has been widely used since. Walker and Avant (2011) truncated the 11 steps by Wilson (1963) into eight, beginning with the selection of an appropriate concept through the development of model cases and ending with the identification of empirical referents (Walker & Avant, 2011; Duncan, Duff-Cloutier & Bailey, 2011). Walker and Avant's (2011) adaptation of Wilson's original work has been criticised for being a reductionist positivist approach, which suggests causal relationships in human behaviour can be found and observed free from theoretical interpretation, leading to objective truth (Beckwith, Dickinson & Kendall, 2008). Walker and Avant (2011) quite openly discussed the criticisms of their model, but defended its ability to provide a reasonable and logical method for analysing concepts. Indeed, it has been used widely in nursing and other contexts in a range of ways (Beckwith et al. 2008; Morse et al. 1996, & Gardener, 2014). In this study, it was used simply as a framework rather than a way of determining causal relationships in a positivistic sense. It provided a systematic way of considering, exploring and understanding concepts emerging from my qualitative data collection and analysis.

As suggested by Walker and Avant (2011), the identification of attributes associated with the emerging concepts was undertaken first. These attributes were then used to show how the concept works, looking at different occurrences of the concept (called cases by Walker and Avant) and which of the identified attributes were relevant to determine similarities and differences. This added to the depth of my analysis. Two key safety initiatives were used as a focus, falls and recognising the sick patient, as discussed in chapter six. Through this, eight

attributes were identified as fundamental for the successful permeation of these safety initiatives through the various layers of the organisation.

These attributes were:

1. Investment, from the executive team.
2. Performance measures. Directly observable 'here and now'.
3. Audit data.
4. Communication.
5. Significance/common place.
6. Degree of fit with current practice.
7. Commissioners and external influences.
8. Leadership.

Together these provided a model case of permeation as an outcome of my data analysis. The model case, i.e. the one with all attributes present, was the safety initiative developed by the CEO of the Trust. As discussed within the results chapter, my data showed that falls was the only safety initiative that permeated throughout the whole of the organisation, and was identified as a priority by all staff. There was heavy investment by the executive team in this safety initiative. It was discussed within their executive meetings, and during the implementation of the 'falling stars' and 'slipper swap' scheme. There were a number of performance measures surrounding falls. These were the KPIs that allowed a reportable and visible method of recording and reporting the number and severity of falls.

All falls were reported using the incident reporting form which was then automatically escalated to the ward managers and matrons, allowing falls to be easily identifiable. The audit of falls was conducted on a daily basis. This was then discussed by the ward and executive teams, which again made falls easily identifiable. This also linked into the communication attribute, as falls was discussed using a variety of methods, including meetings, emails and nursing handovers. Falls was seen as a significant event and commonplace, as this was a daily risk to patients on all wards. People did fall, making the risk of falling and its prevention a daily priority. Falls are seen as a national priority and a component of the safety thermometer (as discussed in chapter 5), making falls visible locally to the executive team, and nationally to the commissioners and the Department of Health. What was clear was the consistent message that falls was the main priority within the Trust.

The leaders all emphasised the importance of falls prevention, and ensured all staff understood this. As identified, falls was the only safety initiative of the five that permeated through all the layers of the Trust and all staff within those layers. It can be seen that this

was due to the eight attributes being present and adhered too. The attributes (model) will now be applied to this model case to demonstrate that this application can aid in permeation (table 9 below).

Table 9: Model case: Falls risk permeated all layers of the Trust		
Attribute	**Application**	**Attributes present**
Investment from executive team	The executive team ensured that falls risk was regarded as a major initiative for the Trust.	Yes
Performance measures, directly observable 'here and now'	Falls were classed as incidents and so recorded on the incident reporting form. This report was then seen by the ward management team and the matrons, making falls easily identifiable.	Yes
Audit data.	Falls were audited on a daily basis, and the record is seen by the matrons and management team. The audit data were also discussed at the executive team meetings monthly. Falls were one of the KPI measures and the results were on public display on the KPI board in the ward corridors. Falls were also recorded using the safety thermometer.	Yes
Communication.	Falls was the main focus of communication from the executive team. This communication used face-to-face contact, emails, paper based communication. Falls were discussed in all ward meetings and handover sheets.	Yes
Significance/common place.	Falls were significant events, recognised by all teams and layers within the Trust. Falls were a daily risk on the wards and departments. Falls cause harm in real time to the patients and relatives.	Variable
Degree of fit with current practice.	Falls are a nationally recognised event, and are a component of the safety thermometer. Falls were a main focus of practice. Many initiatives were considered to prevent falls (slipper swap, falling stars, falls teams, study events on falls).	Variable
Commissioners, external influences.	Falls are seen as a major risk from the Department of Health and many other external agencies.	Yes
Leadership	Ward managers and matrons were constantly focusing on falls. The Director of Nursing and CEO often have 'walk arounds' in an attempt to communicate with staff, but also to see what is going on.	Yes

Table 9 shows that all attributes of the concept of permeation were present, making falls the priority within the Trust and gaining commitment from all teams and all staff. However,

within the observational studies what was discussed was not always practiced. For the borderline case (Walker & Avant, 2011) (one containing most of the attributes), infection prevention will be used to highlight how, without all the attributes being present, there can be some deficits in permeation. Infection prevention was communicated by the executive team as one of their priorities, following the national and local recommendations discussed within this thesis.

Infection prevention was generally seen within the results chapter as focussing on MRSA and CDiff by all the teams, even though, during the interviews conducted by myself, no specific type of infection was identified by me. The infection focus appeared to follow from the KPIs and the reportable infections i.e. MRSA and CDiff, and no other type of non-reportable infections were identified. This borderline case will only focus upon the permeation of information surrounding MRSA and CDiff. There did appear to be investment from the executive team. The very nature of the reportable infections to the Department of Health make this priority crucial to the Trust as this can affect foundation status and aid in the prevention of special measures being implemented by the Care Quality Commission (CQC). This priority has led to the implementation of performance measures and the recording of MRSA and CDiff.

Audits took place on a daily basis surrounding intravenous cannula sites, commode hygiene, hand hygiene and ward cleanliness. The audit results were then communicated to the executive and ward teams via meetings, emails, and face-to-face contact, as well as the KPI communication board on the ward walls for public viewing. Infections were seen as a significant event but not by the HCAs on the wards. The HCAs did not identify infection prevention as a priority. Moreover, this layer of staff delivered the majority of the basic care, thus infection prevention should be one of their easily-identifiable priorities. Infections are nationally recognised as identified, and make up a component of the safety thermometer. Once again, infections are visible to the commissioners and the Department of Health. The attribute of leadership appeared to be missing, in that the leaders on the ward did not appear to encourage staff awareness of infection prevention, making this appear to be of little consequence.

The following Table will demonstrate a borderline case, one that contains most of the attributes, (Table 10)

Table 10: Borderline case: Infections permeated all layers of the Trust		
Attribute	**Application**	**Attributes present**
Investment from executive team	The executive team ensured that infections were regarded as a major priority for the Trust.	Yes
Performance measures, directly observable 'here and now'	Infection prevention was not truly directly observable. What was more important was that infections were not really recognised as a consequence of behaviour i.e. not washing hands. Only MRSA and CDiff were measured, and classed as incidents and recorded on the incident reporting form. This report was seen by the ward management team and the matrons, making some infections easily identifiable.	Variable
Auditable data.	Only MRSA and CDiff were audited on occurrence (root cause analysis). Hand hygiene and commode cleanliness were audited daily. The audit data was discussed at the executive team meetings monthly. Hand hygiene and commode cleanliness were KPI measurements and were on public display on the KPI board in the ward corridors. Infections were also recorded using the safety thermometer.	Yes
Communication.	MRSA and Cdiff were discussed by the executive team. This was then communicated using face-to-face contact, emails, paper based communication. MRSA and CDiff were discussed in all ward meetings and handover sheets. Computer screens and wall posters all highlighted infections on wards and departments.	Yes
Significance/common place.	MRSA and CDiff were significant events, recognised by most of the teams and layers within the Trust, but not by the HCAs. The HCAs deliver basic care to the patients and have a large amount of patient contact.	Variable
Degree of fit with current practice.	MRSA and CDiff are a nationally recognised event, and are a component of the safety thermometer. MRSA and CDiff were a main focus of practice. Many initiatives were considered to prevent Infections, hand gel, etc.	Yes
Commissioners, external influences.	Only MRSA and CDiff are seen as a major risk from the Department of Health and many other external agencies.	Yes

Leadership	Ward managers and matrons discussed infections but this mainly focused on MRSA and CDiff, those that had to be reported back to the executive team. Leadership was poor on observable behaviour on the wards.	No

Table 10 demonstrates that nearly all the attributes of permeation were present, but the focus was not the same as that for falls. Most of the staff did identify infection prevention as a priority, except the HCAs who deliver the majority of direct patient care. Although infection prevention was seen by most as a priority, this was not confirmed during observations, which found that compliance with hand hygiene was poor. As identified this is a nationally recognised priority. That said, the executive team did not have the same investment in this initiative as was found with falls or infections (table 11).

The executive team did not provide a consecutive opinion on this priority. In fact, one of the executive team did not discuss this important priority at all. Recognising the sick patient was not easily observable, and was not discussed or observed on the ward during the observational study. There were reported audits for the National Early Warning Score (NEWS) which could help to identify the sick patient, but again no incidents of this were identified. Recognising the sick patient did not appear to be discussed during the handovers (although there may not have been a sick patient on the ward at that time of data collection).

There was also a lack of documentation within the executive and ward meeting minutes about this priority. There was also a lack of awareness about recognising the sick patient' on the ward, which could be the result of lack of investment and its measurable significance reducing its perceived importance as a safety priority.

Table 11: Related case: Recognising the sick patient.		
Attribute	**Application**	**Attribute's present**
Investment from executive team	Recognising the sick patient did not have universal investment from the executive team. The executive team's opinions varied and lacked agreement to the importance of recognising the sick patient as a safety initiative.	No
Performance measures, directly observable 'here and now'	Recognising the sick patient was not easily observable or performance measurable. NEWs charts were available to measure deterioration but rely on retrospective audit.	Variable
Auditable data.	The only auditable data came from the NEWs charts.	Variable
Communication.	Recognising the sick patient was not readily discussed in any meeting or during the interviews or observation study.	No
Significance/common place.	Recognising the sick patient did not appear significant or common place by anyone but the executive team.	No
Degree of fit with current practice.	Recognising the sick patient did not appear to fit into current practice.	No
Commissioners, external influences.	Recognising the sick patient was not discussed by any of the teams.	No
Leadership	Leadership was poor in terms of observable behaviour on the wards. There did not appear to be any focus from a leadership perspective on initiatives to detect patient deterioration.	No

Within table 12, a contrary case, one that was not considered to be associated with the concept of permeation, is examined. Identification of this case was an important step within the concept analysis as it showed clearly what the concept was not. It also showed that if none of the attributes were present, then permeation was not seen to occur (Walker & Avant, 2011). This case focussed on the concept of nil by mouth. This practice, of starving a patient prior to an operation, is to ensure that the surgical patient has an empty stomach, preventing vomiting and aspiration during the induction of anaesthesia and endotracheal intubation (Walsh & Ford, 1992).

The length of starvation varies from eight and a half to 22 hours, making patients vulnerable to dehydration. According to Walsh and Ford (1992) nil by mouth is often a case of unthinking and ritualistic behaviour rather than a rational action. This nil by mouth concern has been known for quite some time. The classical research by Smith in 1972 found that the majority of pre-operative patients were fasted far too long, but this fasting was seen as the norm (Smith, 1972).

Rituals can clearly become custom and practice (the norm) and fall outside of evidence-based practice. If the nil by mouth concept were to be examined, and the model of permeation applied using the 8 attributes, then how such rituals become commonplace can be explained. Analysing the attributes within this case, it is evident that there was no investment from the executive team. It was left up to the decision of the anaesthetist in charge of the operation. No performance measures exist directly related to this practice, nor are there any audits to identify this poor practice. Often the staff on the wards have to ask the anaesthetist if the patient can eat and drink, but it is anaesthetist's decision to authorise this. This type of practice is commonplace and fits with what is practiced, as this becomes custom and practice. There are little, if any, external influences surrounding this practice, and little observable leadership supporting this.

Table 12: Contrary case: Nil by Mouth from Midnight		
Attribute	**Application**	**Attributes present**
Investment from executive team	None	No
Performance measures, directly observable 'here and now'	None	No
Auditable data.	None	No
Communication.	None	No
Significance/common place.	Very consultant led	Variable
Degree of fit with current practice.	None	No
Commissioners, external influences.	None	No
Leadership	None	No

It is evident with the contrary case that this is not associated with the concept of permeation. Again the attributes model I have discussed does not fit with the nil by mouth practice in a consistent manner. Arguably, if all the attributes were present, then permeation would be possible, which is reflected in the model case, but when some of these attributes are missing then permeation is not possible or consistent.

To gain further insights into permeation, Walker and Avant (2011) discussed the need to identify the antecedents, consequences and empirical referents of the concept; table 13 identifies these from my study. The first antecedence of permeation was the need for all staff to see what the safety priority meant to them, and to the patient. The staff within the Trust needed to understand the significance of not only knowledge of the safety priorities, but also the significance of not knowing these, as this could be detrimental to safer care delivery.

The second antecedent was the number of external and internal influences, including those from the Department of Health and local pressures (discussed in the chapter 2). These needed to be carefully considered prior to the introduction of any concept. Finally, the last antecedence was leadership. This needed to be at all levels to ensure that the process factors (those that drive the concept) were able to deliver the outcomes. The process factors within the table are reflected in the eight attributes shown earlier in this chapter. There has to be the investment, communication, degree of fit, audit data and performance measures to ensure that permeation is successful. Using the attributes should improve the outcomes. This also needs to include the five safety initiatives. Improvement in falls, staff understanding of the nature of falls, and actively preventing falls, should be evident as a result.

The infection prevention element is vital to the health of the patient, and so again the staff should practice the skills of infection prevention and control, but also have a greater understanding in what they are trying to prevent. The outcomes of the other priorities could improve if the staff demonstrate the knowledge and skill of recognising the sick patient, medication errors, and pressure sores. The outcomes also include improved communication. If all the staff use consistent communication then this may result in a unified team, with all staff members understanding the culture.

Overall, the improvements have to include improved patient experience, improved staff satisfaction, and an overall improvement in the understanding of safer care. Walker and Avant (2011) discussed the need to provide a measurable way to demonstrate the occurrence of the concept. This is in the form of the empirical referents. The empirical referents for this concept would need to demonstrate that, overall, the culture as defined by the staff, that being the attitudes, behaviour, values and assumptions, have improved, and also all staff have the same values. Another referent would have to be that staff are fully aware of the safety priorities of the Trust, as well the Trust's values.

Antecedents	Process factors	Consequences (Outcomes)	Empirical referents
Significance (what does it mean) External influences Internal influences Clear leadership	Investment Communication Degree of fit Audit Performance, measurement	Improved communication Reduction in falls Reduction in infections Improved patient experience Improved staff and patient satisfaction	Improved permeation of determinants, including attitudes, behaviour, values, assumptions Staff are fully aware of, and understand the Trust goals and safety priorities

Table 13: (Antecedents, process factors, consequences and empirical referents of the concept (permeation)

6.4 Conclusion

This chapter has provided an understanding of the concepts of permeation and diffusion, suggesting that they are interdependent on each other for permeation to occur within the Trust. A working model (attributes) has also been produced that, if used, allows permeation to occur. It has been applied to four cases to demonstrate how, using the model, permeation can occur (falls). A borderline case was presented, showing that if all the attributes are not present, then permeation lacks flow, and a related case example was given to show that, without the attributes present, permeation is not successful. The examples end with a contrary case i.e. unsuccessful permeation. Without the attributes, then permeation does not occur in this context. An analysis of the antecedents, process factors, consequences and empirical referents of the concept, demonstrate the importance of fully understanding the concept of permeation.

CHAPTER 7: DISCUSSION/INTERPRETATION

7.1 INTRODUCTION

This chapter debates some of the findings presented in the results section of this thesis, and examines the opinions and views of the staff within the NHS organisation from which the sample was drawn. The chapter also uses relevant literature to explore some of the identified concepts further. This chapter relates back to the research question and the sub questions, those being:

'How do top-down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust'

1. How is organisational culture understood throughout the organisation? Do all staff from the Chief Executive to the ward team have the same understanding?
2. What safety initiatives have been conceived by the executive team, and how have these been communicated throughout the organisation?
3. How were the safety initiatives introduced to the ward? Were these understood, and how have they been implemented?
4. Does the executive team's conception of safety initiatives align with ward staff's implementation of them?

The focus throughout this chapter is on the seven themes that were identified from the various data collection methods used (individual interviews, focus group interviews, non-participant observations), as well as the analysis of the executive and ward meeting minutes.

7.2 CULTURAL CONSISTENCY

In chapter two, questions were raised regarding organisational culture, what it is, what it means to an organisation, whether it can be created or changed and also what it means to the staff within the organisation. Current thinking is that organisational culture does exist within the NHS and, as such, can be created, changed and manipulated (DH, 2015).

Arguably the DH are using culture as a panacea for a range of issues and, as a result, there is an emergence of a range of cultures, such as safety cultures, no-blame cultures, learning cultures, and team cultures. An analysis of the literature has revealed that the very term 'culture' is nebulous, making it difficult to define. There is no doubt that accurate measurement of a multi-faceted organisational culture is difficult, and indeed measuring what the organisation wants to measure, for what purpose, and what precisely they want from any outcomes, has many variations.

Researchers and managers often measure the most accessible thing; those being attitudes, values and behaviour, in an attempt to recognise their own organisational culture (Scott et al. 2003a). Despite controversy related to the measurement, and indeed the existence, of organisational culture, the executive team within the studied Trust did not have any questions or concerns over the existence of this concept. Indeed, they talked freely about their own organisational culture fluently and with conviction. There was no hesitation or question as to whether or not it existed. In fact, they described their culture as vibrant, positive and patient-focussed.

This question of existence and acceptance of organisational culture reflected the climate of the organisation and not the culture. The executive team clearly described their culture as a measurable quantity, but as discussed in chapter two culture is difficult if not impossible to measure. Whereas the climate can be measured.

According to the executive team, the Trust's culture was designed to allow people to do their best, to improve things, and to try and get to a position where the staff would want their family to be treated at the Trust. If staff accept that their current culture maintains and promotes safe healthcare without any formal consensus or agreement to a definition of culture, then any change to their practice would be difficult. Organisational culture in this Trust is an accepted concept. However, the executive team never mentioned how they measured their culture, nor did they outline whether any measurement tools were used.

Scott et al. (2003a) highlighted the significance of the lack of an ideal tool to measure organisational culture. They suggested that the ideal tool does not exist, because there is no agreed definition of culture, and instruments would need to be context-specific. Scott et al. (2003a) finally acknowledged that singular attempts to define and measure organisational culture are misplaced. Instead, a variety of concepts, tools and methods are much more likely to offer robust, understated and useful insights. Accurate measurement of all the elements of organisational culture can be very time-consuming and expensive (Scott et al. 2003a). Attempting to undertake an onerous amount of work in designing a tool to measure culture could lead to a deflection away from the most important focus, safe healthcare for patients.

The general acceptance of culture was acknowledged by the management team. They supported the executive standpoint on the existence of a culture, and took this further by not only stating that the culture supports patients and their care, but also supports the staff. No measurement of proof of the existence of a culture was discussed. The Trust could develop and use local measures, which focus upon staff satisfaction surveys, job satisfaction and patient safety measurements, in theory reflecting the culture in their setting. The management team acknowledged the existence of culture. However, they suggested it does

not always flow or filter down to all levels in the organisation. It was clear that some elements of the culture did encompass all levels of the organisation e.g. safety. The results chapter indicated that safety was identified as an important element of the culture. However, this cultural element was inconsistently acknowledged throughout the layers of the organisation.

To explore this inconsistency in safety priorities, as conceived by the executive team, the safety initiatives were used to observe the permeation of the themes throughout the organisation. The executive team were confident that culture did flow throughout the layers of the organisation. However, when these safety initiatives were explored, only one safety priority was carried from board to ward, that being falls prevention. This demonstrated that permeation is achievable if there is investment by all the staff, and the drive by the leaders, to ensure that elements of the culture are accepted by all staff.

Ward staff discussed the organisational culture from a ward perspective i.e. what it felt like on the ward. Many believed that the organisational culture had little to do with them at a macro level and most failed to see its significance. Instead they focussed on the micro level, i.e. how the ward felt and how the manager on that ward contributed to the feeling of the ward. The existence of unsuccessful permeation is illustrated by the fact that all but one of the five safety priorities were lost in the layers of the organisation. Indeed, starting at the very top layer of the organisation (executive team), the priorities radically changed, even by one layer down within the management team. These radical changes may have been the result of the management team having different priorities than the executive team. They recognised the five top initiatives, but added their own patient-focussed initiatives to the list. The table below shows the additions to the safety initiative changes made by the management team.

Table 14: The additions to the safety initiatives by the management team.

Initiatives	**Executive Team**	**Mgt Team**
Falls	X	X
Medications	X	X
Infection	X	X
Recognising the sick patient	X	X
Pressure sores	X	X
Slips, trips		X
VTE		X
Safeguarding		X

Dementia, Delirium		X
Patient Safety (as a global concept)		X
Privacy and dignity		X
Maintaining health and well-being for staff		X
Nutrition		X

All but one of the management team used for this study were nurses, and so the additions are very patient-focused. This may explain the additional nursing focussed priorities added. These additions highlight some of the benchmarks from the Essence of Care document (DH, 2010), which were set after being highlighted as important by the public. The influence of the top-down safety initiatives on the ward depended very much on the leadership/management style of the ward manager and how they behaved on the ward. What is needed is clear leadership to enable understanding and function within the climate of the organisation, and, crucially, this needs to permeate through to the ward climate.

Most ward staff recounted the ward atmosphere which they articulated as the culture, but what they described was in fact the ward climate. It is the local management of the staff and control of the patient/staff interface of the NHS i.e. individual wards and staff which are important, and focussed on the micro and not on the macro of the organisation as a whole. It is important to understand what climate means in this ward context. Organisational climate exists in the perception of the staff working within their own organisation. Their perception of climate can influence their behaviour (Tagiuri & Litwin, 1968). Stringer (2002), however, suggested climate is more of a determinate (is needed for an outcome) rather than an influence. Climate is evidently more precise as a concept than a concept of culture. Indeed, Stringer (2002) suggested climate can be objectively measured, because it moves away from unspoken assumptions to a more accessible perception of the organisation. Thus, because climate is perceived by the participant it can potentially be measured. It can influence the individual's motivation and is a determinate of performance. Polit and Beck (2004) suggested that within the naturalistic paradigm, it is the people that socially construct their realities, existing in their own context. In this case, climate is perceived as reality as socially constructed in the course of daily practice. This social reality is influenced by the interrelationships in practice, how individuals view their context (i.e. environment), and the actions of the people they work with (Lincoln & Guba 1985; Erlandson et al. 1993; Mellon, 1990).

In this study, culture was perceived by managers and executives as an important NHS driver for change. However, climate is perceived as more important at the ward level. This was

reflected in the staff interviews, via what the staff said was important and the way this was managed. This in part reflects the work of Schein (2000), who suggested that managers in organisations talk about changing their cultures, creating new cultures, the impact of their culture, or preserving their cultures, when really what they are talking about is climate. Culture refers to the hard stuff such as strategy and structure, whereas climate refers to the soft stuff, for example the staff and their commitment.

The seminal work of Tigiuri and Litman (1968) suggested that climate is a relatively enduring quality of the internal environment of an organisation experienced by its members. It influences their behaviour and can be described as the values of a particular set of characteristics or attributes of the organisation. It was this that was evident in the data. Stringer (2002) suggested it is better to focus on climate and not culture when seeking to improve performance because, arguably, culture cannot be changed.

Stringer (2002) proposed that climate is developed from five major determinants, these are:

1. **Leadership practices:** What the leader does on a day-to-day basis.
2. **Organisational arrangements:** This can be seen as the formal aspects of the organisation, how jobs and tasks are designed, systems of reward, the policies and procedures, and the physical location of the staff within the organisation.
3. **Strategy:** The organisation's strategy can have a large effect on the climate, and can influence the staff within the organisation.
4. **External environment:** How the organisation competes with the external environment.
5. **Historical forces:** The history of the organisation can have a profound effect on the staff's expectations, that being how the organisation has treated staff in the past with reward, punishment and consequences.

The most important determinant is perhaps the leader's practice, as this can fluctuate at different times. Five determinants of ward-level climate from an organisational perspective were evident in my data:

1. **Leadership practices:** What the ward leaders do on a day-to-day basis, how they act and manage the behaviour of the staff.
2. **Organisational arrangements:** This formal aspects of the ward, how jobs and tasks are designed, systems of reward, the policies and procedures, and the physical location of the staff within the ward environment
3. **Strategy:** The ward strategy and its effect on local climate, how the staff feel, rewards, obstacles to success, and sources of satisfaction.

4. **External environment:** How the ward competes with the external environment and other wards
5. **Historical forces:** The history of the ward influenced staff's expectations relating to reward, punishment and consequences.

Lee (2004) discussed the philosophy of Walt Disney and his views on creating excellence. This excellence was driven by the need to provide a unique experience for the public of all ages. Lee (2004) compared Disney World to hospitals, and using analogies from both, studied their structure, employees and public perception. Lee (2004) suggested that Walt Disney did not just focus on getting things right and meeting an acceptable standard, but he also continually looked at what could be improved, instilling a commitment no complacency in all staff. Lee (2004) further suggested that in hospitals, instead of celebrating perfection, a climate of dissatisfaction needs to be instilled amongst the employees of the organisation. This dissatisfaction helps staff to focus upon becoming better and have greater performance, challenging the status quo where necessary. He used the quote "if necessity is the mother of invention then dissatisfaction is the father of improvement" (Lee, 2004, p.157)

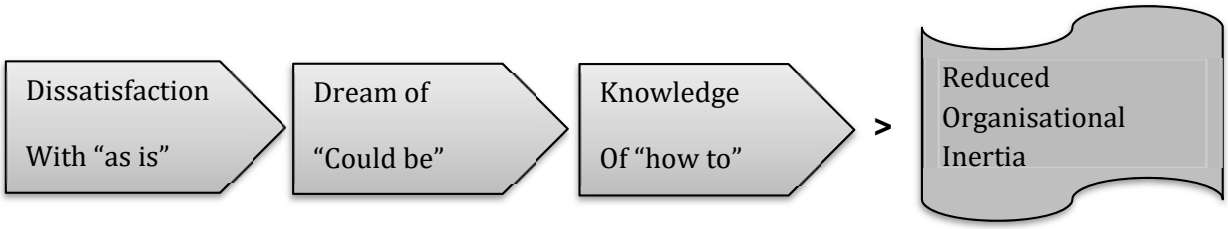


Figure12: Dissatisfaction Model (Lee, 2004, p. 157)

Based on Lee's work, figure 12 presents a simple model for improving quality. When applied to my study, embedding a safety climate would begin with generating individual and collective dissatisfaction with accepting safety failures as inevitable, what Lee (2004) calls "the dream of greatness". The next stage would be to encourage all staff to examine their practice to see what could be (in terms of improvement) instead of accepting what they have already. Staff then need to be equipped with the skills of how to make greater impacts that impact positively, continually improving the safety of the patient. My findings suggested that the Trust do share the philosophy of striving for excellent patient care and safety, but this is not always acted upon in practice. If experienced staff share their aspirations with others, and spend time supervising, leading, and role modelling to achieve exceptional standards of safe practice, this may positively influence ward-level safety climate, reducing organisational inertia.

As identified, climate as a concept emerged from in-depth analysis of the data. In order to discuss its relevance as an outcome of the study, there is a need for conceptual clarity to

differentiate it from the concept of culture on which much of the thesis to this point has focussed. Chapter 2 discussed the concept of culture at length i.e. organisational culture, its relation to healthcare, and the impact of negative, dysfunctional cultures. This discussion progressed to a critical analysis of its link to safety and safety cultures. The review indicated that, in the main, culture remains difficult to measure, and is an abstract concept. Climate, however, is perhaps more tangible and measurable. Arguably, it indicates the internal weather of the organisation, how people think and feel on a daily basis and how this impacts on the work they do. Literature has suggested that climates can be measured using a variety of tools (Winkler, 2002) which often involve measuring indicators of the thoughts and feelings of the staff and their impact on how they practice safely. The ability to measure climate might potentially provide a more tangible starting point than culture for managing teams, as it is a proactive and deliberate way to improve performance and safety (Stringer, 2002). Stinger (2002) suggested that climate is directly related to the motivation of the staff, which potentially has a direct impact on the organisation's performance.

Gershon, Stone, Bakken, and Larson (2004) explored the distinction between culture and climate. They defined organisational culture as the norms, values and basic assumptions of an organisation. Climate, they suggested, more closely reflects the employees' perceptions, experiences and behaviours. They further suggested that climate is more easily measured than culture, as cultural values and beliefs are more intangible. Ashkanasy et al. (2000) suggested that culture shapes climate. Glisson (2015) supported this view and suggested that climate is created by the employees, particularly their shared perceptions of the impact of their work environment on their own personal wellbeing and functioning. Ashkanasy et al. (2000) suggested that if the people of the organisation are functioning and motivated then they will deliver safer care. Bjerkan (2010) supported the work of Gershon et al. (2004) but developed the debate further by suggesting that organisational culture definitions are often vague and overly general, which may impact on staff performance locally. Hale (2000) proposed that culture is often deep and stable. It has been argued that culture is often seen as the invisible part of the organisation, and often taken for granted (Glisson & James, 2002). It is perhaps more difficult to understand how something deep and invisible can impact on the face-to-face care on a ward. In contrast, climate can be seen as a more well-defined, localised, measurable, snapshot of the workforce's attitudes, perceptions and motivation (Farrington-Darby, Pickup & Wilson, 2005; Flin et al. 2000). The perceptions of climate are often seen as critical determinants of an individual's behaviour in the workplace (Carr, Schmidt, Ford, & Deshon, 2003; Probst, 2004). If it is possible to measure the climate as discussed, then arguably it should be possible to examine the impact staff have on safe care delivery at a local level in a given point in time. For example, Gershon et al. (2004) suggested poor motivation leads to lower rates of worker morale, higher levels of stress and

higher accident rates. If motivation is a measure of climate, then the link between climate and safe care can be made.

Denison (1996) described climate as the perceptions of staff about the environmental characteristics of their organisation, such as perceived structure of the organisation, and its corresponding policies, procedures and practices. Winkler (2008) suggested that climate is capable of influencing many different outcomes, including some critical to patient safety. Vincent (2010) supported Winkler's work and also suggested that climate can be measured, and, as such, can directly link climate to patient safety incidents. This is in contrast to culture, which is difficult to measure. This is an important finding for my study, as at the ward level the staff felt they did not have effective communication with the higher levels of the management team. They felt undervalued and pressured. This had a direct impact upon the permeation of the safety themes at ward level. Glisson (2015) suggested that culture and climate have a direct influence on innovation and effectiveness and its spread through the organisation. A positive culture and climate can facilitate the spread of innovation. My study showed that, at ward level, climate played an important role in nursing staff morale, behaviour and safe practices. If the climate is positive, staff felt motivated, and delivering high quality safe care is perhaps more likely.

In summary, the key differences between culture and climate can be identified as follows:

Table 15: Culture and climate differences

Culture	**Climate**
Top end concept, reflects macro level	Measurable, reflects micro level
Unspoken assumptions, values, behaviour	Involves the thoughts, feelings, perceptions, experiences and behaviours of staff
Difficult to define	Can be defined
Difficult to change	Can be changed
Abstract concept	Focussed
Needs support from climate	Needs support from culture

7.3 Leading and shaping

Participants' responses during interviews suggested they perceive the Trust as a hierarchal organisation, despite the fact that some of the responsibilities and leadership had been devolved to their business units, with the CEO as the overarching leader. Earlier within this thesis it was identified that each business unit had its own leadership and management team. This hierarchal structure was evident, with data analysis illustrating the lack of

communication between levels. The ward staff did not feel the executive level listened to or communicated with them. There was also a lack of leadership recognition at ward level. This may be a reflection that leadership at the local level was not influential. The overall leadership style of the Trust was identified by the ward staff as implicit rather than explicit; it was a transactional approach. DaCosta (2012) suggested that the transactional leadership style may be more effective in hierarchical organisations. This style can be seen as an exchange process between the leader and followers. Bass, Avolio, Jung, and Benson (2003) and Lorber, Treven and Mumel (2015) suggested that the transactional leader is very much in charge, uses reward and punishment, and focuses on meeting the specific aims or goals (Aarons, 2006). The influence of leadership at ward level was only highlighted by the ward team when it was a negative experience. For example one ward manager described how she was 'swapped' with another ward manager from a different hospital in an effort to make some changes. This created an air of negativity on the ward, whereby the ward manager stated that the senior team on the ward worked against her, sabotaging her work and ideas, and undermining her authority. The resulting negativity undermined the team (Sloane, 2007). Ineffective leadership can significantly negatively affect care (Ezziane et al. 2012). This change in leadership led to confusion, anger, instability and stress for the ward manager, threatening her own leadership role. Ezziane et al. (2012) suggested transforming a team into a highly performing unit takes the removal of barriers, effective leadership and effective followership.

Leaders need to have followers, as without followers there is no leadership (Uhl-Bien, Riggio, Lowe, & Carsten, 2014). The ward team collectively stated that the wards run more smoothly when the ward manager is on duty. However, the ward manager interviewed said she had experienced poor followership, describing senior ward staff as saboteurs of her work and her ideas. In addition, the ward managers felt unimportant. This was reflected in the interviews when one ward manager suggested that Trust managers (matrons and executive staff) ignore and fail to recognise ward leadership. This feeling of being unimportant was evident within the interviews, particularly when the senior staff said they were unsupported in their role. As already identified, the ward manager was moved, making her new role difficult, but also on her old ward the exchanged manager was having similar difficulties. Both wards were described as having problems. Nurses and midwives are at the forefront of leading, managing and creating the right climate for wise leadership which encourages best practice (Prime Minister's Commission, 2010). Indeed, leadership is the most important influencing factor in shaping organisational culture, and demonstrates clear evidence of the link between leadership and outcomes (The Kings Fund, 2015). However, within the Trust studied, only the management and executive teams were recognised as the leaders by the executive team.

If leadership and management are key in promoting a climate that ensures care is delivered safely, it is worth better understanding the influence of the attributes and styles of a leader. Eckert, West, Altman, Steward, and Pasmore (2014) highlighted the need for collective leadership to ensure that the distribution and allocation of leadership power, capability, expertise and motivation are shared by everyone. Applied to the Trust, this collective leadership would mean all staff share the goals of the Trust as a whole and aim to achieve them. If leaders of frontline staff are not recognised for their contribution, collective leadership will be difficult to achieve. Eckert et al. (2014) suggest there is a need for complete dedication from the board and leadership team to empower all staff as leaders, in the process of collaboration within the organisation. Leadership is clearly central to the delivery of safe care on the wards, but, as discussed earlier, the importance of ward leadership was not recognised by the senior managers or the executive team in this Trust.

During the observations there was little evidence of motivational leadership at ward level. Huber (2013) suggested that motivation is fundamental and key to leadership and the leaders should exhibit behaviours related to motivation as part of their role. Arguably, the staff on the ward knew their roles and responsibilities, and may not necessarily have needed an explicit motivational intervention. However, this apparent lack of leadership could potentially have resulted in demotivated staff. More understanding of the leadership roles within the ward areas and their influence on staff and practice is needed. The leadership observed on the wards displayed some implicit elements of the contemporary style of transformational leadership, as well as some classical style laissez-faire approaches (Huber 2013). Clegg et al. (2011) suggested that transformational leaders can inspire change and innovation, influencing attitudes, behaviours and motivation in others. These types of leaders are visionary and believe in the development of their staff, whereas laissez-faire leaders are inclined to defer judgements and decisions to others (Huber, 2013). Bennis and Nanus (2007) described four traits of a transformational leader:

1. Creating a vision
2. Building a social architecture that provides meaning for employees
3. Sustaining organizational trust
4. Recognising the importance of building self esteem

A transformational leader is one that can motivate followers to perform to their full potential, empowering staff to do their best (Huber, 2013). In nursing, transformational leadership is arguably the most commonly cited leadership style theory for clinical nurses (Welford 2002; Huber 2013; Thyer 2003). Northouse (2004) and Giltinance (2013) suggested a transformational leadership style is the process that changes and transforms individuals, emotions, motives, ethics and long-term goals, and is an exceptional form of influence. It has been linked to staff retention, job satisfaction and empowerment (Laschinger & Finegan, 2005). Stanley (2008), however, suggested that clinical leadership is

more about the leader's values and the beliefs they hold about care, nursing and respect for others. He suggested that the attributes of clinical leaders (ward managers) do not match the transformational leadership style, citing clinical leaders as being:

- Approachable and open
- Strong values-based behaviour
- Effective communicators
- Positive role models
- Empowered/Decision makers
- Visible
- Clinically competent and clinically knowledgeable (usually within the specific area in which they work)

Stanley (2008) described the clinical leader not as transformational, but as a congruent leader. This type of leadership is founded on the leader's values, beliefs and principles. Congruent leaders in nursing are motivational, inspirational, organised, effective communicators, relationship builders, and mostly concerned about local leadership. They use their expertise, beliefs and values to guide and lead their team, and they are leaders at the bedside. Others have suggested that transformational leaders also display motivation, values, focus of development, aspirations to quality, are influence building, and have commitment (Giltinane, 2013; Yulk, 2010; Stone, Russell & Patterson, 2004; Owen, Hodgson, & Gazzard, 2004; Ozaralli, 2003; Limsila & Ogunlana, 2003).

As already identified, leadership is a process of influencing, motivating and inspiring others. However, during the observational period of this research little influencing, motivating or inspiring of others was noted, and little encouragement or motivational language was used. Staff were led by routine rather than leadership (laissez-faire style). As identified above, the staff did state that the ward ran more efficiently with the manager on duty. During observations, only occasional input from the manager was observed. The manager was constantly busy due to low staff levels, patient caseload, and the numerous tasks the managers had to undertake. Thus, this drew them away from direct patient care, ad supervision of the quality of nursing care delivery.

There are many leadership styles and attributes discussed within the literature, (Huber, 2013; Giltinane, 2013; Sloane, 2007; Morden, 1996). Situational leadership was perhaps most suited to the needs of the ward environment observed. This type of leadership style identifies that behaviour is situational and contextual. What is needed is the ward manager to have diagnostic skills to observe abilities and motivate the staff (Huber, 2013; Marquis & Huston, 2012), while also matching leadership styles to the situation (Huber, 2013). Arguably ward managers need to have the ability to use both leadership and management skills, and so be trained and experienced in both (Giltinance, 2013; Gardner, 1990). An integrated leadership

and management approach would allow the ward managers to better function to achieve what is needed in the ward environment.

Gardener (1990) suggested that these integrated leaders need to have six distinguishing traits:

1. **They think longer term:** The leader sees short-term objectives in the context of long-term vision
2. **They look outward, and toward the larger organisation:** They can see how their unit fits into the organisation as a whole.
3. **They can influence others not only from their own group:** Their influence can extend outward and upward within the organisation
4. **They can encourage vision, values, and motivation:** They understand others intuitively, they are sensitive to others, and can react to different situations.
5. **They are politically astute:** They can cope with conflicting requirements and expectations from their role, and ove toward Trust expectations even in times of change.
6. **They can think in terms of change and renewal:** They can examine the ever-changing reality of their organisation, analyse context and direct care accordingly.

The management and leadership of the day-to-day behaviours should include quality control elements of healthcare, facilitating the measurement of safe practice. The integrated leader needs to focus on:

1. Encouraging followers to be actively involved in quality.
2. Clearly communicating expected standards of care.
3. Encouraging high and not just minimum standards.
4. Using control to determine why goals are not met.
5. Communicating quality control findings and their implications to others.
6. Acting as a role model.
7. Distinguishing between clinical standards and resource utilization standards, ensuring the patient receive the required care.
8. Supporting and actively participating in research.
9. Creating a work culture that has patient safety at its heart.
10. Using benchmarks to ensure quality.

These leadership traits clearly have a much more local application for the ward leader within the Trust. They provide them with a focus that outlines the skills, abilities and responsibilities that they need to be a ward leader. The ward leader can lead their team and

ensure quality in the practice and then communicate this to all team members to ensure safe standards of care. An integrated approach could however be challenged, and the ability of nurses as leaders and managers questioned. Stanley (2006) proposed that there are numerous role conflicts in healthcare. The managers of the ward studied identified that there was too much paperwork to complete, affecting their clinical role, and role conflict was experienced as a result. Role conflict can be destructive, resulting in ineffective leadership, diminished clinical effectiveness, a dysfunctional ward and therefore poor care (Stanley, 2006). Doyal (1998) found that nurses who were appointed to managerial positions had a confusion of identity, which led to anxiety and isolation. Spencer (2014) supported the work of Doyal (1998) and suggested that newly-appointed ward sisters often struggle to adapt to a role that requires both management and leadership skills. Reed and Kent (1997) confirmed that the role boundaries between nurse managers and senior nurses had become blurred and had resulted in a loss of nurse leadership. Malcolm et al. (2003) identified that clinical leaders should remain focused on professional issues, quality and care, and not management. However, ward managers have both clinical and management responsibility. Zaleznik (1977) suggested that managers and leaders are two very different types of people. Thomas (2013) suggested that the role of the ward manager is to manage staff and resources, ensuring that the patients receive a good standard of care. Thomas (2013) further suggested that if leadership was effective the role of a manager will be easier. In summary, there is considerable evidence that the functions of leadership and management in the same post can lead to confusion, conflict and diminished clinical and managerial effectiveness. My findings suggest that this issue is exactly what was happening in this Trust at ward level, i.e. conflict of roles and jobs, and dissatisfaction in leaders and staff.

There is a need for investment so that the clinical leader and the ward manager are two separate posts, one to lead the clinical team, the other to operationalise the Trust's objectives. However, such an approach is resource intensive and potentially unachievable in an NHS with diminished budgets. An alternative is to foster an integrated leadership style (Stanley, 2006). Either way, more harmonisation between the two functions is needed. Kotter (1990) explained the difference between leadership and management is management deals with complexity, order and discipline, and doing things right, while leadership deals with change, creates new approaches, and doing the right things. Marquis and Huston (2014) took the idea of management and leadership a little further by suggesting that management involves leading and directing all or a part of an organisation, through the deployment and manipulation of resources.

The idea of the separate roles and role conflict is not supported by all. Kotter (1990) clearly stated that the successful manager will be skilled in both leadership and management. Marquis and Huston (2014) suggested that because of the rapid dramatic change within

nursing and healthcare, there is a need for nurses to develop both leadership and management skills, utilising both skill sets in an integrated approach. Whether or not the role of the ward manager should involve both management and leadership skills in one role is questionable. However, what is important is that the wards are managed, and staff are effectively led to ensure that safe care is provided.

DaCosta (2012) discussed the concept of shared leadership, linked to distributed or devolved leadership, which involves leading to enable others to act. For discussion purposes, the term "devolved leadership" means devolved, distributive and shared leadership. Devolved leadership is dynamic, relational, inclusive, collaborative, and contextually situated (Bolden, Petrov, and Gosling 2008). Its aim is to engage and empower others to make decisions and take appropriate action (Gronn, 2002; Martin, Beech, MacIntosh & Bushfield, 2015). Ezziane (2012) suggested that this type of leadership style is what clinical leaders need to adopt to ensure teamwork is successful. Devolved leadership works best in a team where members have the same values and goals, respect each other and have a commitment to collaborate. Mullins (2010) supported the idea that people can be self-motivating. However, citing the work of McGregor (1987), he suggested that leaders should not make uninformed assumptions about an individual's level of motivation, self-direction and willingness to take responsibility.

As previously discussed, one of the participant ward managers perceived her team to be working against her, sabotaging her work. Devolved leadership might not be readily accepted in this context. On the second ward, the clinical staff felt the ward ran more efficiently when the ward manager was on duty, and may be more accepting of her devolved leadership provided an identified leader is present to take responsibility (Gunzel-Jenson, Jain, & Kjeldsen, 2016). If devolved leadership was to be introduced to the ward teams in the Trust studied, there would be a need for leadership investment and leadership recognition by the whole team. All team members would need to fully understand their roles and develop respect for each other to enable them to take more shared responsibility for patient safety and collaborative working. However, further research is required to explore devolved leadership and better understand its application to a healthcare context (Boak 2015) to ensure the leadership approach taken is evidence-based.

The recommendations from the Mid Staffordshire Report (Francis, 2013) clearly identified the need to have leadership at all levels, from ward to board. These leaders need to constantly reinforce Trust values, standards and compassionate care to all staff. There is ideally a need for the Trust to invest in staffing to ensure enough resources to allow nurse managers to be present in clinical settings, have a firm understanding of their wards and the ability to enforce standards of care. Stringer (2002) suggested the leadership behaviour of

those in charge, in this case (ward manager), should drive the climate. This them stimulates motivation amongst the team, driving performance, not unlike the chain of cause and effect. Leadership is a determinant of climate, and without the leadership element, the climate is likely to suffer, as might performance. Figure 13 demonstrates the relationship between the leader's behaviour and how this influences the climate, how the climate influences how the staff feel, and how this affects the performance for the ward.

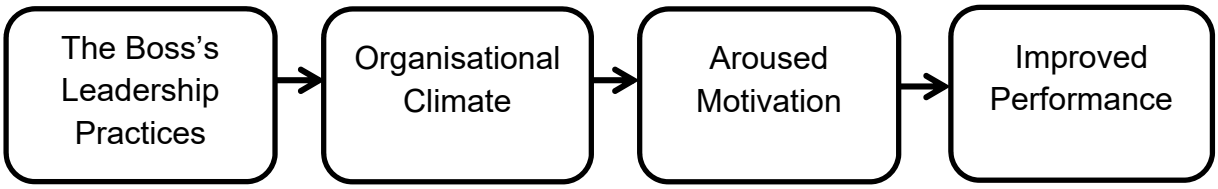


Figure 13: The Influence of Leadership (Stringer, 2002, p. 100)

Leadership clearly has a significant influence on performance, and correspondingly affects the safety of patients. In particular, strong leadership from ward sisters is essential to the successful delivery of high quality clinical care (Trant and Usher 2010). The findings from my study support this view, highlighting that the clinical ward leader plays a pivotal role in protecting patients from harm and that they draw on a range of leadership styles as fits the context. In a complex, turbulent NHS Trust environment, clinical ward leaders need the skills to take a flexible leadership approach, dependent on the ward climate at a point in time. This is necessary to ensure consistency in care quality.

7.4 Safety initiatives and Focus

Safety within the Foundation NHS Trust was considered as a major concern by people throughout the organisation, from the executive team down to the individual ward teams. As identified, the Chief Executive (CEO) identified his five top patient safety initiatives as patient falls, medication errors, infections, recognising the sick patient, and pressure ulcers. These five initiatives are also reflected in the Safety First Campaign by the NPSA (2015). The CEO of the Trust stated that he only wanted the teams to concentrate on these top five safety initiatives, allowing the staff to focus all their energy on these as priorities. Taylor (2010) expressed the need for the executive team to be able to communicate their organisational safety beliefs and values through visible leadership and a commitment to safety. This commitment was clearly identified within the focus groups, as well as the analysis of the minutes from the executive meetings. The CEO did attempt to ensure that the communication about the safety initiatives was delivered to the teams and demonstrated that he was committed to the five initiatives. This appeared be an effective strategy, allowing staff to focus and use their energy on the most important areas of safety; unifying the Trust

to work as one. Although this was a good strategy in theory, one of the other executive team members did not share the same overall vision, only discussing some of the five initiatives identified by the CEO. This participant suggested that staff focused on other safety initiatives, which was diluting the message of commitment. Clear consistent leadership was evidently inconsistent.

This inconsistency of information between the executive team did lead to some confusion further down the management line, as the management team, just one layer down from the executive team, identified thirteen safety issues as priorities. These did include all of the CEO's initiatives, but also several others that they felt were important. Taylor (2010) stated that the middle management team also have to both show the same visible leadership and commitment to safety and demonstrate safety as a business priority. This called into question the effectiveness of communication between the executive and management team.

An important point to note is there was evidence in minutes of meetings that information from the two wards about the implementation of the wide range of safety initiatives, including the five priorities by the CEO, was passed back up to the board. However, it is unclear why the wider focus on safety initiatives beyond the board mandate was unchallenged once this information became available. The issue of a wider range of initiatives being focused on was further compounded by the two ward teams. The ward teams identified only ten initiatives from both the executive and management, these being: three of the executive teams initial five, and seven of the management's initiatives. The two wards then added three additional initiatives that they felt important for their wards. This led the staff on the wards to suggest that there were too many safety initiatives, leading to confusion and a clear lack of agreement and congruence with the executive team.

The Institute of Medicine (Kohn et al. 2000) recommended that a strong, clear and visible attention to safety is essential to ensuring safety. If the communication of safety initiative priorities was congruent throughout the organisation, this may have facilitated focus on and implementation of them. However, within the results chapter, it was identified that only the falls prevention safety initiative flowed from the executive team down to the ward team. Falls was the first priority all teams identified as the main focus of the Trust. This was discussed with passion and energy by all of the teams, irrespective of their level within the organisation. Within the results chapter the successful permeation and congruence of information about falls was demonstrated. This success was documented within minutes from both executive and ward meetings, as well as the data from the interviews and focus groups. This successful permeation was in part due to all the attributes of the permeation model being in place. This, at face value, showed every member of the team had falls as their priority. Nevertheless, during the observations of the handovers on the wards, falls

were rarely discussed on a day-to-day basis, and even tools such as the 'at risk of falls markers' i.e. 'falling stars', were used sporadically. Little consideration was given to transmit this information to all team members, resulting in falls prevention being deprioritised.

Brodie (2010) discussed the term 'memes', and how these can influence peoples' minds, by passing to one mind then another etc. Brodie highlighted that memes can include tunes, ideas and catchphrases, etc. and emphasized that memes are not behavioural changes as such, but as a thought, a meme can greatly or subtly influence behaviour. If used appropriately it could influence the thoughts of staff to always prioritise safety. In support of this idea, Blackmore (2000) proposed that memes are often called imitation. In this way, role modelling can be seen as an important aspect of safety. Dawkins (2006) proposed that everything humans learn is through memes, good and bad. Dawkins also warned, however, that memes can also have a negative effect, bad behaviour breeds bad behaviour. It is vital therefore that the staff on the wards hear positive memes, as that will drive safety and better patient care. Taking this concept of memes further, applying it to the individuals within the Trust could have many benefits in safety by changing behaviour through positive memes. That said, memes need to be passed on by effective communication between one person to the next. It is clear the Trust had difficulties in passing on information throughout the layers of the organisation. If communication is not effective, then the use of meme theory is questionable.

Using memes on the wards could be a very powerful medium to enforce behaviour. On every shift and throughout that shift the leader could reinforce a meme, such as hand washing, or watching out for fallers. There could even be a memorable phrase that reminds people of that safety message throughout the shift. The passing on of memes would perhaps start with the leaders, but as Dawkins (2006) suggested these would catch on very quickly and every staff member would pass on this meme in a snowball effect. Memes used in an informal manner were observed. The ward sister did highlight the need to watch out for falls patients but not to any great extent. The staff appeared to focus only on what they had to do i.e. their jobs, and did not see the bigger picture.

During observations I noticed two posters had fallen off the wall and were lying on the floor. These posters were A4 in size and laminated, which could have been a slip and falls hazard. Approximately 30 members of staff just walked over them, or around them, but not one person from a consultant to cleaner picked them up. Then approximately 20 visitors mirrored the behaviour of the staff and ignored the hazard. Acting within a duty of care as a registrant I picked them up, removing the hazard. The staff appeared to have used window recognition, concentrating on what was in front of them and not around them. The concept

of window recognition can be compared to that of tunnel vision. Tunnel vision is the tendency to only focus on a single or limited view (Collins, 2009). When using this window recognition, the staff appeared to use their frontal vision, ignoring their peripheral vision, and also what was above and behind them. If the staff looked more widely around themselves, they may have seen the floor hazards, and had a greater general perception of hazards surrounding them.

The figure below offers a clearer definition of this:

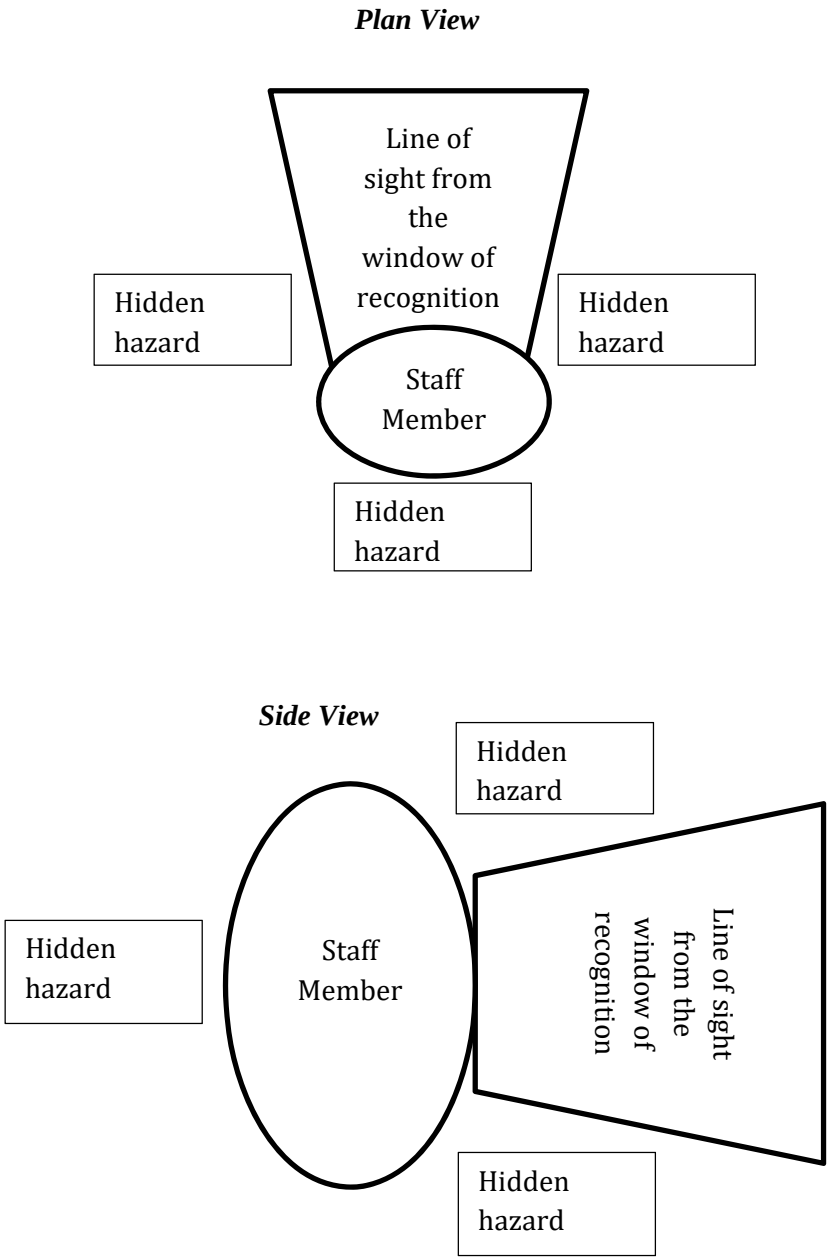


Figure 14: Window of Recognition

This can be related to human factors and situational awareness, in that the staff can become so transfixed on their own tasks that they do not take in all the detail. Vincent (2010) supported this view and offered that situational awareness has three core elements:

1. Gathering information in the sense of ongoing monitoring of the situation.
2. Interpretation of that information.
3. Anticipation of what is the critical information?

Vincent (2010) suggested that people need to understand all the elements in order to see the bigger picture. Using the theory of window recognition, if the staff look up and down, sideways and backwards to gain the whole picture, and this was reinforced by positive memes and constant supervision, then safety would take a priority within their own minds. The Trust did promote a constant reminder of the importance of safety. There were numerous posters with safety messages and alerts found on the walls of the corridors and ward areas. The Trust also displayed Key Performance Indicator (KPI) measures for that particular area. Falls was once again at the forefront of these displays. It is clear that with large investment and measurable outcomes, i.e. falls as a KPI, successful permeation can occur.

In the case of unsuccessful permeation, the recognition of the sick patient, there was little or no recognition of this on the wards, during the interviews, or in the ward minutes. It can be seen where there is constant measurement and emphasis on the safety issue, there is at least discussion of this from board to ward, but little, if any, of the lower priority areas. To ensure the safety initiative is implemented on the ward, local management of behaviour is needed to ensure that verbal information drives the behaviour of the staff to deliver the safety initiatives (memes). If staff are to implement some or all of the safety initiatives that the executive team create, then better communication and investment in the initiatives is needed. A multiple communication approach is needed by the Trust, not just verbal, as this can be ineffective if the verbal information does not transfer into the physical side of care and safety.

The safety culture of the Trust reflected an ownership culture of staff not being frightened to own up to mistakes, and a learning culture that allows people to learn from their mistakes, and is committed to doing the best for patients. These meaningful words came from the executive and management team which reflected their intention to create and manage a culture that ensures that patient safety is at the core of everything they do. This ideal of safety at the core of everything was reflected in a number of the ward staff's opinions, but more so at a senior level within the Trust. However, this overall statement of patient-centred safe care conflicted with some opinions on the ward where the staff identified that the actual culture reflects one of a resource culture that disregarded patient care in favour of resources

and performance. This appeared to be in opposition to the Trust's version of safe care. The ward staff believed it is partly down to low staffing levels, and heavy workloads, which is in line with national enquires into failures in care.

The ward staff were unwavering in their views that the Trust was focused more on public perception, and not on doing the right or wrong thing, as long as the patient is happy. This again suggests that the executive team are not always in tune with the ward staff and what happens at the patient/staff interface, as this differs from the senior team's perception of reality. Leaders who can reinforce safe care, and know what is happening at the patient/staff interface, are needed. Senior staff need to manage the wards, but also role model clinical excellence to inspire their staff to deliver safe care.

7.5 COMMUNICATION

The Trust operates what the executive team termed 'a devolved system built on autonomous business units'. These business units have their own senior team involving finance, management and human resources. Each business unit is self-contained, with an overarching senior executive team. The executive team identified that communication is difficult through the business units. Two business units were explored in this study, one being acute care and one care of the older person. The executive team said they have multiple methods of communication in place. One method appeared to be vertical transmission of communication, i.e. information is passed down from superior to subordinate (Price & Mueller, 1986).

The executive team also stated that they have team briefings, which are then cascaded down to the heads of departments, and the heads of department then cascade this down to their teams. The executive team are clear that these meetings are done face-to-face, and not through emails or written team briefs. This is done to improve both team communication and communication more generally. Cutler (2005) proposed that personal contact is vital to communication and that two-way communication at all levels is needed. This personal face-to=face, two-way approach to communication ensures that all levels of the organisation communicate effectively. The manner in which the executive team try to sell the brand i.e. the five safety initiatives passed to the staff using face-to-face communication, could be misguided. Mitchel (2002) suggested that face-to-face communication is best way to sell the brand, but this has to be effective. The Trust executive exaggerated their team's ability to communicate to the staff. The management team stated that they gain information from the executive team via meetings, emails, and some face-to-face communication, but they have suggested that this could be improved. This reflects the results of the Kings Fund Audit Survey (2014) which found that the executive boards were not in tune with how their staff were feeling about their organisation.

Not only was the executive team's ability to communicate limited but this was also the case with the management team. The ability of the management team to perform face-to-face communication was also limited. The ward staff acknowledged that the matrons do some face-to-face discussions, but mostly communication is by minutes of meetings, newsletters and meetings. The senior staff on the ward felt that the information was not passed down effectively. They stated that they get a large amount of emails, but delete most of them, only acting upon those they feel they have to action. It appeared that emails get a response if the ward staff have to prove that they have read them by producing an end product i.e. an action. The senior staff on the wards described from the data information from their management team. By the time information is passed down it is diluted and inaccurate. The senior staff then pass on what they think is important to their team, but they acknowledged sometimes that they forget to pass information down. One reason for this poor communication identified by the senior ward staff is that the executive teams do not speak to the subordinates much and so direct communication to them if important information is lacking. It appeared that only top-down communication was present within the Trust. The staff identified that little communication was passed up to the executive team. This demonstrated a top-down approach. This was evident within the minutes from the executive and ward team in that information that is cascaded from the executive team was identified within the ward minutes, but not the reverse. There are implications for this Trust and others if upward communication is not recognised or practiced (Tourish & Robson, 2003). Tourish and Robson further suggested that organisations that do not utilise upwards communication that includes positive and negative comments do so at a considerable cost. This cost is mainly focussed around quality decision making, lack of solution searching and organisational decline. Tourish (2005) supported this and proposed that, without upward communication, the senior managers become out of touch with their people. Arguably, not listening to communications from the lower levels makes understanding and learning about capabilities impossible (Tourish, 2005). Ringer and Boss (2000) suggested that without efficient upwards communication the overall effectiveness of that organisation is at risk. Learning and understanding are clearly important to organisational effectiveness, however poor upwards communication can have adverse effects on direct patient care and health outcomes (The Institute of Medicine, 2004). This is an important step linking poor upwards communication to actual potential patient harm. Kath, Marks and Ranney (2010) suggested that poor upwards communication has been shown to have adverse safety effects. This was an important area that was not recognised appropriately within the Trust in this study. Faugier and Woolnough (2002) proposed that lack of communication renders leadership powerless, and, by knowing particular circumstances, effective measures can be taken. Upward communication is clearly an important issue.

Evidence of this poor communication was found in this study, and one-way communication within the minutes of both the executive and ward team's meetings was also identified. It was difficult to decipher the ward team minutes and what the ward staff had understood from the executive minutes, as these were not clear. Any understanding of information passed down from the executive team in their words was poorly understood by the ward. The executive and ward teams did share similar topics for discussion, those being falls, serious untoward incidents and infection rates. The ward team took this further, in response to their need to provide key performance indicators using ward audits. However, there was a distinct lack of action plans to ensure compliance, and the minutes lacked detailed information, making it difficult for the staff who did not attend the meetings to read and alter their practice accordingly. It appeared that the meetings were held as a requirement rather than an aid to communication. The executive and management team used persuasion rather than negotiation, and control rather than a give-and-take relationship (Hersey & Duldt, 1989; Huber, 2013).

The ward staff identified the speed of communication that was passed down to them was far too slow. By the time the ward teams get the communication they felt the deadlines for the required actions are too short. They stated that by the time they got some information and tried to action this, then another action is passed on from other communication, making any change process too quick. It did appear that information did get passed down to the ward staff in some manner. However, this process did not reflect the executive view. They very much saw this process as being a top-down approach and, from their standpoint what they felt happened was not reflected by what happened on the wards. What happens on the wards relied on what the ward manager could decipher and communicate to their team. It was discussed that once again time restrictions on the ward manager hindered his/her ability to communicate with their team effectively. Also, the quality of information they received was often inaccurate, making this communication process more difficult.

Communication difficulties were also noted at ward level. During observations of the handovers of the staff, no information was passed on concerning any cascaded information from the senior teams. It is acknowledged that this may not be the time or place for this, and the use of the ward meetings may be a more appropriate forum. However, very little discussion was observed from the team's ability to pass on important aspects of care, that being any of the five executive team's initiatives. On occasions on one ward, one of the senior members of staff did identify falls and sought to ensure the patients were safe. However, other than this isolated episode, this was very rarely discussed, and often nothing was discussed at the handover. It may have benefitted the staff to discuss those patients who were at risk of falls, and who indeed had suffered falls, using meme theory, but very little was noted. The staff did use handover sheets where falls were recorded, but they did not

refer to the handover sheets or take any actions whilst delivering care. It was not clear that falls was a major problem on the wards, and little or no discussion was noted to highlight this area of practice. This communication may have benefitted from reinforcement on each handover, in that the staff member, by handing over, could highlight potential patients at risk of falls. Falls was not the only issue. Communication that needed to be reinforced about the initiatives was non-existent. This may have prompted staff to believe that these issues are unimportant. West, Eckert, Stewart and Pasmore (2014) identified that, for a successful organisation, each member needs to take on the responsibility for that success of the organisation as a whole.

This approach requires high levels of dialogue, debate and discussion to achieve a shared understanding about quality problems and solutions. The Trust executive perceived they had effective dialogue with all staff, but from the perspective of ward staff members this was contradicted.

7.6 Measurement

Measurement of performance and outcomes within the NHS Foundation Trust was of vital importance in this instance. The CEO stated that the Trust 'measure, measure and measure'. He said he walks around to ensure that things are actually working. He stated that the Trust had several auditing processes going on to demonstrate that the safety initiatives were working. As highlighted in the literature review the measurement of healthcare has a long history. Smith (2002) highlighted the fact that Florence Nightingale in the 1860s pioneered the systematic collection, analysis and dissemination of hospital outcomes to understand and improve performance. Smith further suggested that the collection of healthcare performance data has two broad functions: firstly, to identify what works, and, secondly, to identify the functional competence of specific practitioners and the organisation.

Although this reference was from 2002 and many changes have occurred in the NHS since, the value of measurement has not diminished. There remains a national need to monitor what works, for whom, and in what circumstances. The measurement of staff performance is normally conducted through audits. The audits measure the key performance indicators (KPIs) of the Trust and the Commissioning for Quality and Innovation (CQUIN) targets. The CQUIN safety thermometer was produced to measure any harm to patients at the point of care. CQUIN is data reported to the Department of Health, as against internal targets, such as goals and performance measurements around the organisation's own KPIs. The CQUIN targets and KPIs do reflect the five initiatives of the executive team. The reasons for the five safety themes can be questioned. On one hand they are to follow the NPSA (2012) guidelines to ensure high quality safe care, on the other hand they are to comply with the

CQUIN targets, measuring performance and meeting the government's demands for improvements.

As discussed earlier, the ward staff only recognised three of these five initiatives. What was being audited and what information from audits got fed back to executive team is unclear. Only falls, infections and pressure ulcers were recognised by the ward staff. Once again it appeared that what the executive team thought was happening within the Trust, did not always happen at the patient interface. This was supported by one of the wards when staff felt that audits were the most important determinants of patient care, rather than the care itself. This idea that audits are more important than the care delivered was further supported by a senior staff member on the second ward who referred to the paperwork as being more important to the Trust than patient care.

The staff understood the importance of the audits and the need for these. However, some of the staff seemed to challenge the accuracy of the results. This was confirmed by one lower grade staff member who stated that the results may not have been accurately recorded. One reason for inaccurate results could be due to management insisting on achieving 100%. The management team attended the ward if the results were not at the acceptable level. There is a need to revisit Lee's (2004) work at this point on the dissatisfaction climate. He suggested that there is a need to know the unvarnished truth about performance through effective measurement. Measurement seems to be vital in the struggle to ensure safe care. The executive team appeared to want to measure widely to find out exactly what was happening, including both good and bad practice. This could be a vital step in the generation of a dissatisfaction climate. However, providing evidence of 100% compliance may not be the answer. If the results are not 100%, this needs to be investigated, as does 100% compliance as complacency may creep in. It should be possible to learn lessons from good practice if there is a learning culture in the Trust.

The ward staff said they try to be honest within the audit results. However, distrust of authority created a blame atmosphere and "Big Brother" mentality. Investigating why audit target results were not reaching the required standard using an investigative method should be the preferred approach, rather than apportioning blame where they fall short. Audits are important within the NHS Foundation Trust, but the results need to reflect reality, and measures should be undertaken to address any shortfall in performance affecting patient safety. Huber (2013) argued that staff nurses are intimately involved in quality improvements, and are often considered the prime quality monitor because of their presence with the patients and their consistent monitoring function. The drive for quality improvements and quality monitoring is a very important role of the staff nurse. However, this calls for supervision and leadership from the ward managers. This constant quality

assurance equips the staff with the support of the ward managers. They will have ability to react to any quality breaches with speed and precision, not be afraid to change what needs changing for better patient care and not fear reprisal from senior management. Smith (2002) supported the need to address quality issues and stated that it is important that practitioners recognise opportunities for improvements, and are allowed to make those improvements.

7.7 Development

Providing development opportunities for staff was identified as an important factor to improve the patient care they delivered. Both clinical and leadership development were identified by the Trust Executive as important to safe care delivery. The aim was to enable people in the Trust to do their level best. The Francis Report (DH, 2013) clearly highlighted the need for education and training as one of its recommendations. This should include the availability in clinical areas of the ward managers to supervise, educate and mentor nurses. The emphasis on training and development from the executive team was not reflected in the management's approach. The management team suggested training and development is less of a priority and it was less explicit on the ward, than within the executive team.

Mullins (2010) explained that training and development improves knowledge and skills, changes attitudes, and is a key element of improving organisational performance. The ward staff identified that they are always too busy to attend training. Furthermore, lower grade staff also felt that priority for training goes to the qualified staff. If nurses are the quality assurance gatekeepers on the wards, then they do need to keep their skills and knowledge up to date and also develop new skills and knowledge. Vincent (2010) supported this and made clear links between training and safety, suggesting that there is a need to have the staff close to clinical practice involved in training. One concern identified by the ward staff was that when the ward is understaffed and attendance to training is difficult, safety might be compromised. Vincent (2010) also discussed the need to have multi-professional training; all learning together to improve ward-level teamwork and reduce potential conflict.

Huczynski and Buchanan (1991) took the link between training and performance further, suggesting a management and controlling view of training. They argued that organisations cannot be staffed with people who behave in an unstable, variable, random, and individual way. If the trained staff were educated and learnt together, there would perhaps be less individual behaviour and more of a united group or team behaviour. Huczynski and Buchanan (1991) further suggested that organisations that require stability and predictability of staff behaviour need to have consistent and reliable training. This links with healthcare, where there is an expectation that all staff have predictable behaviour and that they deliver safe care. The training to help in development of staff was seen as vital by the executive team, but, as identified, the senior staff are counted in the ward staffing requirements and so

found it difficult to be able to teach and supervise ward staff. Furthermore, they had no opportunity to leave the ward to further their own training. This lack of investment in not allowing the senior staff to supervise their staff could have partly resulted in some of the poor compliance observed by the observation elements of this research. Lack of education and development can lead to safety incidents and poor recognition of the importance of recognising the safety initiatives. The Department of Health (DH, 2015) identified that there is a need to support frontline staff to deliver good quality care.

7.8 Communities of practice

Work group communities are important when workers organise their lives with their immediate colleagues to get their job done (Wenger, 2008). Being a community of practice ensures that the workers work together in a unified manner, learning from each other and ensuring that all workers work as a team. This insight from Wenger (2008) reflected what is already known about communities, in that they should work together for a common goal to ensure that they are successful. Within healthcare, the workers need to form into one team to ensure that each person functions not only as an individual but also as a team player to provide safe and effective care. However, the communities in the NHS Trust in this study are split between sites and over a large geographical area and fragmented into many specialties and business units. The executive team recognised this fragmentation. They stated that each site did have a different feel, which was linked to their own community and practice focus. The executive team suggested the teams work together to succeed and do the best for patients, and if this is achieved staff are more satisfied in their work. This supports the staff view that the Trust was only concerned with patients and not them. One senior ward staff member suggested that medical interventions are often conducted in response to patient wishes, keeping patients and families happy without being limited by medical need. Often, they suggested, medical needs were being ignored in favour of preventing a complaint. Local behaviours of the ward leaders appeared to have a greater impact on job satisfaction and happiness of the staff.

During observations on the ward, the behaviours of staff produced some unexpected findings. The staff listened to the handover and then proceeded to conduct their daily tasks, including contact with the patients on a one-to-one basis. However, the majority of the staff never washed/gelled their hands between patient contact, and largely ignored the 5 moments of hand hygiene (WHO, 2009b). The staff did show some compliance to the WHO (2009b) guidelines in that some wore aprons and some changed these between patient contact. However, overall, poor compliance was observed. Leadership and ward staff behaviours are very closely linked. The times this poor compliance was observed was when the ward manager had to attend to other duties, and no direct supervision/role modelling was seen, on

the ward. As a registrant, following the NMC's *Guidance for Nurses and Midwives: Raising and Escalating Concerns* (2010), these issues were discussed with the nurses involved as soon as they were observed. They acknowledged my comments and immediately changed their practice. Later that day the ward manager was informed that this had already been discussed with the individuals and improved practice was observed.

The Nursing and Midwifery Council (NMC) (*The Code Professional Standards of Practice and Behaviour for Nurses and Midwives*, 2015) have clearly set professional standards of practice for registered practitioners. These state that each registered practitioner is responsible and accountable for the care they deliver. Patient safety, with a particular focus upon infections, is stated within the NMC Code (2015):

> *"19.0 Be aware of, and reduce as far as possible, any potential for harm associated with your practice To achieve this, you must:*
> *19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
> *19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)*
> *19.3 keep to and promote recommended practice in relation to controlling and preventing infection, and*
> *19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public".*

These standards reflect the duty of care the registered practitioner needs to strive for in the protection of their patients. Clearly the standards had been breached in this single section. Audits of hand hygiene, infection etc. have been used widely as a formality and safety measurement tool. These audits should be an effective method of recording best practice and improving poor practice. However, my study shows poor practice persists in some circumstances. If unsafe behaviours are ignored within the communities of practice, then local management at the patient/staff interface is needed, to provide guidance, teaching and an authority to performance manage. This requires adequate investment in staffing, allowing the ward managers time to fulfil their duties as managers. Leadership and management are clearly needed at ward level to drive quality, and to implement and sustain patient safety initiatives.

7.9 Chapter Summary

Following the in-depth analysis of the data, it is clear that behaviour of individuals at the patient/staff interface is key to the implementation of patient safety initiatives. However, the priorities for this need to permeate from board to ward. My study suggests that, in this Trust, this was often an incomplete process. What is needed is to change focus away from the without definition, immeasurable concept of culture, to something more influential on

behaviours of staff. This, coupled with improved permeation of priorities, should provide a clearer sense of direction and promote organisational responsiveness. The ward climate reflects the reality of the context of daily practice influencing behaviours of individuals within an organisation as they work with patients and families in direct care settings. While it is accepted that culture remains important as it influences the climate of an organisation, it is somewhat nebulous as a concept, whereas climate is more directly observable. However, climate needs to be led and managed effectively as this is crucial to operational success (Stringer, 2002; Ashanasy et al. 2000). A conceptual model demonstrating the results of my research is provided (appendix 22). It shows that the drivers for patient safety came from the Trust's own philosophy of patient safety, national policy regarding safety priorities, and reporting and awareness requirements that result from the measurement of safety priorities. Finally, communication drives patient safety in that clear messages and requests are made and effectively communicated throughout the Trust. The drivers have a direct effect upon the organisation's culture. This culture is made up of the attitudes, beliefs, assumptions and values of the Trust. This then has a direct influence on the leadership, climate and behaviour at a local level, i.e. ward level, and, as a consequence, the safety of patient care.

7.10 Chapter Conclusion

This chapter has highlighted that both the government and the executive team acknowledge the existence of organisational culture; that it can be changed and manipulated to ensure an environment that is fit for purpose, and thus ensure the delivery of safe and effective care. Nevertheless, the development of a culture takes many years and cannot be changed easily, and so a new focus is needed. Ward-level climate is a more accurate, controllable, and measurable way of assessing and improving staff performance. What matters is that wards are managed in a consistent and informed manner, by senior staff working in the clinical setting. Strong leadership is needed to create a climate of patient safety and quality care where staff feel valued and listened to. Permeation of top-down Trust priorities right to ward level will help facilitate cohesive action toward the priorities. The next chapter outlines the strengths and limitations of this study and recommendations for policy and practice in the NHS Trust. The final chapter concludes this thesis, reiterating the original contribution of this thesis to the knowledge field of nursing and patient safety in healthcare.

CHAPTER 8 STRENGTHS, LIMITATIONS AND IMPLICATIONS FOR PRACTICE AND RESEARCH

8.1 INTRODUCTION

This chapter discusses the strengths and limitations of this study. It also presents the implications for policy and practice within the NHS Trust. Opportunities for ongoing research to develop the ideas in this thesis are presented.

8.2 THE STRENGTHS AND LIMITATIONS

An ongoing limitation of this study is that organisational culture has no definitive definition in the literature. However, a common-sense working definition was provided as a context for this thesis. This study enabled an exploration of culture from the staff perspective, providing an insight into this and the concept of climate, which is also difficult to define. Climate is often referred to as the internal weather of the organisation. This research has shown that when staff on the wards are asked about culture, what they talk about was climate. However, further research is needed to explore and measure the climate in more depth to see what effect this has on patient safety.

There is some debate over the term permeation of culture. This can be mistakenly viewed as the flow of information. Permeation is also about interpretation of information and its influence on practice. As identified within the discussion chapter, permeation and diffusion are interdependent concepts. Further research into permeation and diffusion is needed to understand the concepts and their application to organisations further.

This study used NI as a methodology, and case studies to help focus upon different elements of the data collection. NI was used to focus upon a defined organisational context. This context was the executive, management and two ward teams. This narrow focus could be seen as a limitation. However, within the qualitative paradigm, generalisability is not the intended outcome. Instead this type of research is more concerned with data richness and the trustworthiness of data in order that users of the research can understand it, identify with it and potentially use it in their work in other settings. This NI research has provided this deep insight into the context, staff behaviour and interaction.

Both the executive and the management team were interviewed. The management team interviews consisted of the matrons and one other senior manager. It might be suggested that this limited the breadth of the sample, given its nursing emphasis. However, the aim of the thesis was to provide a nursing perspective and this has been achieved.

Within the clinical practice area two wards were chosen for the research by the executive team. The wards were of different specialities, one acute and one care of the elderly. This choice of wards with differing priorities provided a breadth of sample and rich data concerning the communication, thoughts, opinions and behaviour of the staff wards. The individual interviews using semi-structured interview schedules proved very difficult at times, due to staff unavailability and workloads. However, with persistence, all interviews were conducted. The semi-structured interviews were all completed using a pre-set prompt sheet. Although this may potentially have limited participant responses, the use of open-ended questions allowed staff to fully explore their thoughts and feelings in depth. At first, some of the participants were more guarded in what they said, and only short responses were given. With careful probing, they eventually explored their thoughts and feelings. When the staff were asked to discuss organisational culture, they were asked if they knew what this was referring to. Some fully understood, but others did not. In my explanations there could have been some unintentional leading to their responses, however a reflexive approach guarded against this.

Focus group interviews were a strength within the study, as they provided information from a group perspective. Within the focus groups, staff were a little more subdued. The ward manager was definitely an influence on responses, suggesting that a power dynamic may have negatively impacted on the data. However, analysis of individual interview data provided an opportunity to verify interpretations, adding to the trustworthiness of data.

A strength of this study was the peer review of a random selection of transcriptions. This peer support exercise ensured that the categories and themes that were developed were generally accepted as accurate reflections of the data interpretation. This peer review helped in the trustworthiness of the data, facilitating greater confidence in the findings.

One potential criticism of the study was the absence of the perspectives of patients, relatives and other professionals such as doctors. This was deliberate as the focus of the study was to elicit a nursing perspective. An understanding from those who deliver patient care directly on a daily basis was needed to answer the research question and achieve the study aim. Further research is needed to explore other stakeholder perspectives to provide a more holistic perspective on patient safety, climate and culture.

8.3 IMPLICATIONS AND RECOMMENDATIONS

This research has provided a unique insight into organisational culture and its top-down approach to the permeation of patient safety initiatives. There have been many aspects of the permeation of initiatives through an organisation's culture identified within the results chapter using the five safety initiatives. Conclusions can be drawn regarding some important

elements which can be used to enhance care. The results and recommendations may generate some thought and debate towards changing practice at all Trust levels to improve patient safety.

In addressing the research question:

'How do top-down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust'

it is clear that organisational culture, permeation and safety are the central themes. There are a number of recommendations made here that may have a positive influence.

Cultural Consistency

The aim should be that all staff within the organisation have some understanding of the organisational culture in which they work, whether that be the macro or micro view. They should understand and commit to the same values, beliefs, attitudes and behaviours as the Trust. In addition, it is important that the climate of the wards and departments provides support where necessary to ensure that all wards and departments work as effective teams towards improving and maintaining patient safety. Establishing this shared awareness can then be done using a ward-level team approach, meaning the team can then focus this upon patient safety. At ward level, the staff should be aware of the climate of their ward, understand it and acknowledge how it could influence their behaviours and actions.

Communication

The key communication aims proposed are:

1. The attribute of communication should be understood and seen as fundamental to successful permeation of safety initiatives.
2. The organisation should have an understanding of how communication flows through its many layers and business units.
3. The organisation needs to audit the communication flow, speed and how information is passed onto the wards, and whether this occurs in a manner that ward staff understand.
4. The organisation should appreciate the importance of ascertaining how the ward and departmental staff would like to receive important information and their preferred method of communication.
5. Communication should reflect a two-way process from top down and bottom up, and the executive team should acknowledge any communication from the wards and departments.

The organisation, with representation from all levels, should collectively map and discuss their processes of communication. The view from the top and bottom of the organisation suggested there is room for improvement. Provision should be made to allow staff representatives from all areas to attend any meetings and share action plans. Audits should be in place to measure any improvements in an-ongoing sense.

Leading and Shaping

The recommendations relating to this are as follows:

1. Leadership needs to be acknowledged as pivotal to successful permeation of safety initiatives throughout the organisation.
2. The leadership teams should strive for consistency in conveying the same important messages throughout the many layers of the organisation.
3. Ward leaders need to be supported in working with their staff to ensure that the quality of care is of paramount importance.
4. The organisation should work together to ensure any memes used are positive and promote patient safety.

Although the executive team do carry out spontaneous walk arounds in the Trust, these may need to be more frequent and any interactions with staff during these need to encourage open discussion. The executive and management team need to listen to the ward teams and learn from their suggestions, taking action where feasible in order to make staff feel their contribution is valued. Ward-level meetings should facilitate frank discussions. Action points should be discussed and actioned at these meetings. The leaders within the Trust should ensure that they have consistent messages and behaviours, to help role model a unified team. Memes are a powerful means of driving safe practice. Those leading care on wards could use memes to ensure the staff are reminded of important aspects of care.

Safety Initiatives and Focus

1. The attributes of investment, performance measures, audit, communication, significance, degree of fit, external influences, and leadership should be understood by the leaders within the Trust.
2. The organisation needs to work as one team to prioritise their safety priorities.
3. All staff need to be responsible for the safety of the care delivered. Learning sessions need to be held where individual behaviour and responsibilities are discussed.
4. Any safety priorities should be implemented and monitored for their impact on patient safety.

The organisation as a whole should identify which safety initiatives are prioritised. There needs to be a coherent and consistent message within the organisation. They need to be willing to learn and listen to staff. All staff should, as identified, take personal responsibility and accountability for safety, not just patient safety but organisational safety and their own safety, feeling free to own up without retribution.

Measurement

A range of locally-devised adapted measurement tools are needed to accurately assess the safety climate and culture of the Trust. The audit results within the organisation need to be accurate and a learning approach needs to be taken to implement any required changes. Management should ensure that all staff appreciate the importance of measurement as a way of improving safety. Staff should be invited to senior meetings where the audit results are shared. One way of supporting this is, for example, to identify safety champions, who not only lead on the safety issues, but also lead on safe practice meme generation and promotion.

8.4 Chapter Conclusion

This chapter has highlighted some of the strengths and weaknesses of this study. This has included some personal reflection on the process. Opportunities for further research have also been identified. Recommendations for Trust policy and practice have been presented. Many of the recommendations may be transferable to other NHS organisations, which operate in similar contexts. The final chapter summarises the thesis, emphasises its key findings and confirms its originality.

CHAPTER 9: CONCLUSION

This chapter brings together the findings and reflects upon the extent to which the aims and questions posed by this research have been achieved. It involves a considered reflection upon whether permeation of a safety initiative from board to ward is possible and, if so, what factors influence successful implementation.

This study has attempted to address the following question:

'How do top-down patient safety initiatives permeate through organisational culture within an NHS Foundation Trust'

The question principally focuses upon a specifically *top-down* approach to the permeation of safety initiatives and organisational culture. To enable a structured response to answering the question the following specific sub-questions were identified:

1. How is the concept of organisational culture understood throughout the organisation i.e. do all staff, from the Chief Executive to the ward team, have the same understanding?
2. Which safety initiatives have been identifiably conceived by the executive team, and how have these been communicated throughout the organisation?
3. How were these safety initiatives introduced to the ward, i.e. were these understood, and how have they been implemented?
4. To what extent (if any) does the executive team's conception of safety initiatives align with the ward staff's implementation of them?

In order to provide structure to this concluding chapter, findings are discussed specifically below in relation to these questions.

9.1 Key Concepts Re-Visited.

The concept of organisational culture is generally (often uncritically) accepted by both Government and management writers alike. This thesis therefore attempted to explore a number of dimensions of this concept, including the overall conceptual meaning of culture, in order to attempt to arrive at an operational definition of this term. This conceptual explanation concluded that culture is not inherent, but learned, and not a static entity but rather socially constructed and changed by numerous exposures to other people. However, this thesis was concerned with the concept of *organisational culture* and specifically how cultures are developed and sustained (or not) within organisations. It was tentatively

concluded that organisational culture has many different levels, from the surface level, seen and felt by all, to the deeper level which is difficult to understand unless immersed within that organisation. This allowed an evolved understanding of the assumptions shared by social group(s) within the organisation. To fully understand the nature of organisational culture a sociological perspective was provided. This identified that culture entails shared meanings within groups, and is not a property of individuals. This observation has clear implications in terms of how organisations ought to seek to focus upon group-level (as opposed to individual) initiatives and interventions. Repeatedly, social group behaviour has been shown to have both a positive impact upon organisations as well as playing a part in the darker aspects of organisational life and dysfunctional outcomes. In the context of this study, with its explicit focus on patient safety, dysfunctional culture has been implicated in a lowering of effectiveness, efficiency and performance. In turn, these factors clearly risk poorer care outcomes and potential safety breaches. The concept of *safety culture* was explored within a broader consideration of the impact of poor practice. It is arguable that a number of notable serious incidents have led to an expanded awareness of the concept of safety culture. Safety culture(s) can be viewed as a facet of broader organisational culture, reflecting the same layers of complexity as organisational culture. Public and professional awareness has undoubtedly been greatly raised by the number of deaths and serious harm caused to patients within healthcare being made visible by the mainstream media. Notable scandals have meant that safety concerns have been recognised and steps taken to mitigate against errors.

9.2 How is the concept of 'organisational culture' understood throughout the organisation i.e. do all staff, from the Chief Executive to the ward team, have the same understanding?

Within the Trust in which this study was conducted, organisational culture as a concept was uncritically accepted by the executive and management teams, and the *common sense* definition as outlined in chapter 3 appeared to be most frequently used. This taken-for-granted approach to organisational culture was often adopted without empirical evidence, or any evidence of depth of understanding. The blind adoption of this approach perhaps reflects the findings of Hofstede (1983), Tayeb (1994), and Seel (2000) who all identified that the concept of culture defies definitive labels. The Trust leadership viewed their culture with high-esteem and as allowing people to do their best, valuing staff and patients alike.

In spite of limited conceptual understanding, the term culture was deployed readily, discussed openly and seen by the executive and management team as the basis of quality care delivery. Given that this term was readily accepted and deployed, and the pervasive belief that the culture *truly* drove care delivery, it might be reasonable to expect that the impact it made on care would be self-evident. However, this evidence was non-existent. The

Trust appeared to have readily accepted the common-sense definition without formal evidence of its existence, and doing so involved a certain degree of circularity. It was *believed* that (a) culture existed and could be *felt* within the Trust, and (b) if culture could be *felt*, then culture *existed* from the Trust's perspective. One possible explanation of might be the (too ready) acceptance of what the management gurus claim in relation to this topic. However, the common-sense view was not without some advantage: at the very least the Trust was able to recognise that the people within an organisation get a feel for their own organisational culture rather than relying on formal proof. Gaining empirical evidence of cultural existence, as previously identified, is difficult. The contention of this thesis is that a reliable tool to provide an accurate assessment of culture does not exist, and therefore legitimate questions might be raised as to the need to *measure* culture.

To the extent that culture might be empirically captured, it is perhaps arguable that each individual organisation needs to conduct their own assessment, choosing a tool that reflects what it is they want/need to know about their own organisational culture, preferably for the purposes of organisational improvement. The Trust in which this research was conducted viewed their culture in a more informal manner, eschewing the need for formal measurement tools. The underlying and prevailing view appeared to be that if staff *felt* culture existed, then that 'the culture' allowed the Trust to be an enjoyable place to work, Also, if the staff felt valued, and their motivation was increased to deliver better care, then that was an acceptable state of affairs. The term 'culture' was defined by some respondents as being coterminous with *'the climate on the wards'*. For their part, ward staff tended to speak of climate rather than culture. This description was arguably shorthand for the attitudes, environment and behaviour of the staff, and also of the leader of a ward team. It was asserted within chapter 7 that (a) climate exists and exerts influence upon outcomes, (b) climate *can* be measured and therefore (c) it can be changed and managed. Tagiuri and Litwin (1968) argued that climate is the perception of the people within the organisation, their behaviour and attitudes, and if we can control the climate, and the behaviours within that climate, then we can control and manage patient safety. The realisation of the importance of the concept of climate, its potential links to how staff act and how patient safety might consequently be affected are questions that require further investigation.

9.3 Which safety initiatives have been identifiably conceived by the executive team, and how have these been communicated throughout the organisation?

Five identifiable safety initiatives were conceived by the executive team, namely:

- Falls prevention
- Medications safety
- Infection control

- Recognising the sick patient
- Pressure sore prevention

These safety initiatives mirrored those of the Safety First Campaign (NPSA, 2015) and HSCIC (2015). These safety initiatives were chosen purposefully by the executive team and justified by the rationale that staff could focus upon just a small number, instead of a large amount, of issues. However, as discussed in chapter 5 it is arguable that that only one of these safety initiatives (falls prevention) was communicated through all layers of the Trust, from the executive team to the health care assistants on the ward. Other initiatives tended to be lost somewhere between the management and the ward team. It was noted that each layer of the organisation added further identifiable concerns to the initial list of the 5 initiatives, thus growing this number to 16 in total. As a consequence, ward teams typically experienced confusion and frustration as a consequence of having too much to focus on and the attendant paperwork involved. Poor communication was also evident insofar as a top-down, one-way communication process meant that the little people on the ward were not listened to. Furthermore, a pervasive top-down approach to communication meant that bottom-up communication channels were closed off and, consequently, senior leaders remained largely unaware of what was going on within their Trust. This communicative state of affairs was arguably one influential factor in the poor implementation of the safety initiatives, and if effective two-way communication channels had been present the executive team would have been made aware that the 5 initial initiatives had grown to 16, resulting in staff confusion.

The reasons for the successful permeation of the falls prevention initiative were explored in chapter 6, and this was attributed to the heavy investment by the executive team in ensuring that falls was at the forefront of everyone's thoughts. A model for successful permeation was tentatively proposed, consisting of the following attributes:

1. Investment from the executive team
2. Performance measures, directly observable here and now
3. Audit data
4. Communication
5. Significance/common place
6. Degree of fit with current practice
7. Commissioners, external influences
8. Leadership

It was asserted that successful permeation, as evidenced by the example of the fall prevention initiative, displayed many of these attributes. However, as identified, putting this initiative into practice was not without difficulty. The idea that a permeation model might

serve as an ideal vehicle by which to deliver safety initiatives requires further empirical evaluation.

9.4 How were these safety initiatives introduced to the ward i.e. were these understood, and how have they been implemented?

As suggested above, the majority of top-down safety initiatives demonstrably failed to be recognised on the ward, with the falls prevention initiative being the only example that permeated the many layers of the organisation. One key element for this successful permeation was leadership, and specifically it appeared that leadership from the ward managers was pivotal to this example of successful permeation. This observation carries several implications. Firstly, if the ward managers were to be genuinely recognised by the senior leaders as leaders in their own right, then potentially more success may follow, and this may also affect a process of two-way communication within the organisation. It was asserted in chapter 7 that ward managers should take responsibility for *leading* their wards. Instances of poor leadership were observed during the course of this study, resulting in poor implementation of safety initiatives (including the falls prevention initiative) on the wards concerned. Falls prevention was consistently and repeatedly raised as a priority within interviews, focus groups, and minutes of meetings. Nonetheless, in spite of permeation, actual implementation of the initiative was (in places) poor. One possible cause of poor practice in this instance may have been a failure of leadership at ward level, resulting in a failure to sell the idea on a day-to-day basis. One possible remedy discussed above was the potential use of memes in order to increase the visibility of this initiative and potentially instil personal and professional responsibility into individual practitioners.

Leadership is pivotal to the success of an organisation. Where instances of good leadership were evident within this study, it was clear that this was influenced by a variety of developmental sources: academic preparation, peer influence, mirroring / role-modelling influential others, as well as working with a variety of experienced and proven clinical leaders. At the same time, the findings of this study suggest that *the context* in which the leader works, and *how* a leader works within that context, can form a *virtuous circle* by proving influential in developing and shaping the local culture. Earlier it was identified that some authors (and so-called gurus) relate certain leadership styles to different contexts: similar to how these writers treat the concept of culture, there appears to be no shortage of poorly-justified writing on the matter of leadership styles. My personal reflections suggest that if various typologies of leadership styles were truly critiqued, then many could be seen as wanting in explaining how styles require adaptability and reactivity to local contexts and events. It is possible that a truly contextual typology of leadership styles, able to mirror

different clinical contexts, may support and therefore enhance leadership in relation to both patient safety and effective care delivery.

Within this study, it was identified that senior leaders typically claimed responsibility (or even credit) for the way the organisation feels, and that local leaders were typically made responsible for surveillance of staff behaviours on the ward. As suggested above, this belief encompassed an (albeit poorly-formulated) view that organisational culture was important and acted through unspecified mechanisms to shape and set the feel of the organisation as a whole. The extent to which organisational culture permeated and was recognised as important from the ward staff's perceptions remained uncertain, or at least open to contention. It is arguable that this pervasive uncertainty resulted in a staff body who were relatively directionless. The findings of this study at least suggest strongly that effective local management of the patient/staff interface is inextricably linked to patient safety. The ways in which wards are managed has (correctly) always been viewed as pivotal to successful care delivery: paradoxically, the findings of this study suggest that the leaders of the Trust appeared, at least superficially, to pay little attention to the significance of the ward leader/manager role, and by consequence the individuals occupying these roles. The findings of this study suggest that a whole new way of thinking may be imperative to the question of successful implementation of patient safety initiatives: one in which there is a need to recognise the centrality of ward leaders as the quality control safe guarders of the entire service. This is not to dismiss the obvious co-requisite of effective senior leadership within Trusts, able to provide strategic direction and leadership. Nonetheless, the strong assertion of this research is that a concentrated investment in supporting leadership ought to be made at a ward level. Similarly, whilst various types of (abstracted) leadership styles were analysed above, and the significance of differing leadership styles was acknowledged as important, it is also contestable that leadership needs to be able to reflect local need, and this is pivotal to the success of a ward. Various styles considered ranged from controlling to shared leadership patterns. Each has inherent advantages and disadvantages in different contexts and at different times. Shared leadership especially requires committed teams that respect each other This study considered one ward in which this was not the case and a dysfunctional climate pervaded. In contrast, another site of data collection highlighted a ward leader who was valued and seen as instrumental to the smooth running of the ward. Hitherto, the issue of leadership within this thesis has been seen as instrumental in the successful permeation of safety initiatives. The strong concluding suggestion of this study is that any organisation-level attempt at improving patient safety outcomes requires effective clinical leadership at a ward level.

9.5 To what extent (if any) does the executive team's conception of safety initiatives align with ward staff's implementation of them?

This study aimed to explore the degree of correspondence between, on the one hand, the executive leadership team's conception of patient safety initiatives and, on the other, the extent to which this was reflected in the reality of implementation at a ward level. A closed answer to this question, put quite simply, would demand a resoundingly negative answer. As identified, only one safety initiative was *recognised* by the ward staff (falls prevention) but this was *poorly implemented*. Paradoxically, other patient safety initiatives originated independently of the executive team. To a certain extent, some of these were implemented with a degree of success, but the executive team remained unaware of these achievements due to poor (one-way) communication practices. Once again, this highlights the self-evident requirement for effective two-way communication.

It is frequently asserted that patient safety is everyone's responsibility: within the behemoth of the NHS, within individual Trusts, at the level of Higher Education Institutions providing professional education, at a hospital level, at a ward level, and at the level of the individual practitioner. The strong assertion of this study is that the often-repeated mantra that 'patient safety is everyone's responsibility' is (at least) a starting point from which to articulate shared values and beliefs and on which to develop inherent, shared, core values. The data analysed within this study suggested that all the staff within the Trust *actually believed* in the concept of patient safety as a core value. In the context of this study, this belief apparently survived even in spite of the obvious confusion of executive-level and intermediate-level priorities. The importance of patient safety was recognised and raised as a topic during all of the interviews and observations of executive and ward meetings. However, this professed belief did not manifest itself in the practices observed. The question of why this translation did not occur remains of paramount interest. One possibility is that staff appeared to employ a limited window recognition in that they appeared to lose focus on the macro view of patient safety and, instead, tended to respond to the contingencies at a micro level and become (almost) task-focussed in their work. If this is the case, then it is clear that the problem of window recognition needs to be challenged. The findings of this study suggest that safety understanding arises from effective ward managers, their leadership, influence, and the role-modelling effect that this exerts on others. As well as personal attributes, this recommendation would also demand an examination of the role that ward managers are expected to fulfil within the organisational structure. It is unhelpful (to say the least) to have ward managers sequestered in an office attending to administrative tasks and having no time to supervise and motivate their staff. Data gathered in this study supports the notion that in order to successfully (and positively) influence others, ward managers need to be seen (in colloquial terms) to *'walk the walk'* as well as *'talk the talk'*. For this reason, one suggestion arising from this study considered the separation of the role

of the ward manager into two distinctive roles: *ward manager* and *ward leader*. Clearly, implementation of such a suggestion would carry significant financial implications, and perhaps further undermine the future viability of the entire NHS. However, at very least, one implication arising from this study might be to consider practical ways in which to support ward managers in balancing their operational commitments, whilst at the same time providing effective clinical leadership.

Whilst striving for patient safety remains a cogent (and ethically commendable) priority, it is highly unlikely to ever achieve the status of having a totally safe organisation. Even in industries such as aviation, arguably one the safest industries of all, accidents can and still do occur. Against this backdrop, statutory regulators and other external agencies could, with some justification, be accused of citing failures in organisational culture as a convenient catch-all category from which to explain every shortfall in care. Whilst accountable systems are *absolutely* required in order to ensure that staff practice safely, and professional accountability for one's own actions remains paramount, the context in which care is delivered can also create a tipping point beyond which the delivery safe care may be compromised. One moment of irony provided by the observations made during this study involved watching (patient safety-related) laminated signs falling from a wall and onto a floor, thus posing a real slip hazard!

9.6 Concluding Remarks.

In summary, organisational culture is often blamed for the shortcomings in patient safety. This convenient shorthand pervades in defiance of a full articulation of what, exactly, is meant by organisational culture. As long as this discursive blame game persists, it is perhaps unlikely that significant strides will be made towards genuine improvements in outcomes. Whilst organisational culture clearly does mediate patient safety outcomes, a careful consideration of this concept is often lacking. Different elements of this concept need to be examined more carefully - including systems, education/development, support, attitudes, behaviours and/or assumptions. There is a pressing need to assess with integrity what affects the patient/staff interface, what helps and hinders patient safety, and then deal with matters identified. The professional requirements for staff to remain vigilant in relation to their own practices remains: this includes the need to appropriately escalate patient safety issues.

Undertaking this research has involved partial consideration of the many facets that surround patient safety. Although there is no formula for ensuring effective translation into practice, it is hoped that different elements of this research may to help to improve both practice and patient outcomes. This research has contributed to the body of knowledge in several ways, not least by illuminating limited communication practices within one specific NHS Trust. It is at least possible that further instances of poor communication exist in other NHS Trusts.

This study has further contributed by identifying contextual caveats to work advocating a five safety initiatives approach. In order to occur, effective permeation requires much more, and eight attributes have been identified and discussed above. However, the need for further research in this respect is acknowledged. A tentative conceptual model 'from board to ward' (*figure 12*) is offered, although this model remains, for the present, largely theoretical. The underlying contention of the model is that by identifying the drivers surrounding culture, processes and outcomes, a model for safer care would be possible. This study stands alone in exploring (from a nursing perspective) the multiple layers of one NHS Trust from decisions taken by the executive team to the practices of health care assistants on two wards. Furthermore, this study has identified the importance (if a reminder was required) of the absolute need for two-way communication processes within any organisation. If the mantra that 'patient safety is everyone's business' is to have any meaning whatsoever, and Trust teams are to work together in order to reduce patient harm, then the communication channels need to be open and feedback (however negative) be acted upon. It would display a lack of caution to over-generalise the findings of this research due to the paradigm used, however, the hope is that the findings and recommendations contribute to the overall goal of achieving safer care delivery.

Implementing top-down initiatives with the laudable aim of improving patient safety within an NHS Trust setting remains a complex challenge - even in circumstances when the ward and organisational climate appear to be conducive to eradicating avoidable harm. The UK Government aims to reduce (and ultimately prevent) the 850,000 adverse incidents and 25,000 avoidable deaths occurring each year in the NHS. What is important is that nurses and other health professionals positively and proactively engage with emerging (top-down) policy guidance on patient safety. The need to work cooperatively and continuously challenge poor care at ward level remains a priority. The discursive claim that some harm is unavoidable perhaps dilutes intolerance of any aspect of care that places patients and the public at unnecessary risk. However, perhaps equally contemptible is the discursive device that accords all adverse outcomes to failures in organisational culture. Perhaps the words of Florence Nightingale remain as relevant today as they were when first written, serving as a constant reminder of the important role hospitals play in keeping people safe:

> *"It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm*" (Florence Nightingale, 1863, p. iii)

APPENDICES

Appendix 1 Ethical Approval from Northumbria University HCES Research and Ethical Panel

Professor Kathleen McCourt FRCN
Dean

This matter is being dealt with by:
Research and Enterprise Office
School of Health, Community & Education Studies
Room H007
Coach Lane Campus East
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6701
Fax: 0191 215 6083
E-mail: julie.blackwell@northumbria.ac.uk

Anthony Conner
Northumbria University
School of Health, Community and Education Studies
Coach Lane Campus West, Room M204
Newcastle upon Tyne
NE7 7XA

19th January 2012

Dear Tony

School of HCES Research Ethics Panel
Title: Permeation of organisational culture and its effects on patient safety

Following independent peer review of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent CRB and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
http://www.northumbria.ac.uk/researchandconsultancy/sa/ethgov/policies/?view=Standard

You may now also proceed with your application (if applicable) to:

- NHS R&D organisations for approval. Please check with the NHS Trust whether you require a Research Passport, Letter(s) of Access or Honorary contract(s).
- Research Ethics Committee (REC). [They will require a copy of this letter plus the ethics panel comments and your response to those comments]. If your research is subject to external REC approval, a 'favourable opinion' must be obtained prior to commencing your research. You must notify the University of the date of that favourable opinion.

Both the University and NRES strongly advise that the supervisor accompany the student when attending an external REC.

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Professor David Stanley
Chair, School Research Ethics Review Panel

Appendix 2

Invitation to Participate in Research Study Executive Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Date

Dear ……

INVITATION TO PARTICIPATE IN RESEARCH STUDY

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

The aim of the project is to explore what effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust? You are invited to participate in this study. Before you decide you need to understand why the research is being done and what it would involve from you.

The research is not directly funded by Northumbria University however is part of a PhD study.

You are being invited to participate in this study because you are member of the Executive team within an NHS foundation trust.

Enclosed is an information sheet which details the research and what you will be agreeing to do if you agree to take part. Please read this carefully.

In 2-3 days time Tony Conner will contact you via telephone or e-mail to find out if you are interested in taking part in this research. If you are, Tony Conner will make arrangements to meet with you to provide further information and to answer any questions you may have.

You will then be offered a period of one week to consider whether you wish to be involved. If you do get involved all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours faithfully,

Mr Tony Conner

Principal Investigator / Lead Researcher

Appendix 3

Invitation to Participate in Research Study Management Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Dear ……

INVITATION TO PARTICIPATE IN RESEARCH STUDY

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

The aim of this project is to explore the permeation of organisational culture and its effect upon patient safety within an NHS Foundation Trust. You are invited to participate in this study.

Before you decide you need to understand why the research is being done and what it would involve from you.

The research is not directly funded by Northumbria University but is being conducted by Tony Conner who is an employee of Northumbria University as part of his PhD study.

You are being invited to participate in this study because you are a member of the Senior Management Team working within an NHS Foundation Trust.

An information sheet is enclosed which details the research and what you will be agreeing to do if you agree to take part. Please read this carefully.

In 2-3 days time Tony Conner (The researcher) will contact you either by telephone call or via e-mail to find out if you are interested in taking part in this research. If you are, Tony will make arrangements to meet with you to provide further information and to answer any questions you may have.

You will then be offered a period of one week to consider whether you wish to be involved. If you do get involved all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours faithfully,

Tony Conner

Senior lecturer Principal Researcher

Appendix 4 Invitation to Participate in Research Study Ward Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Dear ……

INVITATION TO PARTICIPATE IN RESEARCH STUDY

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Before you decide you need to understand why the research is being done and what it would involve from you.

The research is not directly funded by Northumbria University but is being conducted by Tony Conner who is an employee of Northumbria University as part of his PhD study.

You are being invited to participate in this study because you are a member of Staff working within an NHS Foundation Trust.

An information sheet is enclosed which details the research and what you will be agreeing to do if you agree to take part. Please read this carefully.

In 2-3 days time Tony Conner (The researcher) will contact you either by telephone call or via e-mail to find out if you are interested in taking part in this research. If you are, Tony will make arrangements to meet with you to provide further information and to answer any questions you may have.

You will then be offered a period of one week to consider whether you wish to be involved. If you do get involved all of the information collected from you will be held in the strictest confidence. In addition, you will be free to withdraw from the study at any time without this affecting you in any way.

Thank you for taking the time to consider being involved in this study

Yours faithfully,

Tony Conner

Senior lecturer

Principal Researcher

Appendix 5

Research Study Information Sheet Executive Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Research Study Information Sheet (Version 1.6)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

What is the purpose of the study?
The aim of this project is to explore what effect can effective permeation of organisational culture have upon patient safety. The study intends to examine how information is communicated from the Executive Board down to the ward environment, and how safety initiatives are conceived, and adopted by the NHS trust.

Why have I been asked to take part in this study?
You have been asked to take part in this study because you are a member of the Executive team within an NHS foundation trust.

Do I have to take part in the study?
No, it is up to you to decide if you wish to take part. Tony Conner will meet with you to discuss the study in more detail. You will also have an opportunity ask any questions you may have.

If you agree to take part then Tony Conner will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at anytime, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

What am I being asked to do?
If you decide to take part in this study all the staff will be asked to participate in an individual interview with Tony Conner

If you agree to participate Tony Conner will invite you to participate in an individual interview, this will be recorded and last approximately 45 to 60 minutes

Are there any disadvantages to taking part?
Tony Conner is aware that you may be identifiable due to the nature of the sample chosen, however your name will not be disclosed, and any data generated will be labelled with your unique identifier number, a generic term of the Executive team may be used but and not individual names. You may also experience the potential inconvenience of having to take part in an Interview which may last for up to 60 minutes.

What are the benefits of taking part?
Individuals participating in this study will get an opportunity to identify their perceptions of their organisational culture and how they have contributed in the permeation of a number of safety initiatives and their effect upon patient care.

CONFIDENTIALITY

Collecting the data
The data for this study will be collected using a Digital Dictaphone Recorder during the interview. Once the interview has ended the recording will be transcribed and a written record of our discussions will be created. The data will not contain your name etc. and any paper based record will be securely stored.

Storage of the interview tapes, transcripts and other papers
Any paper based transcriptions will be kept in a locked cupboard at Northumbria University until the research is completed, however all digital recordings will be deleted once the paper based transcriptions have been transcribed. These documents are anonymised and are marked by a unique identifier (allocated to you by Tony Conner).

The only individual who will have access to the tapes and papers is Tony Conner.

Any information which is produced as part of the dissemination activities associated with the project will not bear your name.

What will happen to the results of the research study?
The results will form part of a report which will be completed by Jan 2015. The results will form part of a report which will be disseminated by Tony Conner and will be made available to study participants. The results will also be published in education and health care journals and within a PhD dissertation. You will never be identified in any publication although your words may be published exactly as you said them during the interview.

Who is funding this study?
Tony Conner is self-funding but is supported and sponsored by Northumbria University through its programme of staff scholarly activity

Who has reviewed this study?
The proposed research has been reviewed by the School Research Committee and the NHS Trust Research and Development Department.
.
Where can I find further information about the research?

In the first instance please contact Tony Conner:

Mr Tony Conner – Principal Investigator (0191) 215 6353

If you are unhappy about this study please contact

Dr John Unsworth PhD Supervisor (0191) 215 6548

If I take part can I withdraw from the study at a later date?
You can withdraw from the study at any time. Simply contact Tony Conner to tell him you would like to withdraw. His details are at the end of this information sheet.

When you indicate your intention to withdraw from this study he will ask you if you would like him to destroy all of the data collected to the point of withdraw or whether we can continue to use it in an anonymised form.

Complaints
If you have concerns about any aspect of this study please speak to either Tony Conner, or PhD Supervisor (details below) and we will do our best to address these. If you remain unhappy you

may wish to contact the sponsor of this research who is Mrs Margaret Rowe, Associate Dean, 0191 215 6070 e-mail margaret.rowe@northumbria.ac.uk

Information disclosure
Tony Conner is a Register Nurse and is governed by the Nursing and Midwifery Council (NMC), he will inform you at the initial meeting of the NMC code (2008), and also the NMC raising and escalating concerns guidance (2010)
.

Research Team

Principal Investigator	Mr Tony Conner Northumbria University Telephone (0191) 215 6353 e-email tony.conner@unn.ac.uk
PhD Supervisor	Dr John Unsworth Northumbria University Telephone (0191) 215 6548 e-mail john.unsworth@northumbria.ac.uk

Appendix 6 Research Study Information Sheet Management Team

School of Health, Community & Education Studies
Pre-registration Health
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Room M204
Coach Lane Campus
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Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Research Study Information Sheet (Version 1.6)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

What is the purpose of the study?
The aim of this project is to explore what effect can effective permeation of organisational culture have upon patient safety. The study intends to examine how information is communicated from the Executive Board down to the ward environment, and how safety initiatives are conceived, and adopted by the NHS trust.

Why have I been asked to take part in this study?
You have been asked to take part in this study because you are a member of the Senior Management Team within an NHS foundation trust.

Do I have to take part in the study?
No, it is up to you to decide if you wish to take part. Tony Conner will meet with you to discuss the study in more detail. You will also have an opportunity ask any questions you may have.

If you agree to take part then Tony Conner will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at anytime, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

What am I being asked to do?
If you decide to take part in this study all the staff will be asked to participate in an individual interview with Tony Conner

If you agree to participate Tony Conner will invite you to participate in an individual interview, this will be recorded and last approximately 45 to 60 minutes

Are there any disadvantages to taking part?
Tony Conner is aware that you may be identifiable due to the nature of the sample chosen, however your name will not be disclosed, and any data generated will be labelled as the Senior Management Team and not individual names. You may also experience the potential inconvenience of having to take part in an interview 60 minutes.

What are the benefits of taking part?
Individuals participating in this study will get an opportunity to identify their perceptions of their organisational culture and how they have contributed in the permeation of a number of safety initiatives and their effect upon patient care.

CONFIDENTIALITY

Collecting the data
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Any information which is produced as part of the dissemination activities associated with the project will not bear your name.

What will happen to the results of the research study?
The results will form part of a report which will be completed by Jan 2015. A report will be disseminated by Tony Conner and will be made available to study participants. The results will also be published in education and health care journals and within a PhD dissertation. You will never be identified in any publication although your words may be published exactly as you said them during the interview.

Who is funding this study?
Tony Conner is self funding but is supported and sponsored by Northumbria University through its programme of staff scholarly activity

Who has reviewed this study?
The proposed research has been reviewed by the School Research Committee and the NHS Trust Research and Development department where applicable.

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If you are unhappy about this study please contact

Dr John Unsworth PhD Supervisor (0191) 215 6548

If I take part can I withdraw from the study at a later date?
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If you have concerns about any aspect of this study please speak to either Tony Conner, or PhD Supervisor (details below) and we will do our best to address these. If you remain unhappy you may wish to contact the sponsor of this research who is Mrs Margaret Rowe, Associate Dean, 0191 215 6070 e-mail margaret.rowe@northumbria.ac.uk

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Research Team

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PhD Supervisor	Dr John Unsworth Northumbria University Telephone (0191) 215 6548 e-mail john.unsworth@northumbria.ac.uk

Appendix 7 Research Study Information Sheet Ward Team

School of Health, Community & Education Studies
Pre-registration Health
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Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

Research Study Information Sheet (Version 1.6)

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Why have I been asked to take part in this study?
You have been asked to take part in this study because you are a member of the Ward Team within an NHS foundation trust.

Do I have to take part in the study?
No, it is up to you to decide if you wish to take part. Tony Conner will meet with you to discuss the study in more detail. You will also have an opportunity ask any questions you may have.

If you agree to take part then Tony Conner will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw from the study at anytime, without giving a reason. Withdrawal will not affect you in any way and your decision to withdraw will not be shared with anyone.

What am I being asked to do?
If you decide to take part in this study all the staff will be asked to:

- Participate in an focus group with a number of other staff from your ward with Tony Conner
- Participate in an individual interview with Tony Conner
- Participate in being observed by Tony Conner whilst in practice

If you agree to participate Tony Conner will invite you to participate in a focus group this will be recorded and last approximately 45 – 60 minutes

If you agree to participate Tony Conner will invite you to participate in an individual interview, this will be recorded and last approximately 45 to 60 minutes

Tony Conner will ask you if he can observe your practice that will last for 8 hours. Prior to the observation period Tony Conner will ask you if you are still willing to participate within the research, he will discuss his role as a non participant observer, he will also discuss the

NMC regulations and his position as a Registered Nurse. You can ask Tony Conner not to record any part of the observation; he will not intrude in any personal care.

Are there any disadvantages to taking part?
There are two wards chosen for this research study, your name will not be disclosed, and you will be provided with a unique identifier which will help to label any data generated. You may also experience the potential inconvenience of having to take part in an interview and focus group which may last for up to 60 minutes each, and to be observed in practice over 8 hours.

What are the benefits of taking part?
Individuals participating in this study will get an opportunity to identify their perceptions of their organisational culture and how they have contributed in the permeation of a number of safety initiatives and their effect upon patient care.

CONFIDENTIALITY

Collecting the data
The data for this study will be collected using a Digital Dictaphone Recorder during the interview and focus group, and also an observational chart. Once the interview has ended the recording will be transcribed and a written record of our discussions and observations will be created. The data will not contain your name etc. and any paper based record will be securely stored.

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The proposed research has been reviewed by the School Research Committee and the NHS Trust Research and Development department where applicable.

Where can I find further information about the research?
In the first instance please contact Tony Conner:

Mr Tony Conner – Principal Investigator (0191) 215 6353

If you are unhappy about this study please contact

Dr John Unsworth PhD Supervisor (0191) 215 6548

If I take part can I withdraw from the study at a later date?
You can withdraw from the study at any time. Simply contact Tony Conner to tell him you would like to withdraw. His details are at the end of this information sheet.

When you indicate your intention to withdraw from this study Tony Conner will ask you if you would like him to destroy all of the data collected to the point of withdraw or whether we can continue to use it in an anonymised form.

Complaints
If you have concerns about any aspect of this study please speak to either Tony Conner, or PhD Supervisor (details below) and we will do our best to address these. If you remain unhappy you may wish to contact the sponsor of this research who is Mrs Margaret Rowe, Associate Dean, 0191 215 6070 e-mail margaret.rowe@northumbria.ac.uk

Information disclosure
Tony Conner is a Register Nurse and is governed by the Nursing and Midwifery Council (NMC), he will inform you at the initial meeting of the NMC code (2008), and also the NMC raising and escalating concerns regulations (2010)

Research Team

Principal Investigator	Mr Tony Conner Northumbria University Telephone (0191) 215 6353 e-email tony.conner@unn.ac.uk
PhD Supervisor	Dr John Unsworth Northumbria University Telephone (0191) 215 6548 e-mail john.unsworth@northumbria.ac.uk

Appendix 8 Consent Form Executive Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

CONSENT FORM (Version 1.4)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

Please initial the box

	YES	***NO***
1, I confirm that I have read and understand the information sheet dated …… (Version 1.6)	☐	☐
2, I have had the opportunity to consider the information, ask questions about the study, and these have been answered to my satisfaction	☐	☐
3, I am willing to be interviewed	☐	☐
4, I am happy for my comments to be recorded and my words used in the research	☐	☐
5, I am happy for my comments to be audio recorded and my words used in the research	☐	☐
6, I understand that my participation is voluntary; I can withdraw at any time without giving reason if I change my mind and this will not affect me in any way	☐	☐
7, I understand that relevant sections of the data collected during the study may be looked at by individuals from Northumbria University where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	☐	☐
8, I understand my name and details will be kept confidential, and will not appear in any printed documents	☐	☐
9, I know that because of the study sample that I could be identified and that the researcher will attempt to maintain anonyminity when writing reports	☐	☐
10, I agree to take part in the above study	☐	☐

I ……. [name of participant] understand the information presented to me by ……[name of researcher] and agree to take part in the research

Signature ……. [Participant] **Date …….**

Signature ……. [Researcher] **Date ……..**

Appendix 9 Consent Form Management Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

CONSENT FORM (Version 1.4)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

	Please initial the box	
	YES	***NO***
1, I confirm that I have read and understand the information sheet dated …… (Version 1.6)	☐	☐
2, I have had the opportunity to consider the information, ask questions about the study, and these have been answered to my satisfaction	☐	☐
3, I am willing to be interviewed	☐	☐
4, I am happy for my comments to be recorded and my words used in the research	☐	☐
5, I am happy for my comments to be audio recorded and my words used in the research	☐	☐
6, I understand that my participation is voluntary; I can withdraw at any time without giving reason if I change my mind and this will not affect me in any way	☐	☐
7, I understand that relevant sections of the data collected during the study may be looked at by individuals from Northumbria University where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	☐	☐
8, I understand my name and details will be kept confidential, and will not appear in any printed documents	☐	☐
9, I know that because of the study sample that I could be identified and that the researcher will attempt to maintain anonyminity when writing reports	☐	☐
10, I agree to take part in the above study	☐	☐

I ……. [name of participant] understand the information presented to me by ……[name of researcher] and agree to take part in the research

Signature ……. [Participant] **Date …….**

Signature ……. [Researcher] **Date ……..**

Appendix 10 Consent Form Ward Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA

Tel 0191 2156353
Tony.conner@unn.ac.uk

CONSENT FORM (Version 1.4)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

Please initial the box

	YES	*NO*
1, I confirm that I have read and understand the information sheet dated …… (Version 1.6)	☐	☐
2, I have had the opportunity to consider the information, ask questions about the study, and these have been answered to my satisfaction	☐	☐
3, I am willing to be interviewed	☐	☐
4, I am happy for my comments to be recorded and my words used in the research	☐	☐
5, I am happy for my comments to be audio recorded and my words used in the research	☐	☐
6, I understand that my participation is voluntary I can withdraw at any time without giving reason if I change my mind and this will not affect me in any way	☐	☐
7, I understand that relevant sections of the data collected during the study may be looked at by individuals from Northumbria University where, it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	☐	☐
8, I understand my name and details will be kept confidential, and will not appear in any printed documents	☐	☐
9, I know that because of the study sample that I could be identified and that the researcher will attempt to maintain anonyminity when writing reports	☐	☐
10, I agree to take part in the above study	☐	☐

I ……. [name of participant] understand the information presented to me by ……[name of researcher] and agree to take part in the research

Signature ……. [Participant] **Date …….**

Signature ……. [Researcher] **Date ……..**

Appendix 11 Observational Consent Form Ward Team

School of Health, Community & Education Studies
Pre-registration Health
Studies
Room M204
Coach Lane Campus
Newcastle upon
Tyne NE7 7XA
Tel 0191 2156353
Tony.conner@unn.ac.uk

CONSENT FORM Observational Study (Version 1.5)

What effect can effective permeation of organisational culture have upon patient safety within an NHS Foundation Trust?

	Please initial the box	
	YES	***NO***
1, I confirm that I have read and understand the information sheet dated …… (Version 1.6)	☐	☐
2, I have had the opportunity to consider the information, ask questions about the study, and these have been answered to my satisfaction	☐	☐
3, I am willing to be observed during my span of duty	☐	☐
4, I am happy for my comments to be recorded and my words used in the research	☐	☐
5, I understand I can ask the researcher not to document any part of the observation	☐	☐
6, I understand that my participation is voluntary I can withdraw at any time without giving reason if I change my mind and this will not affect me in any way	☐	☐
7, I understand that relevant sections of the data collected during the study may be looked at by individuals from Northumbria University where, it is relevant to my taking part in this research. I give permission for these individuals to have access to the data.	☐	☐
8, I understand my name and details will be kept confidential, and will not appear in any printed documents	☐	☐
9, I know that because of the study sample that I could be identified and that the researcher will attempt to maintain anonyminity when writing reports	☐	☐
10, I agree to take part in the above study	☐	☐

I ……. [name of participant] understand the information presented to me by

…….[name of researcher] and agree to take part in the research

Signature ……. [Participant] **Date …….**

Signature ……. [Researcher] **Date ……..**

Appendix 12 Individual Interview Schedule Executive Team

Individual Interview for executive team

Date of Individual interview

Document all

Name

Job Title

Ward

Ensure unique Identifier is provided within a sealed envelope

Introduction

Thank you for agreeing and attended this interview

Are you happy to be interviewed today, and are you happy for this to be recorded?

Did you read the information sheet and are you still happy with this?

Have you signed the consent form?

Are you still happy to continue to be part of this research?

Have you any questions before we start?

Inform the participants of the reason for the individual interview

To gain their individual understanding of personal perceptions of the organisational culture and how this has been permeated through to them and its effect on patient safety

Ground rules

This interview is to gain their personal opinions, views, thoughts and feelings and is to be treated as confidential, and should not be discussed outside this room

All information will be recorded and remain anonymised

You can discuss anything you feel relevant, willingly and without coercion

I may have to ask you for clarity of certain information if needed

I may have to 'cut short' some responses so we can cover all the questions

Please do not name other members of staff or patients or refer to them by name

Please just try and relax; this is a discussion surrounding culture and patient safety and not an exam

I am a registered Nurse, and so I am governed by the NMC Code, and raising and escalating concerns, if there is any information that I feel in my professional opinion that needs to be addressed or escalated I will refer to the NMC raising and escalating framework, (copy to be provided to the participant)

1, Could you tell me your perceptions of this organisations culture?

- Does a culture exist
- What kind of culture is it
- What makes up the culture
- Who leads the culture
- Is the culture the same throughout the organisation
- Where do you fit into the culture
- Do sub cultures exist, if yes where and what are they
- Do you think sub cultures are healthy

2, Does the organisational culture have an effect on patient care?

- **How does It affect the care**
- **Is this positive/negative**

3, How does information flow from the executive team down to the ward team?

- How/Who passes this down
- Minutes
- Meetings
- Verbal, by whom
- Management team
- Matron
- Yourself
- Who leads this

4, Do you feel the information from the exec team gets passed down to the ward team in a timely manner, and in a way they understand?

- How long does this take
- What are the reasons for the timings
- Can you see how this could be improved
- Do you think any information gets 'lost' in the system
- Are there any barriers to this

5, How was information passed down concerning patient safety initiatives?:

- Patient accidents, (falls)
- Infection control measures
- Patient deterioration
- Who lead this

6, How were the initiatives implemented upon the ward?

- Team meetings
- Minutes
- Written directive
- Champions
- Leaders
-

7, Do you feel the implementation of the initiatives was successful?

- Were they adopted by all staff
- Was there any 'blocks' to the implementation
- Was the implementation communicated well
- What direction did you give
- Have they audited the results
- Do the initiatives happen all the time, i.e. night and day including weekends
- Do you think these could be improved
- Is there an improvement in patient care
- How do you measure success
- Who lead this

8, Has the ward developed any safety initiatives?

- What are they
- Have they worked
- Do they happen all the time
- Do you think they could be improved
- Have you seen an improvement in patient care
- How do you measure their success
- Who lead this

9, If there was a ward based safety initiative how was this been passed back up to the exec team?

- How was this passed back to the exec team
- Who lead this
- Do you feel the information back up to the exec team was well received

End of interview session

Have you anything more you would like to add to this discussion

Thank you all for your time

Appendix 13 Individual Interview Schedule Management Team

Individual Interview for management team

Date of Individual interview

Document all

Name

Job Title

Ward

Ensure unique Identifier is provided within a sealed envelope

Introduction

Thank you for agreeing and attended this interview

Are you still happy to be interviewed today, and are you happy for this to be recorded?

Did you read the information sheet and are you still happy with this?

You have signed the consent form?

Are you still happy to continue to be part of this research?

Inform the participants of the reason for the individual interview

To gain their individual understanding of personal perceptions of the organisational culture and how this has been permeated through to them and its effect on patient safety

Ground rules

This interview is to gain their personal opinions, views, thoughts and feelings and is to be treated as confidential, and should not be discussed outside this room

All information will be recorded and remain anonymised

You can discuss anything you feel relevant, willingly and without coercion

I may have to ask you for clarity of certain information if needed

I may have to 'cut short' some responses so we can cover all the questions

Please do not name other members of staff or patients or refer to them by name

Please just try and relax; this is a discussion surrounding culture and patient safety and not an exam

I am a registered Nurse, and so I am governed by the NMC Code, and raising and escalating concerns, if there is any information that I feel in my professional opinion that needs to be addressed or escalated I will refer to the NMC raising and escalating framework, (copy to be provided to the participant)

1, Could you tell me your perceptions of this organisations culture?

- Does a culture exist
- What kind of culture is it
- What makes up the culture
- Who leads the culture
- Is the culture the same throughout the organisation
- Where do you fit into the culture
- Is there a separate ward/department culture

2, Does the organisational culture have an effect on patient care?

- **How does It affect the care**
- **Is this positive/negative**

3, How does information flow from the executive board down to you?

- How/Who passes this down
- Minutes
- Meetings
- Verbal, by whom
- Management team
- Matron
- Who leads this

4, How do you pass the information down to the ward team?

- Minutes
- Meetings
- Verbal

5, Do you feel the information from the exec team gets passed down to the ward team in a timely manner, and in a way you understand?

- How long does this take
- Why does it take so long
- Can you see how this could be improved
- Do you think any information gets 'lost' in the system
- Are there any barriers to this

6, How was information passed down concerning patient safety initiatives?:

- Patient accidents, (falls)
- Infection control measures
- Patient deterioration

7, How were the initiatives implemented upon the ward?

- Team meetings
- Minutes
- Written directive
- Champions

- Leaders

8, Do you feel the implementation of the initiatives was successful?

- Were they adopted by all staff
- Was there any 'blocks' to the implementation
- Was the implementation communicated well
- What direction did you get
- Have you audited the results
- Do the initiatives happen all the time, i.e. night and day including weekends
- Do you think these could be improved
- Is there an improvement in patient care
- Who lead this

9, Has the ward developed any safety initiatives?

- What are they
- Have they worked
- Do they happen all the time
- Have you seen an improvement in patient care
- How do you measure their success
- Who lead this

10, If the ward developed a safety initiative was this been passed back up to you, and how did you pass this to the exec team?

- How was this passed back to the exec team
- Who lead this
- Do you feel the information back up to the exec team was well received

End of focus group session

Have you anything more you would like to add to this discussion

Thank you all for your time, I will be in contact with you for the individual interviews

Appendix 14 Individual Interview Schedule Ward Team

Individual Interview Schedule for Ward Team

Date of Individual interview

Document all

Name

Job Title

Ward

Ensure unique Identifier from focus group is used

Introduction

Thank you for agreeing and attended this interview

Are you still happy to be interviewed today, and are you happy for this to be recorded?

Did you read the information sheet and are you still happy with this?

You have signed the consent form?

Are you still happy to continue to be part of this research?

Inform the participants of the reason for the individual interview

To gain their individual understanding of personal perceptions of the organisational culture and how this has been permeated through to them and its effect on patient safety

Ground rules

This interview is to gain their personal opinions, views, thoughts and feelings and is to be treated as confidential, and should not be discussed outside this room

All information will be recorded and remain anonymised

You can discuss anything you feel relevant, willingly and without coercion

I may have to ask you for clarity of certain information if needed

I may have to 'cut short' some responses so we can cover all the questions

Please do not name other members of staff or patients or refer to them by name

Please just try and relax; this is a discussion surrounding culture and patient safety and not an exam

I am a registered Nurse, and so I am governed by the NMC Code, and raising and escalating concerns, if there is any information that I feel in my professional opinion that needs to be addressed or escalated I will refer to the NMC raising and escalating framework, (copy to be provided to the focus group)

1, Can you think of a commercial enterprise that you value, if so:

- what these organisations mean to them
- what do they feel like
- what are they offering
- what do they believe in
- what do you expect from them
- what do you think the staff working in the organisations feel like and think

2, Using the same thoughts from the commercial enterprise, could you tell me your thoughts and feelings of your organisation.

- what does this organisation mean to them
- what does it feel like
- what is it offering
- what does it believe in
- what does it expect from you
- what does it feel like working in this organisation
- do you feel valued
- do you feel part of the team

3, Does the way the organisation communicate and feel too you have an effect on patient care?

- How does It affect the care
- Is this positive/negative

4, How does information flow from the executive board down to the ward team?

- How/Who passes this down
- Minutes
- Meetings
- Verbal, by whom
- Management team
- Matron

5, Do you feel the information from the exec team gets passed down to the ward team in a timely manner, and in a way you understand?

- How long does this take
- Why does it take so long
- Can you see how this could be improved
- Do you think any information gets 'lost' in the system
- Are there any barriers to this

6, How was information passed down concerning patient safety initiatives?:

- Patient accidents, (falls)
- Infection control measures
- Patient deterioration

7, How were the initiatives implemented upon the ward?

- Team meetings
- Minutes
- Written directive
- Champions
- Leaders

8, Do you feel the implementation of the initiatives was successful?

- Were they adopted by all staff
- Was there any 'blocks' to the implementation
- Was the implementation communicated well
- What direction did you get
- Have you audited the results
- Do the initiatives happen all the time, i.e. night and day including weekends
- Do you think these could be improved
- Is there an improvement in patient care
- Who lead this

9, Have you thought of any safety initiatives on the ward?

- What are they
- Have they worked
- Do they happen all the time
- Have you seen an improvement in patient care
- How do you measure there success
- Who lead this

10, If you have developed a safety initiative has this been passed back up to the exec team?

- How was this passed back to the exec team
- Who lead this
- Do you feel the information back up to the exec team was well received

End of Individual interview

Have you anything more you would like to add to this discussion

Thank you all for your time

Appendix 15 Focus Group Schedule Ward Team

Focus Group Schedule for Ward team

Semi-structured focus group interview with ward staff

Date of Focus group

Document all names, Job Title and Ward

Provide unique Identifier number in a sealed envelope

Provide an Introduction

Thank you for agreeing and attended this focus group

Ensure all participants are happy to be interviewed and have this recorded

Ensure all participants are happy with the information sheet they were provided with, have read it, and have had all questions answered prior to this focus group

Ensure all participants have read and signed the consent form, and are still happy to take part in the focus group

Inform the participants of the reason for the focus group

To gain an understanding in their own personal perceptions of the organisational culture and how this has been permeated through to them and its effect on patient safety

Ground rules

This room is to be a safe environment where all information, views and opinions are to be treated as confidential, and should not be discussed outside this room

All information will be recorded then anonymised during the transcription phase

Please do not refer to each other by name

It is important that you respect each other, don't interrupt, and allow the person to express their own views and opinions

All staff will have their say, willingly and without coercion

I may have to ask you for clarity of certain information if needed

I may have to 'cut short' some responses so we can cover all the questions

Please do not name other members of staff or patients or refer to them by name

Please just try and relax; this is a discussion surrounding culture and patient safety and not an exam

I am a registered Nurse, and so I am governed by the NMC Code, and raising and escalating concerns, if there is any information that I feel in my professional opinion that needs to be addressed or escalated I will refer to the NMC raising and escalating framework, (copy to be provided to the focus group)

1, Can you think of a commercial enterprise that you value, if so:

- what these organisations mean to them
- what do they feel like
- what are they offering
- what do they believe in
- what do you expect from them
- what do you think the staff working in the organisations feel like and think

2, Using the same thoughts from the commercial enterprise, could you tell me your thoughts and feelings of your organisation.

- what does this organisation mean to them
- what does it feel like
- what is it offering
- what does it believe in
- what does it expect from you
- what does it feel like working in this organisation
- do you feel valued
- do you feel part of the team

3, Does the way the organisation communicate and feel to you have an effect on patient care?

- How does It affect the care
- Is this positive/negative

4, How does information flow from the executive board down to the ward team?

- How/Who passes this down
- Minutes
- Meetings
- Verbal, by whom
- Management team
- Matron

5, Do you feel the information from the exec team gets passed down to the ward team in a timely manner, and in a way you understand?

- How long does this take
- Why does it take so long
- Can you see how this could be improved
- Do you think any information gets 'lost' in the system
- Are there any barriers to this

6, How was information passed down concerning patient safety initiatives?:

- Patient accidents, (falls)
- Infection control measures
- Patient deterioration

7, How were the initiatives implemented upon the ward?

- Team meetings
- Minutes
- Written directive
- Champions
- Leaders

8, Do you feel the implementation of the initiatives was successful?

- Were they adopted by all staff
- Was there any 'blocks' to the implementation
- Was the implementation communicated well
- What direction did you get
- Have you audited the results
- Do the initiatives happen all the time, i.e. night and day including weekends
- Do you think these could be improved
- Is there an improvement in patient care
- Who lead this

9, Have you thought of any safety initiatives on the ward?

- What are they
- Have they worked
- Do they happen all the time
- Have you seen an improvement in patient care
- How do you measure their success
- Who lead this

10, If you have developed a safety initiative has this been passed back up to the exec team?

- How was this passed back to the exec team
- Who lead this
- Do you feel the information back up to the exec team was well received

End of focus group session

Have you anything more you would like to add to this discussion

Thank you all for your time, I will be in contact with you for the individual interviews.

Appendix 16 Observation Schedule

Observation schedule

Unique Identifier if used

Introduction

Thank you for agreeing to allow the researcher to observe your practice

Are you still happy to be observed today, and are you happy for the researcher to take field notes?

Are you still happy with the information on the information sheet?

You have signed the consent form?

Are you still happy to continue to be part of this research?

Inform the participants of the reason for the observational studies

To gain an understanding how the safety initiatives are implemented on the

Ground rules

The observation will use their unique identifier, and all information collected will be treated as confidential.

I may have to ask you for clarity of certain information if needed

If you mention a patient or colleague by name their details will not be recorded in my field notes.

I am a registered Nurse, and so I am governed by the NMC Code, and raising and escalating concerns, if there is any information that I feel in my professional opinion that needs to be addressed or escalated I will refer to the NMC raising and escalating framework, (copy to be provided to the participant group)

The researcher needs to describe the context, environment, staffing, number of patients, day of week, and time of day.

Using field notes the researcher will observe staff during their normal shift, he will identify if any of the four areas identified below are practiced

Number 1, Patient accidents (patient falls

Number 2, Infection control measures

Number 3, Patient deterioration

Number 4, Internal local driven safety initiative

1, During handover was there any mention of:

Number 1, Patient accidents (patient falls)

Number 2, Infection control measures

Number 3, Patient deterioration

Number 4, Internal local driven safety initiative

2, What was said, did anyone lead these?

3, What were the overall feelings on the ward:

- Moral
- Friendliness
- Communication
- Humour

4, What explicit/implicit communication was experienced?

5, Were any of the 4 safety initiatives focussed upon. If so what were they:

- Were these reinforced to staff
- Was there documentation concerning these areas
- How were they measured, and by whom
- Were the patients involved in the 4 areas, if not all four which ones

6, What help or information was available for the staff concerning the 4 areas?

7, If any of the 4 areas were addressed how was this communicated, documented, followed, escalated, prevented

8, Was there any barriers to communication, if so:

- **What were they**
- **What made them barriers**
- **How were these overcome**

9, What behaviours were identified on the ward

10, If any incident concerning the 4 areas were experienced how were these:

- Identified
- Handled
- Dealt with
- What was the learning from the situation

11, Was there any input from the management team, or Matron:

- What was this input

12, Overall what was the overall communication like on the ward

- Positive
- Negative
- Subdued

13, Was were the overall environmental influences

- Learning
- Positive
- Negative

14, Overall what were the researcher findings/feelings whilst being on the ward, what was the overall culture on the ward?

Appendix 17 Observation Protocol

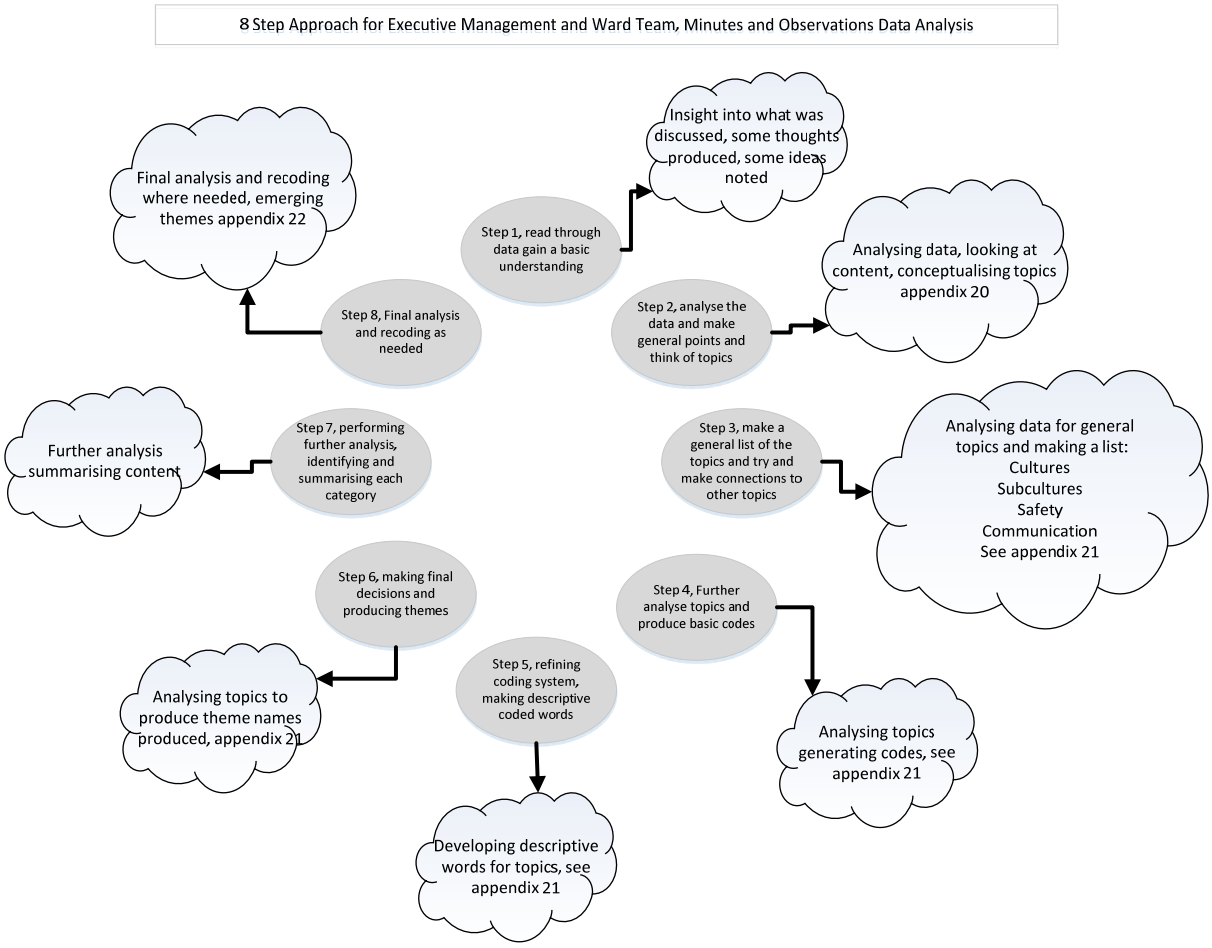
Observation Protocol		
General observation points	**Descriptive Notes**	**Reflective Notes**
1, During handover was there any mention of: Number 1, Patient accidents (patient falls) Number 2, Infection control measures Number 3, Patient deterioration Number 4, Internal local driven safety initiative		
2, What was said, did anyone lead these?		
3, What were the overall feelings on the ward: • Moral • Friendliness • Communication • Humour		
4, What explicit/implicit communication was experienced?		
5, Were any of the 4 safety initiatives focussed upon. If so what were they: • Were these reinforced to staff • Was there documentation concerning these areas • How were they measured, and by whom		

• Were the patients involved in the 4 areas, if not all four which ones		
6, What help or information was available for the staff concerning the 4 areas?		
7, If any of the 4 areas were addressed how was this communicated, documented, followed, escalated, prevented		
8, Was there any barriers to communication, if so: • **What were they** • **What made them barriers** • **How were these overcome**		
9, What behaviours were identified on the ward		
10, If any incident concerning the 4 areas were experienced how were these: • Identified • Handled • Dealt with • What was the learning from the situation		

11, Was there any input from the management team, or Matron: • What was this input		
12, Overall what was the overall communication like on the ward • Positive • Negative		
13, Was were the overall environmental influences • Learning • Positive • Negative		
14, Overall what were the researcher findings/feelings whilst being on the ward, what was the overall culture on the ward?		

Appendix 18

8 Steps to Data Analysis



Appendix 19

Example of analysis with transcript including marginal comments

21

22 That's a good question. I think it's a pretty vibrant, positive, patient focused

23 culture. What we've been trying to do is build a culture about people wanting to

24 do their best , improve things, try and get to a position where they are very happy

25 for their family to be treated here and increasingly if they see a problem sort it

26 out, let's not make a big thing of it, just sort it out.

27

28 **On a local level is it?**

29

30 Yeh, it's a very devolved organization, it's the recognition that you can't do

31 everything at the top of the organization you need the whole 10,000 people doing

32 their best every day.

33

34 **It's a massive organization now and getting bigger things I've heard. So**

35 **what makes up the culture do you think, in this organisation?**

36

37 Well it's built up over time we've probably got lots of little subcultures as well, all

38 the sites feel slightly different, but the thing I've just described is a consistent

39 thing that goes across the board, but if you do walk into each site and talk to staff

40 you do feel differences because they are imbedded in their own little

41 communities that in themselves are different. But over the years we've probably

Appendix 20

Topic Generation

Trust Culture P1
Organisational Culture

Trust has a pretty vibrant, positive and patient focussed culture 26

A culture of people wanting to do their best improve things, try to get to a position where they are happy for their families to be treated here 27-29

If staff see a problem sort it out, let's not make a big thing of it, just sort it out 29-30

P1 leads the culture 63

P1 sets the tone, the team, exec team, the board have to be clear, all the clinical leaders be clear that they are seen as a visible manifestation of the culture 63-65

Culture is complex and has to be part of the fabric 65-66

Culture has to grow from the bottom up 66

Culture cannot come out of a text book, you can't just build a new culture it, it's much more complex than that 67-69

The culture has a different take within the organisation, but when you boil it down to the core 5 or 6 bits i think they are consistent wherever you are 85-87

Social and community is hard to understand what that culture means its tricky 91-92

All staff should know what makes the CEO tick 121-122

P1 has a set of values that flows into all the stuff that is written in the organisation 120-121

P1 has developed with the culture having spent a long time working in the organisation 124-126

P1 hates the idea of the CEO writes down the culture and values and then impose them on the organisation, i think it fundamentally misunderstands how it works 126-128

P1 thinks if you write the culture and values down its sort of broken a bit 132

P1 thinks the organisational culture affects patient care 137

P1 thinks they get great results because of the culture 137

P1 thinks if they had a toxic or less healthy, or less positive culture i don't think most people would take much convincing that would eventually flow into quality 137-139

P1 thinks that culture is organic an complex 265-266

The culture is slightly different depends on where you are, one trust is different to another depending on the community, range of services 83-85

Trust Organisation

Its a very devolved organisation 34

Need to get the whole 10,000 people doing their best not just the very top 35-36

P1 has a set of values that flows into all the stuff that is written in the organisation 120-121

Subcultures

Trust built over time and has lots of little sub cultures as well 41

All the sites feel slightly different 42

Yes there are subcultures, P1 calls these nuances 96-99

As long as the sub cultures are not damaging, or harmful or contradictory to where you're trying to get overall 99-100

Having a bit of a local flavour is not a bad thing 100-101

Different communities

Each site is embedded into its own little communities that in themselves are different 44-45

Models of the organisation

Very clinically engaged being built over odd twenty years 45-46

Leadership

Lots of leadership development 46

Development

Lots of leadership and clinical development 46-47

Patient experience

All that focus is about quality patient experience, doing your level best 47-48

Staff

Staff doing their level best 48

Know how the CEO Ticks, the organisation tick, and actually broader what makes them tick, so that would be 5 or 6 things 121-124

Wards

P1 does walk around the wards, he just turns up, doesn't like planned stuff 52 & 56

Team do IHI checklists things as a team and i just turn up on site, paddle round, speak to people, the girls organise them in a more structured way i don't like them to be a royal visit and we just walk and have chat 56-59

Safety culture

Safety grows and develops over time, it probably changes and adapts and flexes according to circumstances as well 76-78

The culture is slightly different depends on where you are, one trust is different to another depending on the community, range of services 83-85

Internal competitiveness

One ward competes against another, around patient satisfaction 101-103

Competiveness shouldn't be a negative thing 109

Clinical staff are generally quite competitive, the key is to have pride in what you are doing and if pride can be channelled positively is a good thing 113-115

Values

P1 has a set of values that flows into all the stuff that is written in the organisation 120-121

P1 hates the idea of the CEO writes down the culture and values and then impose them on the organisation, i think it fundamentally misunderstands how it works 126-128

P1 thinks if you write the culture and values down its sort of broken a bit 132

Quality

P1 thinks if they had a toxic or less healthy, or less positive culture i don't think most people would take much convincing that would eventually flow into quality 137-139

Have a quality strategy 146-147

Performance, quality, and patient experience measured 147

Have a quality plan 185

Business units

devolved system built on business units 145-146

Communication

Information flows: Performance, quality and patient experience go through the system and internal com's in briefings, and press releases, P1 does notes to staff and all that 147-149

Stuff out of the board just helps to confirm there's consistency, there's a connection 154-155

Information does not flow from exec team to ward team in a timely manner 166

Very large coverage of hospital two and a half thousand mile 166-167

Flow of information is a weakness, and just the distortion by the time it flows through, you know the message can be completely different 167-168

People need to filter out all the things that are actually important 197-198

We need to work hard all the time 198

Teams

Staff are team people, know where they are, and they are getting good flows of information that shows what patients think of what they do 151-152

Teams look after each other, they're performing, they're functioning well as a team 153-154

Managers need to sit with their teams 170

Widespread teams, multi locations 171-174

Teams to sit face to face, don't rely on emails, and written team briefs 175-176

On the safety days there are a huge amount of people, from domestics, hca's to finance ???? 238-243 and 246-248

Safety

Trust have a safety plan 185

Falls, medication, infection, recognising the sick patient, pressure sores 185-190

On the safety days there is an Executive presence, who feed back up to the exec team, clinical policy group, board etc 255-258

Measurement

Loads of Auditing 208

Engagement when things are important 209

Measure, measure and measure 210

walks around scratching and sniffing and listening 212

P1 cannot rely on one measurement tool but needs to see the data and walk around's 213-214

Hand hygiene cannula care, commode compliance are generally ninety eight percent and above 221-222

Management

Lots of management presence and senior nurse presence, matrons on nights and weekends, matrons are there to be viable who are responsible for safety and make sure we all know if we've got a bit fragile somewhere and that its dealt with properly. 228-232

CEO

People will listen to what you have to say, but will watch what you do, as soon as you something that contradicts what you are saying you're knackered 273-275

Appendix 21

Overview of data analysis process

Appendix 22

A Conceptual Model for Board to Ward

Figure 15: A Conceptual Model for Board to Ward

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