International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Effective workplace culture: the attributes, enabling factors and consequences of a new concept

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Submitted for publication: 7th September 2011
Accepted for publication: 15th October 2011

Abstract

The culture of the healthcare workplace is influential in delivering care that is person-centred, clinically effective and continually improving in response to a changing context. The consequences of ineffective cultures have resulted in highly publicised failings. Since 2000, there has been increasing attention on culture in healthcare particularly organisational and corporate cultures, rather than, the immediate culture experienced by patients and users at the interface of care – the micro-systems level which we term 'workplace culture'. This is the level at which most healthcare is delivered and experienced and we argue it has to be given greater attention if healthcare reforms are to be implemented and sustained. Drawing on expertise with practice development - a complex methodology that aims to achieve effective workplace cultures that are person-centred, in different healthcare settings, the authors, within the context of an international colloquium on theory in practice development, present the findings of a rigorous concept analysis. Informed by data from a variety of sources the concept analysis identifies the attributes, enabling factors and consequences of an 'effective workplace culture'. The emerging framework will help those involved in transforming the culture at the patient and client interface to focus on and critique strategies that will directly and positively impact on patients, users and staff.

Implications for practice:

- The framework presented will enable workplace teams to begin to assess their workplace cultures and determine the areas that require action
- Individual clinical leaders may wish to self assess themselves in terms of their own role clarity and their own skill-set as transformational leaders and facilitators of others' effectiveness

Keywords: concept analysis, enabling factors, effective workplace culture, framework, microsystems, practice development

Introduction

Workplace culture in healthcare settings impacts on patients' and users' experience (Kennedy, 2001; Francis, 2010); the motivation, commitment and effectiveness of staff (Manley, 2001; 2004; Lok et al., 2005); evidence implementation and use in practice (Kitson et al., 1998; 2008; 2010; Rycroft-Malone et al., 2004); patient safety (NPSA, 2004); innovation uptake (Apekey et al., 2011) and

productivity (Naydeck et al., 2008; Goetzel and Ozminkowski, 2008). The consequences of ineffective and toxic cultures have resulted in serious implications for patient outcomes (Kennedy, 2001; Francis, 2010); staff well-being, and also wastes valuable economic resources. The relationship between workplace culture and its potential consequences therefore highlights the need to recognise, understand and develop effective cultures in healthcare, specifically at the level of care delivery where patients, service users and staff interface.

With recent reports of poor care and failures in healthcare focussed at the level of the patients' experience (Francis, 2010; Patient Association, 2009, 2010; New South Wales Department of Health, 2009), the importance of understanding workplace culture and the strategies necessary to improve it are urgent priorities for policy makers, clinical leaders as well as healthcare provider organisations, regulators and policy analysts. If healthcare services are to meet the needs of patients (Department of Health, 2002; 2009; 2010; Rycroft-Malone et al., 2002a,b; Bevington et al., 2004a, b; Scalzi et al., 2006; Manley et al., 2011) and those people who support them; as well as recruit and retain valuable staff expertise (Manley, 1997; 2001; 2004; Buchan, 1999) the need for cultural change is of significant importance.

To understand workplace culture, to know what is an effective culture at the frontline, and also, how to develop one is therefore an essential skill-set for all clinical leaders and facilitators of change in healthcare settings. Culture is not about individuals but about the social contexts that influence the way people behave and the social norms that are accepted and expected. To transform how things are done at the practice level, requires fundamental changes in mindsets and patterns of behaviour as it is these that manifest culture reflecting the values, beliefs and assumptions held or accepted by staff in the workplace.

Healthcare policy and literature suggests that cultural change is achieved through leadership (Patterson et al., 2011; Apekey et al., 2011; Bevington et al., 2004a, b; Peplar et al., 2005; Lok et al., 2005; Mulchay and Betts, 2005; Mannion et al., 2005; Manley, 1997; 2001); and that effective cultures are recognised by teamwork (Mannion et al., 2005; Wilson, McCormack and Ives, 2005); learning in and from practice (Manley, 2001; Garbett and McCormack, 2004; Manley, Titchen and Hardy, 2009); placing the patient at the centre of care (McCormack et al., 2011; McCance et al., 2011;Garbett and McCormack, 2004; Mannion et al., 2005; Department of Health, 2005a); clinically effective care (Manley, 2001; Rycroft-Malone, 2004; Kitson et al., 2010); safe care (Hewison, 1999; Clark, 2002) and, continual improvement, flexibility and innovation in response to a changing healthcare context (Manley, 2000a, b; 2001; Mannion et al., 2005; Department of Health, 2005b). Yet no comprehensive framework exists for guiding clinical leaders with culture change at the local level (Patterson et al., 2011). In this paper we describe a framework for recognising and enabling an e*ffective workplace culture* relevant to all healthcare settings. We use the term 'workplace culture' to differentiate it from corporate and organisational culture, based on our assumption that it is the local workplace culture that has the most significant impact on the everyday experience of patients, their supporters, service users and staff, whether that is in the context of a team or patient pathway.

The notion of culture: corporate, organisational and workplace

In its simplest form culture can be understood as `how things are done around here' (Drennan, 1992, p3). Schein (1985) proposes that culture is best thought of as a set of psychological predispositions called basic assumptions held by members of an organisation and which tend to influence the ways in which they behave. However, the concept 'culture' is complex reflected in the lack of consensus about how it is defined with most general and health related literature focusing extensively on corporate and organisational culture (Davies et al., 2000; Scott et al., 2003; Mannion et al., 2005) rather than culture at the local level – 'the workplace' which is the focus of this paper.

Corporate culture refers to values and practices shared across all groups in an organisation, at least within senior management (Kotter and Heskett, 1992). Anthony (1994) argues that corporate culture reflects what is espoused, that is, the culture that organisations want to portray for the purpose of influencing public relations or employee motivation, rather than, the organisational culture which is the actual culture experienced by staff and service users. Organisational culture in the past has been assumed to be singular and pervasive, monolithic and integrative, but all organisations have multiple cultures usually associated with different functional groupings or geographical locations (Kotter and Heskett, 1992; Bolan and Bolan, 1994), shared common interests, assumptions and associated values (Schein et al., 1985). Now, organisational culture is considered to include every aspect of an organisation and cannot be understood as separate from it, that is, culture is not an objective tangible or measurable aspect of an organization; organisations are cultures (Pacanowsky and O'Donnell-Trujillo, 1982; Bate, 1994).

In the context of healthcare the interplay between corporate, organisational and workplace cultures has major implications for merging different organisations, achieving consistent standards, and establishing social norms based on shared values of all employees. Over the last decade in healthcare, there has been a focus on organisational culture linking it in particular to performance (Mannion et al., 2005). The rationalist/instrumental approach to organisations has led to increasing standardisation and uniformity, with the false assumption that if all units operate the same, they will perform the same. Healthcare regulators and change facilitators with a more holistic approach to patient, service user and staff satisfaction, will have to delve under this mantle of organisations' overall performance culture, and tackle the workplace culture i.e. the culture that has a direct impact on user and staff experiences. If each organisational unit is acknowledged as having its own workplace culture, each will have its own point of departure in terms of change and development (McCormack et al., 2011). However, with the predominant focus on corporate and organisational culture in the literature, little attention has been given to local workplace cultures (Patterson et al., 2011), although there is a growing recognition of the importance of a local safety culture (NPSA, 2004).

Bolan and Bolan (1994) suggest that understanding organisational culture may be enhanced if groups or subunits are viewed as carriers and possible creators of culture. They introduced the term `idioculture' in order to challenge the assumption that 'subcultures' are derived from the organisational culture. Their proposition is that idiocultures interact with and influence each other, and from this emerges the organisational/corporate culture and vice versa. This view is consistent with findings in one healthcare study that identified the impact of one workplace culture on organisational culture (Manley, 2001). This position endorses our focus on 'local workplace' culture which we argue is also aligned with the micro-systems level of healthcare, a level already identified as pivotal to quality care (Nelson et al., 2002) and defined as:

> '…*small functional, front-line units that provide most healthcare to most people. They are the essential building blocks of large organisations. They are the place where patients and providers meet. The quality and value of care produced by a large health system can be no better that the services generated by the small systems of which it is composed*' (Nelson et al., 2002, p 472).

Our interest in local workplace cultures stems from our argument that workplace culture represents the immediate culture impacting on both healthcare users and providers. Whilst there may be many similar elements of effective cultures across different cultural levels, our aim is to explore the aspects of effective cultures relevant to front line care. We therefore define local workplace culture as:

> '*The most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders. This is the culture that impacts directly on the delivery of care. It both influences and is influenced by the organisational and corporate cultures with which it interfaces as well as other idiocultures through staff relationships and movement.'*

Whilst our focus is on workplace culture when working with individuals and teams on programmes of practice development, it is still necessary to understand how different cultures and levels of culture interact with each other so as to 'navigate' ways 'through' and 'around' different multiple sub-cultures (idiocultures) along with the broader organisational culture (Webster, 2007). The following quote illustrates this challenge:

> *'…I recognised the complexity of both the clinical and organisational cultures I was working with, and as such the challenges participants were facing in developing practice that was at odds with the beliefs of peers or other members of staff and the collective values of the teams they were part of' (Webster, 2007, p 260).*

Whilst we recognise that workplace cultures within the same geographical area or directorate may have distinctly different cultures, we propose that there are factors and characteristics that can positively influence the effectiveness of an idioculture. We use the term 'effective' carefully to mean cultures that achieve and sustain person-centred, safe and effective care and workplaces that enable patients and staff to flourish - the stated purpose of practice development (Manley et al., 2011).

Developing our theoretical and practical understanding of *effective workplace culture*

Bevan (2004) argues that the theoretical base underpinning healthcare quality improvement requires development. Concept analysis provides one approach towards this end, as concepts are the building blocks of theory (Chin and Jacobs, 1983). Concepts are socially constructed, evolve over time through use and can be associated with a set of attributes developed through socialisation and debate associated with this use (Rodgers, 1989; 1993; Morse, 1995; Walker and Avant, 2005). This approach is consistent with the idea that culture is a social phenomenon (Bate, 1994); is a concept that is still evolving; and our focus is on concept use so as to inform practice development interventions in the workplace.

In theoretical terms, *effective workplace culture*, is a complex construct comprised of inter-related concepts and values, some of which are not clearly defined. Within Morse's (1995) framework, *effective workplace culture* would be classified as an immature concept because it is nebulous and ill-defined although the surrogate (different but synonymous) term 'transformational culture' is linked with a specific set of cultural indicators (Manley, 2001; 2004). *Effective workplace culture* is therefore ripe for concept development. Rodger's (1989, 1993) approach to concept analysis, was used to identify the attributes, the enabling factors that precede *effective workplace culture*; and, the consequences that follow its occurrence. A framework for describing and understanding e*ffective workplace culture* in healthcare has resulted, aimed at informing research, theory development, and cultural change facilitation in the workplace from exploring the following three questions:

- How would an *effective workplace culture* be recognised – the attributes?
- How can an *effective workplace culture* be enabled - the enabling factors?
- What are the consequences of an e*ffective workplace culture*?

Developing the framework

The framework for *effective workplace culture* has developed through four different phases over the period of a decade, with each phase informing the next.

Phase one

A three year action research study formed the initial basis for the framework (Manley, 2001; 2000a; 2000b; 2002; 2004). Manley's study drew on the culture literature preceding the year 2000, most of which focused on business insights into corporate and organisational culture, to make sense of the processes and outcomes of a transformation project exploring the role of the consultant nurse in facilitating quality care in a healthcare practice setting (Manley, 1997). As well as identifying a number of cultural change processes, this study identified cultural indicators that described a transformational culture. Manley described a transformational culture as one that:

> *'…changes its form and disposition, readily adapting and responding to a changing context, but based on fundamental core values that in turn enable individuals to develop their own potential, and their practice too. Such a culture nurtures and enables innovation through practitioner empowerment, practice development and a number of other workplace characteristics - all prerequisites to quality patient care.'* (Manley, 2004, p 51)

To build on these insights, a formal two phased project followed (phases two and three) under the auspices of an International Practice Development Colloquium (a co-operative inquiry of practice developers and researchers from healthcare and educational organisations) which led to the identification of data to construct the framework. How this data was collected and analysed is described below.

Phase two

Verbal and written data, including research evidence and expert opinion were gathered during an International Practice Development Colloquium on Theory Development in July 2003. Thirty three practice developers (from Australia, England, Netherlands and Northern Ireland), used Meleis's (1985) theoretical analysis tool to undertake a rigorous and collaborative analysis of the key frameworks informing practice development and cultural change activity at the time (Habermas, 1972; Manley, 1997; 2001; Manley and McCormack, 1999; McCormack, 2001; Hoogwerf, 2002; Titchen and McGinley, 2003; Manley and McCormack, 2003; Rycroft- Malone, 2004; McCormack, Manley and Wilson, 2004). This led to data that informed a tentative understanding of the different attributes, enabling factors and consequences of an *effective workplace culture*.

Phase three

The research team comprising of five practice developers/researchers (Kim Manley, Kate Sanders, Shaun Cardiff, Lyn Garbarino, Moira Daven) clarified their values and beliefs about culture and change (see Box 1) prior to undertaking a systematic review of the literature between 2000-2006 to enable their own assumptions to be made explicit. The data from the review challenged and refined the emerging understandings from phase two. Literature prior to 2000 was unanimously focused on business culture and had been included in the literature review of Manley's (2001) doctoral thesis and synthesised with the findings of her study to describe the characteristics of a transformational culture.

Box 1. Values and beliefs held by the practice developers/researchers about culture and culture change

- An effective culture is one that is person-centred, evidence-based and continues to adapt to changing healthcare needs
- Culture change involves identifying and addressing internal and external barriers to change through critique, structured reflection, debate and contestation
- Different types of evidence need to be blended to develop an understanding of workplace culture
- The resulting framework would inform cultural change facilitation
- As healthcare contexts develop and change, so too will the perceptions and interpretations of an *effective workplace culture*. Continued analysis through contestation and debate would therefore be required

Table 1 outlines the search strategy for identifying data in phase three. Due to duplication of the predominant business emphasis evident in the pre-2000 literature, the strategy was focused down to include:

- Healthcare
- More recent theoretical understandings
- Those electronically available in English

Table1. Search strategy covering 2000-2006 and resulting literature identified

Key Words	**Search engines**	**Databases**
• Transformational culture • Corporate culture	OVID	• AMED • CINAHL • EMBASE • MEDLINE • PsycINFO
• Transformational culture • Workplace culture • Corporate culture • Organisational culture • Cultural change • Effective culture	The Emerald Full Text	
• Transformational culture • Workplace culture		The BNI, RCN Library database HMIC (DoH items)

Resulting literature	
Transformational + Culture	50 papers were identified with the two concepts of transformation and culture in the paper. Most included reference to 'transformation' in relation to e.g. transformational leadership or transformational strategies in relation to culture 5 papers within the 50 identified referred to the concept of 'transformational culture'
Corporate culture	421 papers were identified in relation to 'corporate culture'
Organisational culture	Organisational culture was identified in 33 papers + 17 books (including one book on transformational leadership and 2 on healthcare culture)
Workplace culture	64 articles identified the concepts of 'workplace' (sometimes referred to as workplace sometimes inferred through the use of 'unit', 'ward'), and 'culture' separately 3 of these referred to 'workplace culture'
Cultural change	2 in relation to healthcare
Effective culture	0 in relation to healthcare

Of the total papers reviewed (n=97) the majority focused on organisational culture with a smaller number on corporate culture or combinations of these with variations of workplace culture becoming more evident towards the end of the search period. Generally, workplace culture was referred to implicitly rather than explicitly for example by using the words, 'ward', 'unit' culture, or sub-culture, environment or climate. The vast majority of papers were drawn from health related areas (82) followed by business (13) and then education (2). Research and theoretical papers combined (65) were more evident with practice critique (20) and some anecdotal papers (12) providing other insights.

The practice developers/researchers used their expertise of developing *effective workplace cultures* in a range of different healthcare settings to inform the process of verification and critique of the data emerging from phase three.

Literature reviewed was shared between the researchers and a template used to capture the analysis of implicit and explicit factors that contributed to answering the three questions the concept analysis aimed to address (see Table 2 for an example). Concept clarification is also achieved by describing what a concept is not, and so any insights relating to this were also noted.

Once analysis of the 97 retrieved papers was complete and subsequent data captured on the template, each researcher exposed their own analysis to mutual critique and verification by the research team. The amalgamated data emerging from the literature was used to challenge the tentative attributes, enabling factors and consequences arising from phase two. As many of the components identified in the concept analysis were also concepts that had not been fully clarified themselves, discussion was required to ensure that there was a common understanding of the meaning of different elements, such as, shared governance, organisational readiness etc. From this process of critique within and across the phases two and three, a synthesised framework resulted to describe the concept of e*ffective workplace culture*, its enabling factors and consequences (Manley et al., 2007).

Phase four

The final phase of the project, since 2007, has involved informal critique and use in practice, as well as formal testing of different aspects of the framework in the field across a number of practice development projects internationally. This has led to minor refinements of the framework in response to research findings post 2006, as indicated by post 2006 references in the framework descriptors. During this time other related practice development concepts have also been further explored, researched and refined e.g. practice development processes and methods (McCormack et al., 2006); person centred care (McCormack and McCance, 2010; McCormack et al., 2011; McCance et al., 2011); critical creativity (McCormack and Titchen, 2006; 2007); human flourishing (Titchen and McCormack, 2008); work-based learning (Manley et al., 2009; Wilson et al., 2006); facilitating individual and team effectiveness (Manley and Titchen, 2011); active learning (Dewing, 2008); clinical leadership (Manley et al., 2008) and many others; and also, the political context has accentuated quality, safety and productivity (Department of Health, 2010).

The framework: *effective workplace culture*

The framework describing an *effective workplace culture*, how it would be recognised and enabled, as well as its consequences is presented in full in Table 3. The attributes, enabling factors and consequences are described in the sequence following the framework.

Table 2. Template for capturing analysis of literature with one example

AUTHORS	CATEGORY 1-4 See Header	FOCUS 1-3 O/C/W	Attributes	Enabling factors	Consequences	What an effective culture is NOT
Binnie A (2000) Freedom to practice: changing ward culture Nursing Times 96(6) 41-42	**1**	**1 W(ward)**	• An atmosphere where individuals feel free to learn, risk, make mistakes and grow • Providing personalised care to patients • Individuals take responsibility for managing own work • Flexibility	• Leaders provide support and trust • Opportunities to discuss a common approach • Opportunities to reflect on real situations for learning • Facilitation strategies • Role modelling shared values	• Patient-centred care • Greater therapeutic potential of work with patients • Increased commitment to patients and colleagues	• Rigid routine • Focus on tasks rather than patients • Accepting orders unquestioningly
CATEGORY: 1. Research (has mention of methodology/methods/analysis); 2. Theoretical/literature, systematic or less formal; 3. Practical critique – individual reflecting on own/collective practice experience; 4. Opinion/commentary based on expertise/anecdotal views FOCUS: 1. Healthcare 2.Business 3. Education O= Organisational culture C= Corporate culture W=Workplace culture						

Table 3. Effective[1] workplace culture[2] framework

Enabling factors	Essential attributes	Consequences
EF1. Individual: a) Transformational leadership b) Skilled facilitation c) Role clarification EF2. Organisational: a) Flattened and transparent management b) An enabling approach to leadership and decision-making c) Organisational readiness d) Human resource management support	A1. Specific values shared in the workplace, namely: • person-centredness • lifelong learning • high support and high challenge • leadership development • involvement, collaboration and participation by stakeholders (including service users) • evidence-use and development • positive attitude to change • open communication • teamwork • safety (holistic) A2. All the above values are realised in practice, there is a shared vision and mission and individual and collective responsibility A3. Adaptability, innovation and creativity maintain workplace effectiveness A4. Appropriate change is driven by the needs of patients/users/communities A5. Formal systems (structures and processes) enable continuous evaluation of learning, evaluation of performance and shared governance[3]	C1. Continuous evidence that: a) Patients', users' and communities' needs are met in a person-centred way b) Staff are empowered and committed c) Standards, goals and objectives are met (individual, team and organisational effectiveness) d) Knowledge/evidence is developed, used and shared C2. Human flourishing for all C3. Positive influence on other workplace cultures

1. Effective = Achieving the outcomes of person-centredness and evidenced-based care (performance).
2. Workplace culture = The most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders. This is the culture that impacts directly on the delivery of care. It both influences and is influenced by the organisational and corporate culture as well as other idiocultures. Idioculture is used to imply that there are different cultures that exert an influence on each other rather than one organisational/corporate culture with sub-cultures within a hierarchical arrangement.
3. Shared governance = The formal engagement of stakeholders in using evidence from a variety of sources (e.g. audit, feedback, reflective practice, research) for decision making.

The attributes

Five attributes are identified, all of which would be considered necessary for an *effective workplace culture* to be judged to be present at the microsystems level.

Attribute 1: Specific values shared in the workplace

A specific set of values have previously been acknowledged as characterising effective cultures in both business and healthcare (Manley, 2000b; 2001; 2002, 2004). This concept analysis endorses the need for a consistent set of values and principles (Stordeur et al., 2000; Welford, 2002) that are common and shared (Clark, 2002) in healthcare workplaces. There is a strong consensus about the ten values that are important, desirable and influential (see Box 2), embellishing those values previously identified.

Box 2. The ten core values

Person-centredness is broader than patient-centredness. The latter concept is reflected in the view that the 'patient is king' (Jones and Redman, 2000; Huq and Martin, 2000; Gough, 2001); treating each patient as an individual person; (Stordeur et al., 2000; Binnie, 2000) and the importance of therapeutic relationships between professionals, patients and others significant to them (Manojlovich and Ketefian, 2002). We use 'person-centredness' rather than patient-centredness because this recognises that the set of values underpinning patient centred approaches are the same as those that underpin good staff relationships. Being person-centred involves valuing staff (Haworth, 2000) as well as patients as persons, with all their diversity, and encompasses the interpersonal skills that are necessary to achieve this, and to instil faith and respect (Stordeur et al., 2000; Clark, 2002). Person-centred relationships are built on mutual trust, understanding and the sharing of collective knowledge (Binnie and Titchen, 1999; McCormack, 2001; Nolan et al., 2004; McCormack, 2004; Dewing, 2004); are interrelated with values, caring processes and the environment of care (McCance, 2003) and are realised through humanistic caring frameworks (Dewing, 2004). Person-centredness is the core value underpinning person-centred care (McCormack and McCance, 2010) and this in turn is underpinned by other values such as respect and the right to self determination: 'an approach to practice established through the formation and fostering others therapeutic relationships between all care providers … patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development' (McCormack, Dewing, Breslin et al., 2010, p 13).

Lifelong learning is evident in the development of a positive and enabling learning environment and culture (McCance, 2003; Shimko et al., 2000; McMahon et al., 2000; McCormack et al., 2002; Sim et al., 2003) where learning is active (Shimko et al., 2000; Dewing, 2008) and encouraged constantly (Chan, 2001); where feedback is pervasive (Clark, 2002); and people learn from their mistakes rather than from blame (Mahony, 2000; Scott et al., 2003). Learning in and from practice is a manifestation of this approach (Mulchey and Betts, 2005) and there is a commitment to learning and sharing knowledge Peplar et al., 2005). Manley and Titchen (2011) and Manley et al., (2009) have demonstrated how practitioners need to be helped to both learn from and inquire into their own practice and that the development of these skills help practitioners to both develop their own effectiveness as well as to develop the effectiveness of others.

Box 2 cont'd.

High support and high challenge are key factors for enabling the achievement of potential, learning and increased productivity (Titchen, 2000; Haworth, 2000; Ward, 2002; Gould, 1998; Manley, 2001). Workplace culture must first be supportive of staff before staff can support others (Boyer, 2005). Individuals need to be encouraged to question and challenge and this is manifested in the giving and receiving of feedback (Kalisch and Aebersold, 2006). It is alright to 'rock the boat' (Coccia, 1998) as this is characteristic of a therapeutic rather than a harmonious team (Johns, 1992; 1995). The provision of high support and high challenge has continued to be a key value underpinning practice development approaches (Manley and Titchen, 2011).

Leadership development refers to the development of leadership skills, these include the ability to enable others to be effective as well as find creative and innovative solutions (Stordeur et al., 2000; Manley, 2001; Ward, 2002; Haworth, 2000; Manojlovich and Ketefian, 2002; Scott et al., 2003). The leader being any person with professional responsibility for leading positive change (Grindel, 2006).

Involvement, participation and collaboration with all stakeholders including service users involves formal systems enabling participation in decision-making processes relevant to each stakeholder group and the implementation of decided changes (Clark, 2002; Gough, 2001; Bevington et al., 2004b; Huq and Martin, 2000). Staff are trusted and valued for their contribution (Haworth, 2000; Shimko et al., 2004; Mulchay and Betts, 2005; Jones and Redman, 2000; Davies et al., 2000; Manley 2001); and there are a diversity of voices (Davies et al., 2000). Individuals' views are heard and taken seriously and there is integration of clinical and managerial agendas (Bevington et al., 2004b). These values engender ways of working that have since become the identified key principles underpinning practice development arising from an extensive evaluation of practice development as a specific methodology (McCormack et al., 2006).

Evidence-use and development. The role-modelling of evidence-based practice by clinical staff is valued (Mahony, 2000; Manley, 2001; Rycroft-Malone, 2004; Newman et al., 2000) and is linked to facilitation expertise and leadership (Manley, 2001; Peplar et al., 2005; Rycroft-Malone, 2004). Its importance within the culture will rely on whether there is active use of information to improve effectiveness (Clark, 2002); a focus on evaluation (Rycroft-Malone, 2004) as well as the skills and personal mastery of staff (Chan, 2002) with opportunities to rigorously research one's own practice (Titchen, 2000). Implementing evidence into practice is a key international movement that focuses on using the best evidence to support clinical effectiveness which is influenced in turn by contextual factors and facilitation expertise (Rycroft-Malone et al., 2004; Kitson et al., 2010). Drawing on evidence from practice complements this movement and reflects the multiple knowledges used in practice to support decision-making and identify the strategies that are effective in transformation of practice (Manley and Titchen, 2011).

Positive attitude to change and commitment to continuous development. Change is perceived as positive (Ingersoll et al., 2000; Marshall et al., 2002), and there is a 'can do' approach (Bevington et al., 2004b). Change is embraced actively (Manley, 2001), ideas are recognised (Thyer, 2003) and innovation welcomed (Manley, 2001). It is alright to 'rock the boat' (Coccia 1998; Johns 1995). There is a focus and commitment to continual improvement and development and learning from work-based change (Huq and Martin, 2000; Manley, 2001; Gibb et al., 2005).

Open communication. Open, direct and honest communication between different groups is valued (Martin, 2000; Welford, 2002; Clark, 2002; Northcott, 1999). Processes are transparent (Bevington et al., 2004b). Individuals are encouraged to speak out (Kalish and Aebersold, 2006).

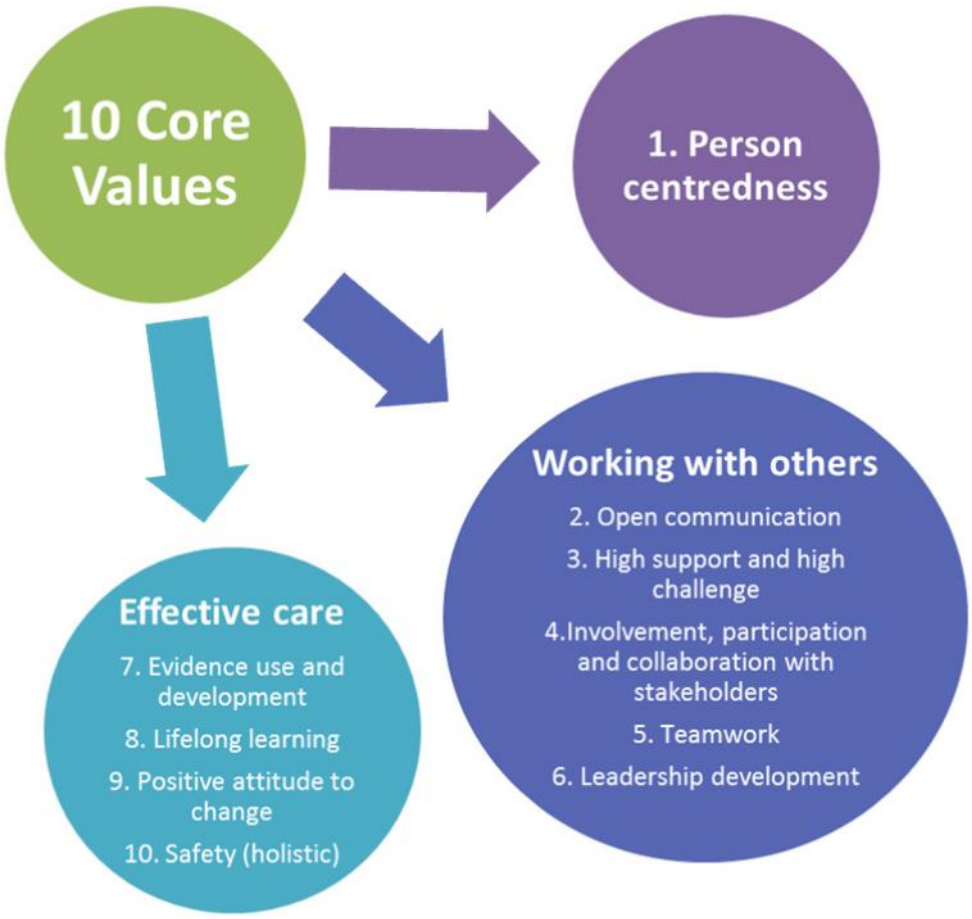
Box 2 cont'd.

Teamwork. Team learning and effectiveness is valued (Northcott, 1999; Chan, 2001; Manojlovich and Ketefian, 2002); promoted (Kalish and Aebersold, 2006) and recognised through interdisciplinary collaboration (Raiger, 2005; Forsythe, 2005) and team development (Mulchay and Betts, 2005; Manley and Hardy, 2005).

Safety (holistic) is valued rather than just complied with (Clark, 2002). This is consistent with value driven units' influence on development of a safety culture (Kalish and Aebersold, 2006). Safety embraces physical, psychological and social aspects for all staff, patients and users (Firth-Cozens, 2001; Groah and Butler, 2006). This is reflected in a commitment to reduce adverse events for patients (Bhatia et al., 2003); fostering prevention (Schneider et al., 2003); disclosure of errors (Clark, 2002; Hart and Hazelgrove, 2001); as well as the encouragement of error reporting and looking for the unexpected (Kalish and Aebersold, 2006); promotion of a safety culture for all (Hewison, 1999; Clark, 2002); with the identification and management of risk (Cox et al., 2006) is considered part of the job (Scalzi et al., 2006).

The ten values, as an aide-memoire, can be organised around three interrelated domains or clusters as outlined in Figure 1. *Person centredness* is the value that guides the overarching approach taken in relationships with everyone; patients, service users and colleagues as well as other stakeholders. W*orking with others* identifies the key values influencing how staff work with each other and stakeholders. Finally, the specific values necessary for sustaining *effective care* to patients and service users are clustered together.

Figure 1. Ten core values classified into three key domains/clusters



Attribute 2: The ten values are realised and experienced in practice, there is a shared vision and mission with individual and collective responsibility

'Espousing values' is different to 'living them'. A strong culture, where people practice what they preach, is characterised by a shared and common vision and mission (Bevington et al., 2004a; Bernick, 2001) with consistency between the espoused and the lived values (Manley, 2001; Ingersoll et al., 2000; Owen et al., 2001). All the values above are therefore realised in practice (Raiger, 2005) and experienced by patients, users and staff (Scalzi et al., 2006; Manley, 2001). A sense of mission and vision is reflected in everyday work (Stordeur et al., 2000) with self-directing (Manley, 2001), motivated, collaborative staff (Coats, 2006), who are autonomous (Stordeur et al., 2000; Welford, 2002) but take personal and shared responsibility and accountability (Clark, 2002) for achieving shared goals (Northcott, 1999). Everyone knows what is important (Jones and Redman, 2000; Manley, 2001), so values guide decision-making (Manley, 2000b; 2001) and provide the basis for challenging inconsistencies between what is professed and what is practiced/experienced (Manley, 2000a; 2001).

Attribute 3: Adaptability, innovation and creativity maintain workplace effectiveness

Extensive business studies have recognised that strong cultures alone do not ensure effectiveness (Anthony, 1994; Kotter and Heskett, 2002). Adaptability is maintained when there is a positive attitude to change with continuous development and flexibility (Manley, 2001; Binnie, 2000; Welford, 2002; Gough, 2001; McMahon et al., 2000). This very notion encourages staff and stakeholders to use creativity (Shimko et al., 2000; Thyer, 2003; Coats, 2006); on-going innovation (Scalzi, 2006; Shimko et al., 2000); innovative problem-solving (Stordeur et al., 2000) and critical thinking (Davies et al., 2000; Newman et al., 2000). Experimentation with new ways (Welford, 2002; Service, 2004) and risk taking is encouraged and rewarded (Davies et al., 2000). The role and use of critical creativity in developing cultures where all can flourish has developed its theoretical and practical relevance over recent years (McCormack and Titchen, 2006; 2007; Titchen and McCormack, 2010). Technical innovation has become a key policy driver for achieving more effective and productive use of resources (Department of Health, 2010). Fostering creativity offers a way forward in generating innovations that also include ways of working (Coats, 2006).

Attribute 4: Appropriate change is driven by the needs of patients/communities

Whilst being adaptable, innovative and creative, a culture of 'change for change sake' is not experienced. Change is purposeful, enables flexibility and continuous adaptation (Owen et al., 2001); is driven by the needs of patients and communities (Manley, 2001; Gough, 2001) and the implementation of effective and evidence-based interventions as well as their systematic evaluation (Manley, 2001; Garbett and McCormack, 2002).

Attribute 5: Formal systems exist to continuously enable and evaluate learning, performance and shared governance

In an *effective workplace culture* formal systems and systems thinking exist for enabling values to be realised (Chan, 2001). Formal systems and systems thinking comprise specific structures, processes and patterns of behaviour (Capra, 2002) that enable the implementation of values so that they become a reality in the workplace (Bevington et al., 2004a).

Formal systems are therefore required to:

- Evaluate the achievement of person-centred, safe and effective care which is now also a key professional focus in healthcare (McCormack and McCance, 2010; RCN, 2011)
- Implement all learning in and from practice to enable ongoing practice transformation
- Implement shared governance to enable stakeholder participation in decision-making (Clark, 2002; Thyer, 2003; Doherty and Hope, 2000; Burnhope and Edmonstone, 2003; Waldman et al., 2003; Bamford-Wade and Moss, 2010)

Shared governance contributes to an atmosphere of 'respect' for staff (Boyer, 2005; Bamford-Wade and Moss, 2010); enabling evidence use from a variety of sources (e.g. audit, feedback, reflective practice, research) (McCormack et al., 2002; Owen et al., 2001) to inform internal debate (Martin, 2000) and decision making (Manley, 2001; McCormack et al., 2002).

Subsequently, it is important to recognise that systems are also required to support and recognise active learning outcomes and accredit work-based learning locally if learning from work related activity such as practice development, innovation and quality improvement is to achieve practice transformation in the workplace (Manley et al., 2009). Such systems would include staff support and development, such as, provision of supervision, mentorship and coaching to enable staff to develop the skills required for facilitating others' effectiveness (individual and team) through work-based learning and practitioner-inquiry approaches (Manley and Titchen, 2011).

The development, implementation, continued evaluation and adaptation of systems that reflect core values in the workplace requires skilled facilitation in the workplace as near to the point of care as possible (Manley, 2001; Manley and McCormack, 2003; Titchen, 2000). Skilled facilitators draw on a specific skill set that enable practitioners to develop their expertise in using and developing evidence in practice, learning in and from practice, working with stakeholders and evaluating their practice at the individual and team level as well as developing skills as transformational leaders (Webster, 2009; Manley and Webster, 2006). The ongoing presence of skilled facilitation is one of several enabling factors needed to sustain the attributes of an *effective workplace culture.*

The enabling factors for an *effective workplace culture*

Having evidenced the presence, or absence, of the five attributes, clinical leaders and facilitators will need to consider those factors that enable the development or sustaining of an *effective workplace culture*. Enablers identified are classified as either individual or organisational in their focus.

Individual enablers include the presence of transformational leadership (Shermont and Krepcio, 2006; Bamford-Wade and Moss, 2010) particularly in ward managers (Scott et al., 2005; Patterson et al., 2011) skilled facilitation (Manley, 2001) and role clarity (Raiger, 2005).

Leadership is key to cultural change (Bate, 1994), particularly transformational leadership (Manley, 1997; 2001). Leadership also includes paying attention to culture (Jones and Redman, 2000; Manojlovich and Ketefian, 2002); role-modelling shared values (Bevingtone et al., 2004b; Binnie, 2000; Haworth, 2000), and achieving a common vision through engaging hearts and minds (Davies et al., 2000). Some disagreement exists about whether transformational leadership by immediate supervisors (Block, 2003), rather than more distant leaders (Stordeur et al., 2000) is more influential in achieving job satisfaction and organisational commitment.

Transformational leadership shares some similarities with skilled facilitation of others' effectiveness however few authors make a clear distinction between the processes used in leadership and those used in facilitating others' effectiveness (Manley, 2000b; 2001; Rycroft-Malone, 2004; Binnie, 2000). Whilst some do not refer to facilitation at all (Clark, 2002; Haworth, 2000), others recognise that change, (cultural and other) is facilitated not managed (Marshall et al., 2002; Moss et al., 2008).

Transformational leaders and skilled facilitators act with a moral intent, using sociological, psychological and learning theories, multiple intelligences and teaching/learning skills that enable individuals and teams to change themselves and their context for the better (in this case, an *effective workplace culture*). Strategies for developing clinical leaders and facilitators with the requisite skills and values are essential for achieving cultural change (Manley et al., 2009; Webster,

2007). When helping consultant nurses and aspiring consultant nurses to become more effective as clinical leaders and facilitators, Manley and Titchen (2011) showed that these practitioners needed help to explore their own effectiveness and become skilled facilitators before they could assist others to become more effective in their work.

Role clarity and/or clear expectations and responsibilities are recognised as important enablers to an effective culture (Bevington et al., 2004b; Jones and Redman, 2000), evidence-based practice and critical thinking (Davies et al., 2000; Newman et al., 2000), and the implementation of Total Quality Management (TQM) (Huq and Martin, 2000). Qualitative 360 degree feedback has been the most frequently tested strategy for achieving role clarity, which at the same time also focuses on giving and receiving of feedback necessary for providing high support and high challenge in the workplace (Garbett et al., 2007; Hardy et al., 2009).

Organisational enablers include flattened and transparent management (Haworth, 2000); an enabling approach to leadership and decision-making (Raiger, 2004); organisational readiness (Huq and Martin, 2000; Newman et al., 2000; Ingersoll et al., 2000; Lewis, 2001; Parisi et al., 2003) and a supportive human resource department (Manley, 2001; Clark, 2002; Chan, 2001; Owen et al., 2001). Flattened and transparent management may be characterised by devolved, participative or non-hierarchical management structures and processes (Haworth, 2000; McMahon et al., 2000; Coccia, 1998; Tiernan et al., 2002; Brayford, 2004) where professionals are viewed as 'partners in a solution', not a 'problem' (Scalzi, 2006). Good leadership at all levels (Alimo-Metcalf and Alban-Metcalf, 2006), participative management (Shermont and Krepcio, 2006), with executive and organisational support (Raiger, 2005; Manley, 1997, 2001) for trust, empowerment, consistency and mentorship (Kane-Urrabazo, 2006) will help embed values in practice.

Organisational readiness in relation to evidence based practice (Newman et al 2000), TQM (Huq and Martin, 2000) and cultural change (Scalzi et al., 2006) has been defined as 'a state of preparedness for change that is influenced by the organisation's previous history of change, its plans for continuous organisational refinement, and its ability through its social and technical systems to initiate and sustain that change' (Ingersoll et al., 2000, p 13). These researchers showed that employee perception of organisational readiness, followed by organisational culture were the strongest predictors of commitment by employees to the organisation's goals.

The final organisational enabler is human resource department support. Human resource departments are highly influential because they are responsible for both maintaining the organisation's values, particularly in relation to recruitment and selection, staff expectations and performance, as well as, being responsible for enabling organisational learning and development (Manley, 2001; Clark, 2002; Chan, 2001; Owen et al., 2001).

The consequences of an *effective workplace culture*

Attending to and working with the enabling factors will assist facilitators of cultural change to increase the likelihood of developing an *effective workplace culture* with its five defining attributes. Once established, it is proposed that the consequences of having an *effective workplace culture* can be divided into those impacting on stakeholders, and those impacting on other workplace cultures.

Stakeholders' goals or needs would be met and demonstrated through the provision of continuous evidence that:

- Patients, service users and communities have their needs met in a person-centred way (Owen et al., 2001; Martin, 2000; Parisi et al., 2003; Binnie and Titchen, 1998; Ruvol and Bullis, 2003), including the receipt of both clinically effective and person-centred care

(Manley, 2001; Stordeur et al., 2000; Welford, 2002; Gough, 2001; Manojlovich and Ketefian, 2002; Binnie and Titchen, 1998; McCormack and McCance, 2010)

- Staff demonstrate commitment and empowerment (Manley, 2001; Gough, 2001; Bevington et al., 2004b; Mulchay and Betts, 2005; Scott et al., 2003; Stordeur et al., 2000; Tiernan et al., 2002; Ingersoll et al., 2000; Thyer, 2003; Martin, 2000; Bernick, 2001; Bamford-Wade and Moss, 2010), reflected in improved recruitment, retention (Manley, 2001; Mulchay and Betts, 2005; Moss et al., 2008) and job satisfaction (Wilkins and Hawkins, 2005). It should be noted that staff well-being (feeling and being valued as a staff member in addition to physical and psychosocial wellbeing) is strongly related to positive patients' experience and outcomes (Patterson et al., 2011; Maben, 2010; NHS Institute for Innovation and Improvement, 2010)
- Individuals and teams achieve pre-stated goals, corporate objectives and local and national standards, for example, in the areas of patient safety, reduced waiting times, improved access, and improved outcomes etc. (Manley, 2001; Stordeur et al., 2000; Welford, 2002; Mahony, 2000; Tiernan et al., 2002; Martin, 2000; Parisi et al., 2003; Jabnoun, 2001)
- Evidence-based practice exists with explicit knowledge development from practice, knowledge sharing and knowledge use (Manley, 2001; Peplar et al., 2005; Clark, 2002; McCormack et al., 2002; Newman et al., 2000; Waldman et al., 2003; Lewis, 2001; Binnie and Titchen, 1998; Ruvol and Bullis, 2003; Manley and Titchen, 2011). This consequence recognises that evidence based standards and national guidelines are implemented consistently across patient pathways and services

Human flourishing of all (patients, users and staff) as the ultimate end and process of critical creativity emerged as a consequence from phase two of this study (McCormack and Titchen, 2006). It is proposed that staff empowerment and motivation associated with an *effective workplace culture* (Manley, 2001; Huq and Martin, 2000; Owen et al., 2001) may be manifestations of human flourishing. Subsequent research and debate has positioned human flourishing as a powerful indicator and outcome of *effective workplace cultures* (McCormack and Titchen, 2006, 2007; Titchen and McCormack, 2010), one that integrates and achieves person-centredness, patient safety and effectiveness to enable all to flourish. It has been defined as focusing:

> *'… on maximising individuals' achievement of their potential for growth and development as they change the circumstances and relations of their lives. People are helped to flourish (i.e. grow, develop, thrive) during the change experience in addition to an intended outcome of well-being for the beneficiaries of the work. Flourishing is supported through contemporary facilitation strategies, connecting with beauty and nature and blending with ancient, indigenous and spiritual traditions (cf. Senge et al., 2005) and active learning (Dewing, 2008)' (Titchen and McCormack, 2010, p 532).*

An *effective workplace culture* positively influences other workplace and organisational cultures (Manley, 2001; Huq and Martin, 2000). This therefore impacts on how effective workplaces may be achieved across organisations as once an *effective workplace culture* is established; it is through the metaphorical flow of seeds to barren areas that other effective cultures can be grown, rather than rolling out a technically focussed cultural change programme across organisations. Cultural change programmes will therefore need to be 'enabling' and not 'prescriptive', cultivating the (bottom-up) growth of seeds rather than imposing ready-made carpets of grass. Through working with the enabling factors, values and attributes, other effective cultures can be nurtured.

Definition, related and surrogate concepts

Based on the framework presented we define an *effective workplace culture* as:

> *'A local workplace characterised by the experience of three value sets by all who come into contact with it: a focus on person-centredness, collaborative, inclusive and participative ways of working; and a focus on providing effective care. These values are embedded in local formal systems of evaluation, learning, development and stakeholder participation that reflect and sustain them. Effective workplace cultures are recognised by flourishing of all involved, consistent achievement of standards and goals, evidence-based and continuous development, improvement and innovation in practice linked to the needs of patients, and, empowered and committed staff. These cultures are enabled by transformational leaders, skilled facilitation and role clarity and are complemented by organisational readiness with a flattened and transparent management structure and supportive human resource department.'*

Effective workplace cultures can be illustrated in different ways for example; see the vignette in Box 3.

Box 3. Working towards an effective culture (adapted from Webster, 2007)

Specific enabling factors, *(EF),* attributes *(A)* and consequences *(C)* are italicised in brackets. These refer to Table 3. Values comprising Attribute 1 *(A1)* are abbreviated as follows: *PCC* – person centredness; *LLL* – lifelong learning; *HSHS* – high support high Challenge; *LD* - leadership development; *CIP* – collaborative, inclusive, participative; *EUD* – evidence use and development; *PAC* positive attitude to change; *OC* – open communication; *T* – teamwork; *S*- safety

As a practice development nurse new in post I was asked to review the number of incidents reported on one of the wards I worked with *(EF2b,c).* I saw that monthly the number of patients falling was high. On talking with staff and the ward sister there appeared to be a resigned acceptance that 'this happens to people when they get old', it was considered the 'norm' and was just accepted. I sensed that nothing appeared to change and that no one seemed to own the issue. Staff appeared 'neutral' and 'unmoved' to this situation, and I experienced a strong sense that people just wanted to maintain the status-quo and not to question, critically reflect or change practice. There was no proactive, partnership working with older people. There was no creativity in how people worked, each staff group worked in a professional silo, and there was little communication between professional disciplines or shared decision making and risk taking. There were no goals for practice or understanding of the values underpinning how the team worked. But nobody saw this as an issue; it was just 'how things were'.

After working with the ward for a few months I saw that the new Ward Sister was collaborative and transparent in her decision making, she was clear about her role including responsibility and accountability and the roles that team members held *(EF1a/EF1c)*. As a practice development nurse she saw me as providing (and developing in others) facilitation skills *(EF1b)* to help develop practice and improve care for patients. Having worked with team members and observed practice I felt that the ward and team were now willing and committed to improve care for patients *(PAC);* I sensed an energy and excitement in the team to think and work in new and different ways *(A3).* Having had contact with the ward before I came into post, I knew that they had (over a period of time) experienced a number of challenges – a succession of leadership changes (clinical and operational), merging with another ward and a reputation that it was a 'difficult' place to work. I knew also that there had been a number of 'performance' issues that had been addressed by the new Ward Sister.

Box 3 cont'd.

Having reviewed with the Ward Sister the number of incidents reported on the ward I was concerned because 'falls' appeared to be the biggest risk recorded *(EUD).* She asked me if I would share this information and facilitate a discussion at the monthly team meeting *(CIP/EUD)*. I used a stakeholder evaluation approach to help structure discussion *(CIP)*. Those present (included nursing, medical and therapy staff *(T))* identified a number of positive factors that were linked to shared values *(A1/A2):* e.g. a willingness to explore and develop new ways of working *(PAC)*; success in raising the profile of person-centred care *(PCC),* specific examples related to work in nutrition, dignity, continence care and ward based information *(PCC/S)*; a strong team working ethos *(T),* underpinned by challenge and support related to team values and objectives which were owned by the team *(T/HCHS/A2);* a better profile in the hospital and value placed on the work of the team *(C3)*; stability in leadership both at ward and operational management levels; it was ok to work in different ways that aimed to improve care for patients *(A4); o*penness to report and learn from incidents (*OC/LLL);* and better continuity of care due to changes in shifts and handover patterns *(C1a).*

However the staff team recognised that there were still concerns and issues around for example; how to improve falls screening assessments; manage patients at risk; improve communication between nursing, medical and therapy team members in relation to people who had fallen or were at risk of falling; involve patients and supporters more; improve information and awareness of staff about the evidence base underpinning falls management and prevention; help staff to feel supported as well as challenged, so that they don't feel threatened; and, to manage staffing and clinical dependency more effectively.

From this discussion and by using the stakeholder tool (*CIP)* we agreed the need to develop an action plan that team members would own and take forward so that falls prevention was proactively managed by the team (nursing, therapy and medical) as a whole. I sensed and saw a willingness to bring about 'real change', not just tick a box! *(PAC).*

We agreed that falls would appear as a rolling agenda item for the divisional clinical governance group *(AF5)* and that a sub group would be set-up (AF5), the junior charge nurse offered to chair this in the first instance however this would be shared with the physiotherapy and occupational therapy leads (leadership development) *(LD/T).* The first action plan included: root cause analysis of a month's falls *(EUD)*; audit of the risk assessment tool, identification of 'best practice' and the latest clinical evidence to reduce/prevent falls (EUD/S); review of relevance to the falls work of the observations of care and patient stories framework previously used in the nutrition and dignity projects *(A3);* agreement if a patient had fallen this would be handed over to the next shift so as to increase vigilance and daily morning nursing, therapy and medical rounds all patient would be reviewed *(OC/T/S);* discussion about funding options for a slipper exchange scheme and better resourcing to support practice; and, sharing learning at the trust wide senior nursing forum to influence development and a trust wide commitment as we recognised that the 'issues' were larger than just one ward *(EF2a,b,c/C1d/C3).*

We also saw the vital need to better develop ways of working that made patients and their supporters more central to screening and assessment processes so that there was shared ownership of 'risk' between the team and patients *(PCC/S/A4/A5*). Three members of staff volunteered to become 'falls prevention champions' *(C1b);* we also developed a programme of work based education and practice support *(A2)/A5).* We agreed as a team to meet every four weeks to review actions and to measure outcomes against agreed standards and goals *(C1c/C1d).*

Box 3 cont'd.

I observed that having recognised an issue that was compromising patient safety, the team as a whole were both empowered and committed to proactively leading and enabling change *(C1b).* I saw clinical evidence being used and shared widely across the team coupled with an authentic approach to enabling person centredness (C1a/C1d). Robust systems and processes were also developed that embedded shared governance *(AF5).* Although I provided facilitation support, I saw that the team were driving the agenda forward themselves (A2/C1b). I felt and saw that ownership clearly sat with them, and as such it was possible to see how creativity and workplace effectiveness was growing and thriving underpinned by continuous learning and evaluation. The ward team was beginning to flourish! *(C2)*

Effective workplace culture is, as highlighted earlier, an immature concept with its characteristics distilled from a range of sources (theoretical analysis of practice development frameworks, expertise of practice developers, literature and research analysis) that implicitly suggests what it is. These characteristics have been brought together in the framework outlined in Table 3. Similar terms in the literature include: *positive organisational culture* (Department of Health, 2001a, b*), healthy culture* (Bevington et al., 2004a, b*)* and '*transformational culture*' (Manley, 1997; 2000b; 2001; 2002; 2004). Further analysis would be required to ascertain the degree of fit between these different terms if indeed they are different concepts.

Changing workplace culture: implications for practice and research

The framework aims to help healthcare teams develop an *effective workplace culture* if used to support systematic implementation of the individual and organisational enabling factors and attributes required. This will involve:

- Making explicit core values
- Supporting and challenging each other as a team/across the patient pathway to ensure behaviour reflects the values espoused
- Developing a shared vision that reflects the purpose and direction of the team/patient pathway
- Implementing the vision and direction through transformational leadership and skilled facilitation
- Developing and modelling ways of working that are:
    - Collaborative, inclusive, and participative
    - Flexible, creative and innovative
- A willingness to adapt and implement changes through continuous learning and evaluation driven by the needs of patients

A number of tools and processes already exist to support aspects of the framework, for example; to enable ownership and enactment of a shared vision; to help reveal (in)consistencies between what is said and done; as well as other strategies for developing *effective workplace cultures* (McCormack et al., 2006; Coats, 2006; Warfield and Manley, 1990; Manley et al., 2007; McCormack et al., 2009; Lieshout and Cardiff, 2011). In addition to developing skills in challenging and supporting each other and giving and receiving feedback around patterns of behaviour, as well as implementing systems (structures and processes) that keep values at the forefront of daily decision-making and learning, there is a need to align these systems with organisation-wide approaches exemplified, for example, by magnet hospital research (McClure et al., 1983; Kramer and Schmalenberg, 1988). Organisational systems aligned to key values can support local workplaces to sustain key values in practice, but the opposite can also happen if organisational systems cause values to be dissonant. Whilst there is a need for organisational and strategic support, the actual work of changing the culture and developing effectiveness should be targeted at the micro-systems level.

It is therefore at the micro-systems level where there is a need for skilled facilitation of others' effectiveness through learning in and from practice, inquiry and evaluation, evidence use and implementation within the workplace. This highlights the importance of incorporating the essential facilitation skill-set into clinical leader roles, such as, those facilitating the development of practice, and others who work at the patient-provider interface (Manley and Webster, 2006). We argue that skills in facilitating others effectiveness are crucial to enabling *effective workplace cultures* as this will not happen by 'accident'. Skilled facilitation is a core component of practice development (Simmons, 2004) along with enabling effective working of both individuals and teams in the development of person-centred cultures of practice (Webster, 2009). Being internal or external facilitators to the workplace is unimportant as a facilitator or clinical leader. Of more importance is role negotiation and clarification consistent with purpose (McCormack et al., 2006) together with workplace culture development (linked with evaluating and improving patient, user and staff experiences) being included in job descriptions, to prevent it being lost in the daily challenges of operational issues and the pressure of service delivery.

It is proposed that organisations can support the development of *effective workplace cultures* by investing in the development of both transformational leadership and facilitation skills through skills development, and the provision of ongoing supervision, support and peer review for these key players.

We would argue that more research is required to identify:

- The local, national and international indicators needed to provide evidence of achievement of the attributes and consequences of an *effective workplace culture*. This key priority has been highlighted in relation to aligning the attributes of an *effective workplace culture* with the process outcomes necessary to achieve improved health outcomes and patient experiences, as well as, the cost effective use of resources (Manley et al., 2011)
- How workplace cultures influence each other and the organisational culture, for example, whether this is achieved through formal channels such as (knowledge dissemination) meetings, or informal channels such as 'corridor conversations' and stakeholder movement from one workplace culture to another, or how clinical leaders work and rotate around different areas
- The relative importance of each attribute, enabling factor and consequence

In addition we would also suggest that the importance of e*ffective workplace culture*s needs to be made more explicit and a core, underpinning component of the current healthcare policy focus on 'quality' as it is our view that the quality agenda will not be achieved in full if the culture (organisational and workplace) is not enabling or supportive of this - *this we would argue is more than espoused support alone as without action rhetoric will remain rhetoric.*

Limitations and conclusion

The concept analysis approach has drawn on the expertise and the values of the researchers and contributors as well as propositional knowledge of expert practice development facilitators. The assumptions held by the authors and contributors may not have been adequately challenged and unconsciously influenced the data analysis, although the researchers have made their own values explicit.

Although the papers reviewed are sourced from different health disciplines, the research has been undertaken by practice developers from different countries, all nurses. Other disciplines may interpret the concept of workplace culture and emerging data differently.

The concept e*ffective workplace culture* is not mature and data retrieved from the literature for the proposed enabling factors, attributes and consequences was predominantly implicit. Whilst some components of the framework are well developed concepts e.g. transformational leadership (Bass et al., 2006) and person-centredness (McCormack, 2004; Dewing, 2004), others are less developed e.g. organisational readiness, or there is contention about how they are measured for example, individual, team, organisational effectiveness, human flourishing. We would also assert that there is a need to consider what happens when organisations are not 'ready' to take on development to enable an *effective work place culture*.

The resulting framework challenges us to move our gaze from organisational and corporate culture to the culture of the workplace because it is at this level that the patient/practitioner interface occurs. Whilst there is an interdependence between corporate, organisational and workplace culture, it is the workplace culture that is experienced by patients, users and staff - it is at this level that most potential exists for transformation that benefits all.

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Acknowledgements

The authors would like to acknowledge the contribution made to data analysis in stages two and three by Lyn Garbarino and Moira Davren.

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