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***The Influence of Organisational Cultures on Employee Voice:
The Case of a 'Financialised' English Care Home***

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Abstract

Organisational culture and employee voice are two key concepts which have over the years been contested in the management literature. Within the English Health and Social Care sectors, these concepts have emerged over the past decade as essential factors for consideration when investigating how organisational failings resulted in poor quality care and patient deaths. Evidence in the extant literature suggests that care homes are organisational environments that exhibit characteristics which disproportionately predispose them to the cultivation of closed organisational cultures. Despite this, research evidence is currently lacking as to the relationship between care home cultures and employee voice; thus, this study aims to undertake an in-depth, rich analysis of the realities of the influences of care home cultures on employee voice.

To do this, a three-stage qualitative case study design was adopted to analyse the cultures of two units within one care home, with the resulting data thematically analysed. Findings highlight that this care home did not possess a homogenous culture, but rather, was comprised of strong unit-based subcultures characterised metaphorically as 'family' culture in case study one and a 'clique' culture in case study two. Indeed, in all instances, the existing culture did influence the ability and willingness of participants to voice themselves. Such influences were both negative in relation to the legacy of previous management regimes, and positive concerning personal relationships. All this points to complexities associated with care home cultures which are not fully appreciated within the literature, and the need better to understand the micro-level influences of care home cultures.

As a result of this study, it has been possible to put forward theoretical contributions and organisational and policy-level recommendations all geared towards improving our understanding of care home cultures and employee voice. I propose future research exploring the influence of care home cultures on employee voice within different business models and larger sample sizes to further our knowledge within this area.

Keywords; Care Homes, Employee Voice, Learning Environments, Open Cultures, Organisational Culture, Subcultures.

Table of Contents

Abstract	ii
Table of Contents	iii
Table of Diagrams	xi
Table of Tables	xi
Table of Abbreviations	xi
Chapter One.....	1
Introduction	1
1.0 Background; the influence of organisational cultures on employee voice within the care home context ..	1
1.1 Organisational culture	2
1.2 Employee voice.....	2
1.3 Aims of the Study	3
1.4 Philosophical position.....	3
1.4 Study context: the care home	4
1.6 Study context: the case study units.....	4
1.7 Study design	4
1.8 Main findings and conclusion	5
1.9 Next Steps.....	6
1.10 Structure of the thesis	6
Chapter Two	9
The historical and political context of the English Health and Social Care sectors	9
2.0 Introduction	9
2.1 Health and Social care context	10
2.1.1 Health Care context.....	10
2.1.2 Social Care context (economic)	12
2.1.3 Social Care context (political)	13

2.2 Health and Social Care failings	14
2.2.1 Mid Staffordshire Inquiry	14
2.2.2 Winterbourne View Review	15
2.2.3 The Francis Report.....	16
2.2.4 Kirkup Report.....	17
2.3 Government responses (reports)	18
2.3.1 Reviews into organisational failings	18
2.3.2 The role of closed organisational cultures	21
2.3.3 The need for increased employee voice	22
2.3.4 Review recommendations.....	23
2.4 Government responses (policies).....	25
2.4.1 Chief Inspectors of Hospitals and Social Care	26
2.4.2 The promotion of openness and transparency	26
2.4.3 Introduction of a statutory duty of candour	27
2.4.4 Updated NHS whistleblowing procedure in England	28
2.4.5 The Freedom to Speak Up principles.....	28
2.4.6 Increased oversight by professional regulators	29
2.5 Ineffective governmental policy agenda towards voice culture	30
2.5.1 Policy level understanding of organisational culture	30
2.5.2 Ineffective implementation of organisational culture policy.....	31
2.5.3 Ineffective employee voice initiatives	32
2.6 Distinctive characteristics of closed organisational cultures	34
2.6.1 Characteristics external to the organisation	34
2.6.2 Characteristics internal to the organisation	34
2.7 English Care Homes context	35
2.7.1 English care homes	35
2.7.2 Economic context	36
2.7.3 Political context	37

2.7.4 Characteristics of care homes which disproportionately predispose them to the cultivation of closed organisations cultures	38
2.7.5 Combined characteristics of care homes	43
2.7.6 Analysis of 25 ‘inadequate’ CQC care homes	44
2.8 Summary.....	45
Chapter Three	46
Organisational culture and employee voice.....	46
3.0 Introduction.....	46
3.1 Defining organisational culture	46
3.1.1 The contested nature of organisational culture.....	48
3.2 Culture in care homes.....	51
3.2.1 Justification for researching culture in care homes	52
3.3 The role of care home organisational culture in the international context.....	53
3.3.1 International approaches to organisational culture.....	54
3.4 Schein’s theory of organisational culture.....	55
3.4.2 Schein’s three levels of organisational culture model	57
3.4.3 Subcultures	60
3.5 Employee voice.....	61
3.5.1 The contested nature of employee voice.....	62
3.5.2 Factors influencing employee voice	64
3.5.3 Employee voice theory	65
3.6 Employee voice and employee silence.....	67
3.6.1 Whistleblowing.....	68
3.7 Organisational culture and employee voice.....	69
3.7.1 Voice culture.....	70
3.7.2 Research landscape	71
3.8 Research Questions	72
3.8.1 Question one: how do care home employees understand the term ‘employee voice’?.....	72

3.8.2 Question two: how do care home employees understand the term ‘organisational culture’?.....	73
3.8.3 Question three: what are the care home cultural characteristics and factors which facilitate employee voice?.....	73
3.8.4 Question four: what are the care home cultural characteristics and factors which mitigate against employee voice?.....	74
3.8.5 Question five: how can employee voice be elevated to gain greater impact in care home organisational decision-making?	74
3.9 Summary.....	75
Chapter four	76
Methodology	76
4.0 Introduction.....	76
4.1 Philosophical approach and research design	76
4.1.1 Postpositivist approach	77
4.1.2 Ontological position.....	77
4.1.3 Epistemological position.....	78
4.1.4 Reflexivity and knowledge experience	79
4.2 The company	81
4.2.1 The care home	81
4.2.2 Hierarchical structure of the care home	82
4.3 Approaches to organisational culture	83
4.3.1 Martin	84
4.3.2 Schneider	84
4.3.3 Schein	85
4.3.4 The integration of pivotal and peripheral values into Schein’s three levels of organisational culture model.....	85
4.3 Case study design	87
4.3.1 A three-stage case study design for two units within one care home	87
4.3.2 Choice of case study sites.....	88

4.3.3 Unit one context (case study one).....	89
4.3.4 Unit two context (case study two)	90
4.4 Research methods	91
4.4.1 Gaining access to the care home.....	91
4.4.2 Navigating the researcher’s field role	94
4.4.3 Inductive methodologies.....	97
4.4.4 Unstructured, overt non-participatory observations.....	98
4.4.5 Document and artifact collection.....	99
4.4.6 Semi-structured interviews	100
4.5 Data collection process.....	101
4.5.1 Stage one: sensitising concepts.....	102
4.5.2 Stage two: information sessions and recruitment of participants.....	102
4.5.3 Stage three: unstructured, overt, non-participatory observations.....	103
4.5.4 Stage four: documentary and artifact data collection	104
4.5.5 Stage five: semi-structured interviews.....	105
4.5.6 Data tables overview	106
4.6 Data analysis process.....	106
4.6.1 Data analysis stages.....	107
4.6.2 Cross analysis of themes and generation of participant recommendations.....	108
4.7 Theorisation.....	109
4.8 Methodological considerations	110
4.8.1 Ethical considerations.....	110
4.8.2 Limitations	111
4.9 Summary.....	111
Chapter Five.....	113
Care Home Culture and Voice.....	113
5.0 Introduction.....	113
5.1 Participants understanding of employee voice.....	113

5.1.1 Theme one: employee voice is being listened to	114
5.1.2 Theme two: employee voice is a dialogue between employee and employer.....	114
5.1.3 Theme three: employee voice is an expression of one’s views	115
5.2 Participants understanding of organisational culture	116
5.3 Participants’ perspectives on the care home’s culture	117
5.3.1 Theme one: positive perspectives of care home culture	118
5.3.2 Theme two: negative perspectives of care home culture.....	119
5.3.3 Theme three: a mixed perspective on care home culture	120
5.4 Cultural manifestations within the care home.....	121
5.4.1 Artifacts	122
5.4.2 Espoused beliefs	126
5.4.3 Basic underlying assumptions	134
5.5 Influences facilitating employee voice: the training environment	138
5.5.1 Characteristics of the training environment which facilitated employee voice	140
5.6 Influences mitigating against employee voice: the legacy of previous management regimes.....	141
5.6.1 Characteristics of the legacy of previous management regimes	145
5.7 The care home culture as a collection of unit-level subcultures.....	147
5.8 Summary.....	149
Chapter Six.....	150
Unit Culture and Voice	150
6.0 Introduction.....	150
6.1 Metaphors in use.....	150
6.2 Cultural manifestations in unit one (case study one): the family metaphor	151
6.2.1 The family culture in case study one	152
6.2.2 The family’s perspective of its unit’s culture.....	153
6.2.3 Artifacts	154
6.2.4 Espoused beliefs	158
6.2.5 Basic underlying assumptions	165

6.3 Influences facilitating employee voice: the sense of belonging.....	169
6.4 Influences mitigating against employee voice: informal hierarchy and power imbalance.....	172
6.4.1 Informal hierarchy power imbalance	173
6.5 Cultural manifestations in unit two (case study two): the cliques' metaphor	178
6.5.1 The clique culture in case study two	178
6.5.2 The clique's perspective of its unit's culture.....	179
6.5.3 Artifacts	181
6.5.4 Espoused beliefs.....	185
6.5.5 Basic underlying assumptions	192
6.6 Influences facilitating employee voice: social relationships	195
6.7 Influences mitigating against employee voice: misrepresentation of employee voice.....	197
6.8 Summary.....	201
Chapter Seven.....	202
Discussions and Conclusions	202
7.0 Introduction.....	202
7.1 Context of the study.....	202
7.2 Contributions.....	203
7.2.1 Qualitative analysis into the influence of care home cultures on employee voice	204
7.2.2 The combination of Schein's theory of organisational culture with his views on pivotal and peripheral subcultures as an analytical framework with which to study care homes.....	205
7.2.2 Perceived position within the care home hierarchy and participants' understanding of employee voice.....	206
7.3 Organisational level recommendations of the study	209
7.3.1 The need for a process of 'unlearning' elements of an organisation's culture that contribute to silence.....	210
7.3.2 The need for Organisational Environments of Learning (OEL) as a way of facilitating employee voice and greater employee decision making	211
7.3.3 The need for a bottom-up approach to the cultivation of open care home cultures and the facilitation of employee voice	219

7.4 Policy level recommendations.....	226
7.4.1 An acknowledgement of organisational differences and the accommodation of a multi-level understanding of care home cultures	227
7.4.2 National-level leadership training for frontline managers within care homes on how to cultivate open learning environments which facilitate employee voice	228
7.4.3 A minimum level of training for all staff on national policies and procedures relating to employee voice provided independently of the care home	230
7.5 Limitations of the study.....	233
7.6 Future research	234
7.7 Conclusions.....	235
Bibliography.....	238
Appendix	249
Appendix One: Analysis of 25 ‘inadequate’ CQC care homes	249
Appendix Two: Care Home Information Sheet	258
Appendix Three: Care Home Consent Sheet	261
Appendix Four: Observation Information Sheet for Participants.....	262
Appendix Five: Observation Consent Sheet	265
Appendix Six: Interview Information Sheet.....	266
Appendix Seven: Interview Consent Sheet	269
Appendix Eight: Unstructured, overt, non-participatory observations strategy for case study one and two.....	270
Appendix Nine: Interview Times in Case Study One and Two.....	272
Appendix Ten: Initial codes from the data analysis process	273
Appendix Eleven: Initial themes from case study one, two and care home	277
Appendix Twelve: Theme One; participants understanding of employee voice data distribution	279
Appendix Thirteen: Theme Two; participants’ perspectives on the home’s culture data distribution	280
Appendix Fourteen: Theme Three; the care home as a collection of unit level subcultures data distribution	281
Appendix Fifteen: Theme four; training Environment data distribution	282

Appendix Sixteen: Theme Five; the family culture data distribution283

Appendix Seventeen: Theme Six; the clique culture data distribution284

Appendix Eighteen: Participant recommendations on promoting employee voice within care homes285

Table of Diagrams

Diagram 2: Care Home Hierarchy..... 83

Diagram 1: Organisational Culture and Subculture Analytical Structure 86

Diagram 3: Data Collection Strategy Framework for Case Study One and Two..... 102

Diagram 4: Data Analysis Framework..... 107

Diagram 5: Cross Unit Thematic Analysis Framework 109

Diagram 6: Unit-Based Subculture 148

Diagram 7: Participants’ Perceived Hierarchy Position and Employee Voice 207

Diagram 8: Bottom-Up Framework..... 220

Table of Tables

Table 1: Total Data Collected in Case Study One and Two 106

Table 2: Cross Unit Themes..... 108

Table of Abbreviations

NHS.....	National Health Service
CQC.....	Care Quality Commission
OEL.....	Organisational Environments of Learning
DoH.....	Department of Health

Chapter One

Introduction

1.0 Background; the influence of organisational cultures on employee voice within the care home context

In the aftermath of the report into the failings at the Mid Staffordshire NHS Foundation Trust (Francis Report), where continued failings and patient deaths rates were between 27-45% higher than expected, there was a recognition that fundamental changes were needed to how Health and Social Care was organised within the English context (Francis, 2013; DoH, 2014; Dixon-Woods et al., 2019). It was from this position I embarked on a journey of exploration to better understand how such failings had occurred, and the lessons which could be learnt moving forward, within the organisational management context. Through a critical exploration of the subsequent Government reports into the failings at Mid Staffordshire (post-Francis Reports) in chapter two, it was possible to highlight the significant role played by *closed organisational cultures*, (Davies & Mannion, 2013; Francis, 2013; Flynn et al., 2014; NHS England, 2016a), and *employee voice*, (Cavendish, 2013; Keogh, 2013; Tingle, 2014) in influencing the occurrences which took place within Mid Staffordshire NHS Foundation Trust.

With continued failings within both the Health and Social care contexts, I detailed the ineffectiveness of governmental policies post-Francis geared towards culture change and promoting employee voice (Baylis & Perks-Baker, 2017; Mannion & Davis, 2018; Goodwin (2019). Chief amongst these was the way in which the Government and post-Francis reports went about reporting on the nature of culture within different organisations. Goodwin (2019) argued that the inconsistencies in how the nature of culture was reported resulted in an oversimplification of what Riley (1982) and Schein (2010) both see as a complex concept. From this point, critics such as Mannion & Davis (2018) argued that it was no surprise that failings attributed to organisational cultures continue.

From this position, a broader analysis of the whole English Health and Social Care context was undertaken (Baird & McKenna, 2018; Department of Health and Social Care., 2018) which I argue clearly demonstrated that at the political and economic level, there was a significant disparity between the Health Service and the Social Care Service (Dayan, 2017; Thorlby et al., 2018). This disparity was also evident in the amount of research investment which over the past decade has been directed towards the Health Service compared to the Social Care Service (Baird & McKenna, 2018; Thorlby et al., 2018). I consequently argued that moving forward; there was a need to direct

more research attention towards the Social Care context (Bachtler & Begg, 2017; Baird & McKenna, 2018; The King's Fund, 2019).

Therefore, I undertook an analysis of the English Social Care context with reference to the post-Francis Reports, and the two key concepts of closed organisational cultures and employee voice. Through this analysis, I was able to identify care homes as being organisational environments which possess characteristics which I argue disproportionately predispose them to the cultivation of closed organisational cultures (Centre for Policy on Ageing, 2012; Francis, 2013; CQC, 2015b; The Carer, 2019). Through an exploration of these characteristics, it became evident that it was their combination (Skills for Care, 2017; Thorlby et al., 2018; Horton, 2019) within the care home context which increased the disproportionality to which care homes were likely to exhibit the characteristics of a closed organisational culture. All this was further substantiated by my content analysis of 25 care homes which had been rated 'inadequate' by CQC (2016). In all examples, the reasons provided by CQC (2016) for the care homes failing their inspection indeed link back to the characteristics of closed organisational cultures, thus providing a strong justification for the context of my subsequent study.

1.1 Organisational culture

Concerning organisational culture, this study aligned itself with the position that organisational culture is something an organisation has as an internal variable. As such, an organisation's culture can be realised through the objective exploration of inter-subjective processes (Cummings & Schmidt, 1972; Davis, 1981; Deal & Kennedy, 1982; Schein, 1985). This position was an important consideration, as it set the philosophical grounds from which my study could contribute organisational and policy level recommendations (Cook & Campbell, 1979; Guba & Lincoln, 1994; Johnson & Duberley, 2015). This position on organisational culture also meant it was possible to call on Schein's definition of that term to help position this study within the literature (Schein, 2004; 2011).

1.2 Employee voice

A general definition of employee voice as '*the optional provision of information, to somebody with the power to act*' (Adelman, 2009, pp 134) was adopted for this study so as not to restrict the study's ability to explore participants' perspectives on voice (Eisenhardt & Graebner, 2014). The study then

integrated Morrison's (2011) proposition that the three key factors influencing employee voice within organisations are context, the behaviour of leaders and individual differences between employees. Finally, the three-part framework on employee voice developed by Van Dyne et al. (2003) was drawn on to help better understand employee voice within the context of care homes.

1.3 Aims of the Study

This study aimed to explore the influence of care home cultures on employee voice (Baines & Cunningham, 2011; CQC, 2016; Skills for Care, 2017). Hence, the following five research questions are underpinned by the following overarching research question '*what is the status of voice cultures within the care home context*'? This overriding question provides the driver for the five key research question below, which will be posed to participants during this study.

- 1)** How do care home employees understand the term 'employee voice' (Van Dyne et al., 2003; Morrison, 2011)?
- 2)** How do care home employees understand the term 'organisational culture' (Schein, 2004)?
- 3)** What are the cultural characteristics and factors of care homes which facilitate employee voice (DoH, 2014; Baylis & Perks-Baker, 2017)?
- 4)** What are the cultural characteristics and factors of care homes which mitigate against employee voice and speaking out (Schein, 2010; Francis, 2015)?
- 5)** How can employee voice be elevated to gain greater impact in care home organisational decision-making (Francis, 2015; Skills for Care, 2017)?

1.4 Philosophical position

To tackle these questions, this study took a Postpositivist philosophical approach underpinned by a critical realism ontological position, which Cook & Campbell (1979) and Levers (2013) both argued should not be mistaken for the critical realist social theory name. This study also followed the epistemological position taken by the postpositivist paradigm of modified objectivity, which argued that attaining absolute objectivity within a study was according to Guba & Lincoln (1994), a 'regulatory ideal', thus not fully attainable. The decision to incorporate methodological reflexivity (Bryman & Bell, 2007), in the form of a reflexive diary, added what Symon & Cassell (2012) saw as another layer of objectivity to this study. I argue that this decision also enabled the study to develop

a clearer understanding of 'how things really are' concerning culture and voice, and 'how things really work' in the care home (Guba & Lincoln, 1994; Symon & Cassell, 2012).

1.4 Study context: the care home

This study was conducted in an organisation which is part of a 'financialised' chain (Burns et al., 2016; Hulse et al., 2019), which operates 26 homes within England, UK. According to the company's website, their care homes are registered to provide 'specialist nurse-led care' for adults with a range of different complex needs. The specific care home case studied provides nursing and personal care for 82 younger adults and claims to 'strive to provide a high standard of round the clock person-centred care' (CQC, 2016). At the time of this study, the home employed over 100 full-time members of care staff, five full-time kitchen staff, ten domestic and four maintenance staff. In the 24 months either side of my study, the care home had 23 managers at different positions within the home, as detailed in chapter four and five, pointing to the turbulent managerial landscape within this care home (Dayan, 2017; Ronnerhag & Severensson, 2019).

1.6 Study context: the case study units

The first unit case studied was a 14-bed unit which provided care for clients with 'mental health and behavioural diagnosis'. At the time of this study, the unit had 12 full-time care workers, which included two full-time team leaders, four full-time nursing staff and one unit manager, who was also a registered nurse. On average, this unit had 4-5 care staff and one nurse on duty during the day and 2-3 care staff at night with one nurse.

The second unit to be case studied was a 17-bed unit, which provided care for adults between the ages of 18 and 65 with predominantly physical disabilities. At the time of this study, the unit had 26 full-time care staff, which included one full-time team leader, three full-time nursing staff, and one unit manager who was also a registered nurse. On average, this unit had 8-9 care staff and two staff on duty during the day, and 4-5 care staff and one nurse on at night.

1.7 Study design

A three-stage case study design was developed (Yin, 2013; Eisenhardt & Graebner, 2014; Gehman et al., 2018), to analyse two units within one care home. Unstructured, overt non-participatory observations (Mulhall, 2003; Beck & Polit, 2014; Heslop et al., 2018), along with document and

artifacts analysis (Burrell & Morgan, 1979; O'Connor, 2007), and semi-structured interviews (Berg et al., 2004; Eisenhardt & Graebner, 2014) were used to conduct this study. The three levels of Schein's theory of organisational culture (Schein, 2004) were integrated with Schein's position on organisational subcultures (Schein, 1984), to establish the *Organisational Culture and Subculture Analytical Structure*, which was used to conduct the study. The *Data Collection Strategy Framework* was developed to guide the data collection process for both case studies. A *Data Analysis Framework* informed by the data analysis process developed by Eisenhardt (1989) and Eisenhardt & Graebner (2007) was utilised to analyse all the data from this study which is detailed in chapter four.

1.8 Main findings and conclusion

Through my analysis, it has been possible to establish that at the home level this care home did not have a homogenous culture, but rather was underpinned by strong unit-based subcultures (Trice & Beyer, 1993; Davies et al., 2000). At the unit level of analysis, metaphors were used (Morgan, 1983) to discover a family culture in case study one (CS1), and a clique culture in case study two (CS2). From the data, it is also apparent that care home cultures did influence employee voice.

I subsequently put forward contributions and organisational and policy level recommendations. For the first time, a study has undertaken qualitative research exploring the influence of care home cultures on employee voice. The second theoretical contribution is the combination of Schein's theory of organisational culture with his views on pivotal and peripheral subcultures as an analytical framework to study care homes (Schein, 1984; 2004). Finally, this study identified the relationship between the perceived position of participants within the care home hierarchy and their understanding of employee voice (Morrison, 2011; Ruck & Welch, 2012; Martin & Waring, 2013).

I also propose three organisational level recommendations which I argue care homes should put into practice: first, the need for a process of 'unlearning' those elements of an organisation's culture which contribute to silence (Smith & Simmons, 1983; Davies & Nutley, 2000; Robyn, 2019). Second, the need for Organisational Environments of Learning (OEL) as a way of facilitating employee voice and greater employee decision making (Jones, 2016). Last, the need for a bottom-up approach to the cultivation of open cultures which accounts for micro-level influences on care home culture such as leadership, group formation and informal hierarchy as a way of better understanding care home

cultures and employee voice (Smircich, 1983; Guba & Lincoln, 1994; Davies & Nutley, 2000; Sheard, 2013; Kingsmill, 2014; Havig & Hollister, 2018).

Finally, I put forward three recommendations for future policy initiatives relating to employee voice and care home cultures in England. First, a recommendation for policymakers to acknowledge organisational differences and accommodate a multi-level understanding of care home cultures in their development of employee voice policies (Donaldson-Feilder et al., 2014; Baylis & Perks-Baker, 2017). This was followed by the need for more national-level leadership training for frontline managers, and finally, training for all care staff on national policies and procedures relating to employee voice were the first two recommendations put forward (Dayan, 2017; Surr et al., 2019). Together, these contributions and recommendations address all the research questions put forward by the study.

1.9 Next Steps

Efforts to develop a feedback and recommendations document for the care home outlining the main areas discussed during the thesis are already underway. The aim is to have a document for the home, and specific documents for each of the two case studies. The purpose of these documents would be to highlight the areas in which the home and the units are doing well and areas for improvement in relation to employee voice. These documents will also put forward recommendations at both the care home and unit levels, and I will seek to work with the home to implement change. Due to the rapidly changing management situation within the home, it has not been possible to gain full access yet. At the time of writing this thesis, the home was without a Home Manager or a Deputy Home Manager, but contact has been made with the Caretaker Manager who said they would contact me as soon as a permanent Home Manager is in place.

1.10 Structure of the thesis

This thesis is structured into seven chapters, which together provide a detailed insight into all the considerations which went into conducting this study.

Chapter one: introduction

The first chapter of this thesis provides an outline of the key sections of the study, such as the study's background, aims and findings. This chapter also provides an overview of all the chapters which make up this thesis.

Chapter two: English Health and Social Care context

Chapter two aims to detail the background of this study by setting out the context within which this study emerged. After explaining the concepts of closed organisational cultures and employee voice, the focus of this chapter turns to analysis of the Social Care sector. This analysis results in care homes being identified as possessing characteristics which disproportionately predispose them to the cultivation of closed organisational cultures. In sum, this evidence provides due justification as to why this study was undertaken within the care home context.

Chapter three: organisational culture and employee voice

Chapter three then proceeds to explore the management literature on organisational culture and employee voice. With both concepts emerging as being contested, a position is taken on both, which helps to guide the direction of the study. Schein's theory of organisational culture is integrated with his views on organisational subcultures, resulting in the *Organisational Culture and Subculture Analytical Structure* used for this study. Finally, the five question areas which I concluded would enable me to explore the influence of care home cultures on employee voice are detailed.

Chapter four: methodology

Having established the aims of the study, chapter four explains my postpositivist philosophical position, which, I argue, aligns all the various strands of this study. A detailed exploration is provided of the three-stage case study design which underpins this study, followed by a step-by-step guide of the process I undertook to conduct this study. In addition, the analysis process is detailed within this chapter, before finally setting out the methodological considerations which shaped the study.

Chapter five: care home culture and voice

The first findings chapter of this thesis explores the culture within the care home through the deployment of the *Organisational Culture and Subculture Analytical Structure*. This made it possible to establish that this care home did not possess one homogenous culture but, rather, differing unit-

based subcultures. Furthermore, the training environment was identified as a facilitator of voice, and the legacy of previous management regimes as mitigating against voice.

Chapter six: unit culture and voice

The second findings chapter then deploys the *Organisational Culture and Subculture Analytical Structure* to case study two of the four units within the care home. Within case study one, the family culture emerged as influencing the day-to-day functioning of participants on the unit, including their voice. The family culture was predominantly influenced by the unit manager, who proactively implemented policies to maintain this culture within the unit. In case study two, the clique culture emerged as having a significant impact on the working lives of participants and their voice. This culture was underpinned by the assumption that those who had been working on the unit for a prolonged period had more power and voice than other staff.

Chapter seven: discussions and conclusion

Finally, the discussions chapter sets out the theoretical contributions and organisational and policy level recommendations that emerged from this study. In doing so, this chapter also answers the five key research questions detailed in chapter three, and which have underpinned this study. This chapter concludes by putting forward potential future research directions emanating from the study.

Chapter Two

The historical and political context of the English Health and Social Care sectors

2.0 Introduction

During this chapter, I will review existing literature relating to both the English Health and Social Care sector, with a specific focus on care homes, but also recognising the important role the National Health Service (NHS) has played in the evolution of care homes, and the broader Social Care context within which care homes reside (Aveyard, 2014; Department of Health and Social Care, 2019). In doing so, I will establish a backdrop from which to explore a decade's worth of publications into organisational failings within both sectors. From this position, I will be able to offer a detailed insight into the complexities associated with organisational failings, by drawing on a host of public interest and investigatory reports into such failings (Francis, 2010; CQC, 2011; Cavendish, 2013; Kingsmill, 2014; Francis, 2015; Pyper, 2016). To further our understanding on these matters, I will also draw on a rich body of literature (Davies & Mannion, 2013; Flynn et al., 2014; Jones & Kelly, 2014; Baylis & Perks-Baker, 2017; Department of Health and Social Care, 2019) which has over the past decade sought to document and explain why care failings have occurred, the nature of such failings, and what appropriate responses should be initiated to address such failings (Mannion & Davis, 2018; Goodwin, 2019).

With this understanding, I will undertake a review of the main responses and recommendations to emerge, highlighting *closed organisational culture* and *employee voice* as the two key concepts underpinning this study. Through a critical exploration of how organisational cultures were understood within each review, it will be possible to identify the opposing approaches used to understand and qualify cultures within different Health and Social Care environments (Goodwin, 2019). With the Social Care sector seen as playing second best to its Health Care counterpart (Dayan, 2017), I shall put forward the case that care homes possess characteristics which disproportionately predispose them to the cultivation of *closed organisational cultures* (Francis, 2013; 2015). The subsequent exploration of these characteristics will provide due justification as to why this study will

focus on care homes, and the influence or understanding of organisational cultures have on employee voices within them (Adelman, 2009; Morrison, 2011; Mannion & Davis, 2018).

2.1 Health and Social care context

Although this study is focused on the Social Care context, specifically care homes, it is essential to acknowledge the vital role the Health Service has played in shaping the current day Social Care environment. The creation of what is now known as the National Health Service (NHS) started in 1942 with the publication of the *Beveridge Report*, which set out proposals to create a welfare system underpinned by a national health service (Nuffield Trust, 2018). The Government's White Paper, *A National Health Service*, which was published in 1944, set in motion many events leading to the creation of the NHS (Nuffield Trust, 2018). Since then, the NHS has undergone several significant changes resulting in its current-day manifestation (Department of Health and Social Care, 2019). In establishing the health service, the government of the day acknowledged the need for a social care element to provide support to those impacted by old age, illness or disability (Age UK, 2018; Nuffield Trust, 2018).

Since their initial inception, the Health and Social Care services have tended to drift apart (Costa-Font, 2017). This drift has resulted in what some observers (Dayan, 2017) see as a two-tier health system in which the Social Care sector is consistently playing second best to the Healthcare sector concerning governmental funding, political intervention, and academic input. Despite the recent decision made by the Department of Health to change its name to the Department of Health and Social Care, a review of the literature indicates that there have not been any significant increases in economic or political commitment to the Social Care industry since this name change (Department of Health and Social Care, 2018; Thorlby et al., 2018). As a result, it continues, according to Dayan (2017) to play second best to the Healthcare sector, particularly in relation to its economic and political standing.

2.1.1 Health Care context

According to Appleby et al. (2014), the fluidity of the Health Services current economic position can be understood from the viewpoint of the last decade in which there have been numerous occurrences which have affected most significantly on the NHS (NHS England, 2018). Chief of these

was the financial crises of 2008, which resulted in what Appleby et al. (2014) referred to as a 'financial cliff edge' for the health service. Subsequent studies by the King's Fund (2014) into the economic state of six Trusts identified trends associated with the difficulties of attempting to cut costs while maintaining high-quality care. It is argued (NAO, 2014) that the introduction of the Health and Social Care Act by the Coalition Government in 2012 was responsible for pressuring Trusts in such positions, and also broadening the market-based approach to the NHS. These moves, I argue, would have had a noticeable impact on the economic positioning of some Trusts.

According to Campbell (2012), the Health and Social Care Act of 2012 was also a catalyst for furthering the government's 'efficiency savings' agenda, which aimed only to cut costs. Subsequent to the Health and Social Care Act, it was observed by Gwinn et al. (2010) that the NHS was undergoing moves towards a more managerial style of operation. It is argued that this was an effort by the government to offset the unavoidable impact of its efficiency savings agenda which NHS England (2018) estimates represents a 'real terms reduction' in funding to the service with increased marketisation (Campbell, 2012). Despite this, the most recent productivity results from NHS England (2019) indicate that Health service productivity 'outstripped' that of the rest of the economy. These results would suggest that despite a decade's worth of cuts, employees within the service are still motivated to give the best quality care possible (Baines & Cunningham, 2011).

At the political level within the NHS, the financial crises of 2008 resulted in what Appleby et al. (2014) saw as a fundamental shift in the ideological, and subsequently political management of the sector. Such shifts, Appleby et al. (2014) argued, resulted in more decentralisation and cost-cutting (u; NHS England, 2018), resulting in what the National Audit Office (2011) estimated to be £20 billion in savings by the 2014-15 tax year. This political decision, I argue, could only have had a detrimental impact on the delivery of care within the health service. More recently, the decision of the United Kingdom (UK) to leave the European Union (UE) (Brexit) will, according to Bachtler & Begg (2017), Costa-Font (2017) and the King's Fund (2018), have far-reaching implications for the English Healthcare service. According to Costa-Font (2017), such implications will include a deepening of the financial crisis faced by the NHS and increase the cost of hiring EU nationals. Such costs are predicted by the King's Fund, (2018) to result in a considerable shortfall in NHS staffing, which currently accounts for 62,000 health service posts (Dayan, 2017).

With ‘implicit promises’ of an extra £350 million a week for the NHS failing to materialise in the aftermath of the referendum, Costa-Font (2017) and Dayan (2017) both put forward the view that post-Brexit the political outlook for the English Healthcare sector looks problematic. However, with continued political engagement, it is highly likely that the NHS will be ring-fenced from any adverse financial ramifications resulting from Brexit (Dayan, 2017; Department of Health and Social Care., 2018.). With a no-deal Brexit looming ever closer (Fahy et al., 2019), political uncertainties over the health sector will only deepen.

2.1.2 Social Care context (economic)

Within the Social Care sector, statistics from Age UK (2018) indicate that almost 1 in 4 of the population of England will be over the age of 65 by 2040. Such figures, according to Griffiths et al. (2017), prove the economic importance of the social care sector. According to Skills for Care (2017), Social Care in England is an area which continues to see significant growth, with around 20,300 organisations, 40,400 care providing locations and a workforce of approximately 1.58 million (Griffiths et al., 2017). These figures are substantiated by data from Thorlby et al. (2018), indicating that the social care sector employs more people than the NHS, accounting for 6% of the national employment rate. Nevertheless, all financial projections indicate that governmental support within the sector falls far below that of the NHS (Griffiths et al., 2017). The 2017 national audit estimates that the Social Care sector contributes an estimated £41.8 billion per annum to the English economy, and with the number of jobs in the sector continuing to rise, Griffiths et al. (2017) estimate this figure will only continue to increase. As a sector which is contributing so much to the economy, it is possible to put forward a view that the Social Care sector, although partially privatised, should be receiving more governmental support (Huws, 2012; Thorlby et al., 2018)

Although the government has now agreed to increase funding to the social care sector to around £3.63 billion by 2019/20, according to Willcox (2017), this is not enough to solve the long-term funding crises within the sector. Humphries et al. (2016) have estimated that the funding gap within the sector will by 2019 be significantly more than £3 billion, indicating that the £3.63 billion pledged by the government is not enough to bring the service onto a financially stable footing (age UK, 2018). This is the case according to the Local Government Association (2019) who argue that such financial

disparity has resulted in a situation in which unpaid female care workers have become the backbone of the industry (Baines et al., 2014b). What has become evident is that at the economic level, the health sector continues to receive significantly more input than the social care sector, which Age UK (2018) and The Kings Fund (2019) have both indicated is continuing to negatively impact on the services it provides.

2.1.3 Social Care context (political)

Politically, neo-liberal shifts in the government's position over the past decade have resulted in a significant amount of the Social Care sector becoming privatised (Huws, 2012; Baines et al., 2016; Jarrett, 2016; Cottell, 2017). The government's position has had a significant impact on the Social Care market, which has become more complex (Skills for Care, 2016), with several large foreign companies entering the market (Burns et al., 2016). This increased marketisation of the Social care industry can be seen as another notable departure from its Health Care counterpart, thus resulting in a reduction in government intervention.

This is evident when analysing research conducted by the King's Fund which found that 26% fewer people were receiving Social Care as a result of government cuts introduced by the Coalition Government of 2010 (Humphries et al., 2016). Willcox (2017) sees such cuts as contributing to the current fragilities within the Social Care marketplace, which is a view shared by Thorlby et al. (2018) who estimate that since 2010 Local Authorities have been hit with a 50% drop in government funding for social care delivery. All of this furthers the perspective that at the political level, Social Care is indeed playing second-best (Dayan, 2017) to the Health Service.

Additionally, Brexit is predicted to have a significant impact on the social care sector, particularly in relation to the proposed end to freedom of movement which accounts for around 95,000 employees within the sector (the King's Fund, 2019). Dayan (2017) puts this shortfall at approximately 70,000 Social Care workers by 2025/26 if net migration from the EU is halted as a result of Brexit. Although this is yet to materialise, if such changes were to take place, it is evident from the statistics (the King's Fund, 2019), that the Social Care sector would encounter more staffing problems. This is a view shared by Baird & McKenna (2018), who argues that staffing levels within the sector are already under immense strain; thus, a failure to reach an appropriate deal post Brexit would only add to this problem.

As in the case of the economic context, the disparity between the political attention given to the Healthcare sector as opposed to the Social Care sector is evident. From an examination of the current English Health and Social Care sectors, what has become evident is that both sectors are facing significant economic and political uncertainty (Griffiths et al., 2017; Thorlby et al., 2018). Such uncertainties, Bachtler & Begg (2017) have argued, will only continue to have a negative impact on both sectors' ability to deliver good quality care moving forward (NHS England, 2018). It is also clear that the Healthcare sector continues to receive more input than its Social Care counterpart (Dayan, 2017; Department of Health and Social Care, 2018). Thus there is a need for increased Social Care engagement and research (Baird & McKenna, 2018; Thorlby et al., 2018; the King's Fund, 2019) as a way of rebalancing the scales. As a result, this study will focus its attention on the Social Care context, but to do this, it is essential first to explore the failings which have occurred in both contexts, and better understand how such failings across the board, related to the Social Care context.

2.2 Health and Social Care failings

While the government has been making significant changes to the Health and Social Care sectors (Campbell, 2012; NAO, 2014) over the past decade, the public has been made aware of several high-profile cases of organisational failings. Indeed, it can be argued that the past decade has been punctuated with Health and Social Care failings in which care quality has been compromised (CQC, 2011; Francis, 2013; Kirkup, 2015). This being the case, it is vital to better understand these failings and analyse how they came into being, and the lessons learned which are of importance to our understanding of the Social Care context. Furthermore, this section will undertake a critical appraisal of said reports to evaluate if they were best placed to report on such failings, in doing so, this section will offer insights into some of the key areas of concern.

2.2.1 Mid Staffordshire Inquiry

Concerns relating to the high mortality rates at Mid Staffordshire NHS Foundation Trust resulted during an investigation by the Healthcare Commission, whose subsequent damning report triggered the 'Francis Inquiry' (Francis, 2010). The finding of this Inquiry was very much in line with the Healthcare Commission's Report finding that the overall organisational culture within the Trust was 'not conducive to providing good care' (Francis, 2010). This culture, according to Francis (2010), was

underpinned by an 'atmosphere of fear, forceful management techniques, low staff morale, an organisational lack of openness, and a culture of denial across the Trust'. Within this inquiry, culture was described within the context of fear and negative managerial practices (Goodwin, 2019).

These factors resulted in a working environment which had little tolerance for rebellious voices, culminating in what Francis (2010) described as a 'weak professional voice within the Trust'. All of this, I argue, cultivated a culture in which poor-quality care became accepted. According to Francis (2010), these characteristics which underpinned the culture of the hospital also influenced how employee voice was enacted. From this analysis, it is possible to say then that a *voice culture*, or in this instance, a lack of, was a significant contributor to the failings uncovered. Indeed, one of the key recommendations to come out of the Inquiry was the need for the Trust to establish a '*culture of openness and insight*,' which would enable employees to voice their concerns within the working environment (Francis, 2010). These findings, I argue, demonstrates the importance Francis (2010) placed on open cultures as a counter to poor quality care, and the link between culture and employee voice.

2.2.2 Winterbourne View Review

Two years later, the public learned of the exposés of abuse by a reporter at Winterbourne View Hospital, where the systematic abuse of patients was the norm (CQC, 2011). A subsequent Serious Case Review revealed that the Care Quality Commission (CQC) had failed to act when staff had voiced concerns relating to the culture of abuse within the hospital. There was a lack of priority given to the voices of employees within the hospital even though during the same period, more than 78 patients had to access Accident and Emergency services as a result of abuse (CQC, 2011).

This Review, I argue, can be perceived as demonstrating how a culture of abuse against vulnerable patients was able to flourish within an organisational environment in which the voices of employees were not taken into consideration at all levels, including those whose job it was to listen (CQC, 2011; Burns et al., 2013). Such findings show that within this review, the notion of culture was very much seen from the perspective of how much voice employees had, and from the findings, it would suggest not very much. Evidently, the lack of voice culture, among other factors meant that patients were harmed unnecessarily.

2.2.3 The Francis Report

The Winterbourne View Inquiry was proceeded by the second investigation into Mid Staffordshire NHS Foundation Trust (Francis Report), resulting from a lack of action by the Trust's management on recommendations from the first Inquiry. In addition to this, continued failings within the Trust and patient deaths rates which were between 27-45% higher than expected in similar NHS Trust triggered this second inquiry (Francis, 2013). It was noted that the organisational environment within the Trust was one which routinely prevented employees from speaking out, creating what Francis (2013) described as a 'closed culture' (Davies & Mannion, 2013; Flynn et al., 2014). These closed cultures were referred to by Francis (2013) as creating a 'climate of silence', which related to the fear's employees had about voicing their concerns. Through a review of this report, I argue that the interactions which led to the cultivation of closed organisational cultures were predominantly those between employees and management, indicating how important this relationship is within the working environment.

From an analysis of Francis Report, it is apparent that the nature of the organisation's culture and its links to employee voice had not changed since the Mid Staffordshire Inquiry (Francis, 2010; 2013). Indeed 'closed culture' which stifled voice, and disengaged management and a breakdown in leadership were all characteristics which underpinned the culture of the hospital during its first investigation. Such breakdown in leadership, coupled with what Goodwin (2019) described as an 'overwhelming emphasis' on finances and achieving Foundation Trust status all fuelled a culture of poor care. Subsequent recommendations put forward by Francis (2013) centred on the need to cultivate open organisational cultures and therefore called for an end to 'gagging clauses' in employee contracts. Francis (2013) also called for more transparency from Trusts in reporting failure, and the implementation of a statutory duty of candour which referred to *employees actively seeking to be open, honest and frank with both patients and fellow employees* (DoH, 2013). Francis (2013) argued that such recommendations were important steps in changing the organisation's culture. This comment by Francis (2013), I argue further underscore the significant influence of cultures on employee voice, but also starts to draw our attention to the conflicting characteristics which have been used to characterise culture within these different investigations (Goodwin, 2019).

2.2.4 Kirkup Report

The Francis Report was then followed by the public inquiry into the Maternity and Neonatal Service at University Hospitals Morecambe Bay NHS Foundation Trust (Ham & Murray, 2015). Kirkup (2015) referred to the failings as being '*reminiscent*' of those detailed by Francis (2013) two years earlier. A review of this report found similarities in the inadequate reporting process to those highlighted by Francis (2013), and misplaced priorities in information sharing. In this instance, there were some similarities in the way in which culture was characterised with that on the Francis Report, but notably, there were also differences. Kirkup (2015) detailed the role tribalism played in shaping the culture within the Trust, especially between midwives, obstetricians and paediatricians. This tribalism resulted in what Kirkup (2015), referred to as an absence of 'cultural openness' tied with a 'lethal ideological culture' at the Trust which he attributed to the preventable deaths at the Trust.

These findings demonstrate the significant influence organisational cultures can have on the working environment, in this instance, resulting in patient deaths (Dixon-Woods et al., 2019). Indeed, Kirkup (2015) commented that the organisational and governance procedures within the Trust were seemingly unable to deal with such ideological cultures, which had formed between specific groups of employees. The complexities associated with cultures within an organisational environment is something that this report brought to the fore, and in doing so further underpinned the importance of understanding the role of cultures within any organisation (Cummings & Schmidt, 1972; Schwartz & Davis, 1981). The above reports have also demonstrated the vital role the voices of employees had within these contexts, and the positive influence voice can have in shaping organisational cultures (CQC, 2011; Francis, 2013).

Despite the fact that these reports were being published, failures continued indicating that such reports were not according to Goodwin (2019) effective in bringing about the changes they were advocating. It is essential not to take such reports at face value, instead, we must interrogate their motives in reporting on such failings. What becomes evident when one considers such an approach is that all of the above reports were commissioned by the government of the day as a response to publicly reported failings (CQC, 2011; Francis, 2010; 2013; Kirkup, 2015). As such, it is possible to argue that such reports would not have been without political interference; indeed it was the government who set the parameters within which such reports had to operate (Thorlby et al., 2018;

the King's Fund, 2019). The politicisation of the Health Service is nothing new; this was on display during the investigation into Mid Staffordshire NHS Foundation Trust in which the remit of the report was outlined by the government (Francis, 2013). As such, it is important to appreciate the limitations and the strengths associated with the above reports ability to provide a holistic account of occurrences.

2.3 Government responses (reports)

In the fallout resulting from the above reports and inquiries into organisational failings, several Governmental reports were commissioned, to explore the key areas of concern detailed by these reports. For the purposes of this study, all commissioned reports published after Francis (2010) will be referred to as *post-Francis Reports*. With closed organisational cultures and employee voice emerging from an exploration of the above reports into organisational failings, this review will now gauge the extent to which these concepts were picked up by the post-Francis Reports. In doing so, it will be possible to provide a critique of such reports to understand better how effective they have been at grappling with the issue of organisational culture and how such reports have approached the nature of organisational culture within the context they have reported on (Mannion & Davis, 2018).

2.3.1 Reviews into organisational failings

The independent *Willis Commission on Nursing Education* was among the first post-Francis Reports to be commissioned with a specific focus on exploring how pre-registration nursing education can equip nurses for working outside the health care context (Willis, 2012). This report emerged from the realisation that nursing education at the time was not adequately equipping nurses for roles within the social care context, thus contributing to poor service delivery (Willis, 2012).

Following the *Francis Report*, *The Keogh Report* was initiated and aimed to review the quality of care provided by 14 NHS hospital Trusts that had comparable death rates to Mid Staffordshire NHS Foundation Trust (Keogh, 2013). Indeed, Keogh (2013) was able to identify similarities between the organisational level failings identified at Mid Staffs and those of the 14 NHS hospitals subsequently investigated. It can be argued that such similarities demonstrate the important role of organisational level analysis in furthering our understanding of Health and Social Care failings.

July 2013 saw the publication of the *Cavendish Review*, which explored how training for unregistered staff could be enhanced within the health service (Cavendish, 2013). This review emerged from the recommendations put forward by Francis (2013), having identified the shortfall in training provision for non-professionalised staff within the health service, and how this contributed to the subsequent failings.

This was followed in October 2013 by the publication of the *Clwyd-Hart Report*, which was concerned with how best to align all complaints about patient care within healthcare organisations into one system (Clwyd & Hart, 2013). This report was a response to the recognition that even in situations in which complaints had been made about poor quality care, for the most part; they were not acted upon appropriately. This lack of appropriate action (CQC, 2011) contributed to the extensive nature of failings identified in reports such as the Francis Report (2013).

Around the same time, the *Berwick Report* was tasked with analysing all previous reports into organisational failings to establish overarching recommendations for the government. Themes relating to the need for employees to voice themselves and the influence of organisational cultures were prominent features in all reports, according to Berwick's (2013) analysis. Such themes, it is argued, further brought to the fore the important role of organisational cultures and employee voice within Health and Social Care organisations.

One year after the Francis Report, Tingle (2014) was tasked with evaluating how far the health service had come since the report (Tingle, 2014). From Tingle's (2014) analysis, it was evident that whilst significant steps had been made, the degree to which these steps had become entrenched at the organisational, group and individual levels was still in doubt. I argue that this is a sign that organisational culture change, although sought after and recommended by the above reports, requires time to embed into any Health or Social Care organisation.

In the same year as Tingle (2014), the *Carr Report* was published on behalf of the Joseph Rowntree Foundation, aimed at investigating the relationship between pay and conditions for care workers and the experiences of people using care services (Carr, 2014). Although Carr (2014) acknowledged that the relationship between pay and improved care quality was inconclusive, this report made evident the need to support care workers through, among other things, the provision of an 'open cultural environment'.

The *Demos Report* was also commissioned in 2014 and was tasked with exploring the state of the care sector which, according to Demos (2014), was ‘fatally damaged,’ and had become a place of last resort for the elderly. The report’s 12-month investigation highlighted some positive elements of care in relation to pockets of quality care given to frail residents. Nonetheless, Demos (2014) warned that the chronic underfunding of social care was undermining the best efforts of organisations within the sector, and perpetuating the likelihood of organisational failings.

The *Kingsmill Review* followed and was aimed at highlighting the low pay, poor status, inconsistent training, and weak regulation within the care sector as opposed to the healthcare sector (Kingsmill, 2014). This review found working conditions within some care homes at the time amounted to what Kingsmill (2014) called ‘exploitative working practices’. This depiction of the care sector was underpinned by data suggesting that about 220,000 care workers at the time were illegally being paid below the Minimum Wage (Kingsmill, 2014). Such pay was in stark contrast to salaries in the Health service, further demonstrating the disparity between the two sectors on all levels.

Following on from the *Clwyd-Hart Report* into complaints handling the previous year (Clwyd & Hart, 2013), the House of Commons Public Administration Select Committee published the *More complaints please!* document in 2014 which explored how complaints within the health service have been handled (Flynn et al., 2014; House of Commons, 2015).

2015 saw Robert Francis QC publish the *Freedom to speak up review*, which had an explicit focus on employee voice within the health service. From his previous publication in 2013, Francis (2015) established the importance of creating a supportive environment in which employees felt able to speak up as a way of countering prolonged failings within the health service.

Later in the same year, the House of Commons published the *Complaints and Raising Concerns Report* which commented on the ‘unwarranted variations’ in how the complaints system within England’s health service worked (House of Commons, 2015a). This report brought to the forefront the issue of disparity between different organisations in relation of complaints handling mechanisms, resulting in discussions being had about how best to align the processes across the sectors (House of Commons, 2015a).

2.3.2 The role of closed organisational cultures

From the above post-Francis Reports, it is apparent that the role of closed organisational cultures and employee voice were a significant factor contributing to the failings detailed above. The notable contextual differences between the Health and Social care organisations explored in the above government reports also becomes evident. As a result, and through my analysis, it is possible to distinguish the role closed organisational cultures played within the failed organisations detailed previously, and within the post-Francis Reports. For example, following on from the *Mid Staffordshire Inquiry*, the *Willis Commission* report established the important role organisational cultures have to play in shaping an environment which is conducive for pre-registration nursing staff to learn effectively. According to Willis (2012), only by creating effective learning conditions could good practice such as patient-centred care be instilled in the workforce. Calls by Willis (2012) for the creating effective learning conditions, I argue, were a counter to the closed organisational cultures, which were blamed for many of the failings that occurred (Nevalainen et al., 2018).

The *Keogh Report* also uncovered closed organisational cultures, which Keogh (2013) described as being a significant element in the facilitation of failure within the health service. Building on the culture of fear notion put forward by Francis (2013), when discussing some of the contributing factors to organisational failures, Cavendish (2013) highlights the need to cultivate 'conducive cultural environments' for employees to voice themselves free from the fear of retribution. Indeed, the *Berwick Report* published in the same year also emphasised the need to cultivate cultural environments within organisations which were free from 'blame, fear, and denial'. This is something which a subsequent report, conducted one year after the *Francis Report* by Tingle (2014), stated had yet to be fully established within the health context. Although potential solutions to countering closed organisational cultures were known, effective methods for the practical implementation of such solutions were still developing (Martin & Waring, 2013).

One way of establishing such organisational environments and mitigating against the potential impact of closed organisational cultures, as suggested by Carr (2014), was to promote staff involvement and ownership of organisational values and cultures within organisations. Although care workers are among the lowest-paid within the industry, Carr (2014) was able to highlight the significant role positive organisational cultures played in ensuring that such care workers felt valued.

This report, I argue, demonstrated that organisational cultures played a more significant role in shaping the working environment than other material factors such as pay. The points put forward by Carr (2014) were also highlighted by Demos (2014), whose report concluded that closed organisational cultures were a significant factor in failings within the care home setting and were underpinned by a lack of empathy, kindness and good leadership (Demos, 2014). All of which, as Flynn et al. (2014) argued, made it more difficult for complaints to be handled appropriately, thus potentially perpetuating existing failings.

2.3.3 The need for increased employee voice

The need to better facilitate employee voice within the Health and Social Care context was the second theme to emerge from my analysis of all the post-Francis Reports. Several post-Francis commentators, such as Willis (2012), touched on the important role the voices of nursing staff play, especially at the board level in organisations, and the need for all nurses at all levels to be listened to as a way of improving the learning environment, and thereby the culture for nurses. This view was also shared by Keogh (2013) and Nevalainen et al. (2018) who both elaborated on the need to engage employees at all levels and listen to their voices. Listening to employees was seen by Keogh (2013) as an effective way by which positive open cultures could be achieved within all health services as it put the focus back onto frontline staff and engaged them in decision-making rather than management (Burns et al., 2014).

The need to facilitate and listen to the voice of employees was brought to the fore by Clwyd & Hart (2013) who found that a 'toxic cocktail' of factors were responsible for preventing employees from voicing themselves and hindering management from listening (Burns et al., 2014). It is this lack of communication to which Clwyd & Hart (2013) attributed the preceding failings which had occurred, thus clearly highlighting the importance of employee voice in countering failings and contributing to open cultures. Cavendish (2013) furthered this standpoint by highlighting the fact that efforts to increase the role of employee voice as a counter to closed organisational cultures can only occur if a conducive environment is established which gives employees the perceived safety they need to voice themselves (Cavendish, 2013). This is also the position Demos (2014) took when reflecting on his report in the Health and Social Care context, which further establishes this link between the status of employee voice within an organisation and its cultures.

Kingsmill (2014) moved this discussion on further by recognising the importance of collective voice within the organisational context through commenting on the need to reverse the continued decline in union membership as one way of safeguarding employees and countering failings. The position taken by Kingsmill (2014) can be seen, I argue, as very much aligning itself with the position that a collective approach to employee voice is an effective tool not only for the enhancement of care quality and the prevention of organisational failings but also to increase job quality for employees (Burns et al., 2016). The *Freedom to speak up review*, authored by Francis (2015), also contributed but placed specific focus on the need to promote employee voice through handing more autonomy to voice, back to employees whilst creating an environment in which employees felt safe to use that voice (Ham & Murray, 2015; Waring, 2016). All these points were underpinned by the House of Commons (2015) who ultimately concluded that for the voices of employees to be promoted within the Health and Social Care context, there needed to be ‘a desire to exhibit openness at all levels’ within such organisations.

2.3.4 Review recommendations

In setting out their views on how the above failings were allowed to happen, the post-Francis Reports also offered several recommendations as to the way forward for failed Health and Social Care organisations. For this study, the focus will be given to those that address the two key study themes of *closed organisational cultures* and *employee voice*. The *Cavendish Review* was among the first of the post-Francis Reports to explicitly recommend the need for an organisational culture change within the Health and Social Care context (Cavendish, 2013). In reference to care workers, Cavendish (2013) recommended that organisations needed a culture change, to ‘recognise the positive contribution of care assistants’ within the health service. To do this, Cavendish (2013) proposed the need to cultivate ‘supportive cultures’ in which staff felt able to express themselves while doing a worthwhile job. This recommendation can be seen as addressing the link between the two key themes of this review, namely the role of organisational cultures in influencing employees and their willingness and ability to voice themselves.

Establishing open organisational cultures, I argue, runs through several of the recommendations to emerge from the post-Francis Reports. Clwyd & Hart (2013), for example, concluded that there was a

'fundamental need' for a more open approach to investigating complaints, which refers to the closed organisational cultures which exist within Health and Social Care contexts. The need for open organisational cultures to facilitate employee voice was also focused on by Berwick (2013) who stressed the need to create open working cultures which avoided a predisposition to blame, and the 'fear, opacity, and denial' which had caused preventable harm to patients as detailed in the above reports. The *Berwick Report* can be seen, I argue, as underscoring two key points: first, the notion that closed organisational cultures bring about preventable harm to patients; second, the promotion of employee voice can be a tool by which open cultures can become the norm within an organisational environment. Both these points very much reflect the recommendations put forward by Keogh (2013) in his report, further underscoring the importance of the links between culture and voice.

The need for employees to be given more opportunities to voice and more power in organisational decision-making was also evident within the recommendations put forward by a number of the post-Francis Reports. The *Kingsmill Review*, for example, recommended the need for care workers to be given a stronger voice within the organisational setting, as a way of enhancing their status and giving them more say in decision-making (Kingsmill, 2014). During his evaluations, Tingle (2014) also recommended the need to enhance the role Health and Social Care workers play in shaping themes around openness, transparency and candour within their organisations. The empowerment of frontline staff to be more involved and have a greater impact was seen by some of the post-Francis Reports as a way of countering the top-down managerialism approach which had contributed to failings in the first place (Francis, 2013).

One way in which frontline employees could be empowered is through what Flynn et al. (2014) highlighted as being the need for more information to be provided to those who wish to voice out against their organisation. Such information, Flynn et al. (2014) argued, had not been available at the time; thus, the supportive environment which would have enabled employees to voice themselves was not forthcoming. The position taken by Flynn et al. (2014) was subsequently supported by Francis (2015) in his recommendations, which also emphasised the need for open environments in which employees can express themselves. These two positions can be seen, I argue, as moving the

discussion away from just the need to give employees a voice, to also recognise the important role safe and open organisational environments play in encouraging employees to voice themselves.

At this point, it is possible to start to see where things went wrong concerning the government's efforts to rectify the courses of the failures detailed above. In the first instance, I have established that there was a divergence in how the reports into organisational failings characterised organisational cultures (Mannion & Davis, 2018). Despite such divergence, the subsequent post-Francis Reports have seemingly brushed over these differences and have instead all called for similar approaches to dealing with the cultural issues which it is argued would not adequately address the root causes. It is possible to argue that the operationalisation of recommendations geared towards culture change detailed above become problematic when this broad-brush approach to characterising culture is taken by the same reports which subsequently put forward recommendations (Goodwin, 2019).

2.4 Government responses (policies)

With an ever-increasing number of damning post-Francis Reports into Health and Social Care organisational failings, the government was under pressure to act and did so by introducing several policy initiatives. With a specific focus on organisational culture and employee voice, the next section of this literature review explores the policy initiatives implemented by the government in the aftermath of the above failings. Additionally, it will be possible to assess the extent and the nature in which such policies have grasped organisational cultures and its complexities (Skills for Care, 2017; Mannion & Davis, 2018).

Critics would argue that such governmental responses have been oversimplified, and have approached the complex issues of organisational culture with a broad brush, thus not allowing for the detailed insight which is needed to address such an issue (Mannion & Davis, 2018). Through this exploration, it will be possible to ascertain the degree to which such policies addressed the recommendations relating to organisational cultures and employee voice proposed by the post-Francis Reports; moreover, to gauge the extent to which such policy initiatives brought about practical change within the Health and Social Care context (Martin & Waring, 2013).

2.4.1 Chief Inspectors of Hospitals and Social Care

One of the first responses to emerge from the Government in the aftermath of identification of healthcare failings by such as the Mid Staffordshire Inquiry was the Government White Paper *Caring for our Future*. This white paper set out the Department of Health's commitment to work with care providers to promote culture change and skills development (Cavendish, 2013). This paper also initiated a policy for the introduction of new Chief Inspectors of Hospitals and Social Care who would be responsible for evaluating whether organisations are showing the leadership required to shape and enable positive cultures to flourish (Cavendish, 2013). This policy, I argue, was a direct response to a number of the post-Francis Reports (Cavendish, 2013; Flynn et al., 2014; Francis, 2015) who all recommended the need for a more positive and open organisational environment. The introduction of the Chief Inspectors of Hospitals and Social Care was seen as an attempt by the government to address negative cultures, particularly at the top of organisations, through top-level inspections. Such initiatives arguably were an attempt to address the issues of ineffective leadership raised by reports such as Francis (2013) which linked this directly to preventable failings.

2.4.2 The promotion of openness and transparency

The need for a more open and transparent working environment as a counter to the prolonged organisational failings which occurred within some Health and Social Care organisational contexts was a key theme amongst the recommendations to emerge from the post-Francis Reports. Authors such as Berwick (2013), Clwyd & Hart (2013) and Keogh (2013) all focused on the issues of openness and transparency during their recommendations. The government responded with *The Mandate*, which was a document aimed to implement a number of steps which DoH (2014) referred to as a 'revolution in transparency.' Such steps were geared towards making the health service more open and promoting the voices of employees. From an analysis of this document, the majority of the steps outlined were centred around the desire to create open cultures within the health service and to counter the fear of speaking out which a number of the post-Francis Reports above have pointed to as contributing to the failure.

Following on from *The Mandate*, the government published the 2015 *NHS Constitution* which highlighted a variety of steps required to improve organisational cultures, including the creation of what the constitution referred to as a 'positive working environment' (DoH, 2015b). Such

environments, according to DoH (2015b), would come about as a result of creating cultures of openness and transparency within all Health and Social Care organisations. According to Powell & Mackley (2017), this was also to encourage employees to raise concerns at their 'earliest opportunity'. All this, I argue, was geared towards the creation of safe environments in which employees could openly express themselves (Department of Health and Social Care, 2019). *The Mandate* can also be perceived as responding to recommendations stemming from the post-Francis Reports such as Berwick (2013) and Clwyd & Hart (2013), which both called for such initiatives to be implemented. Despite the introduction of this policy, the top-down manner in which it was implemented within the organisational environment meant that there was little oversight of how effective such policies were at the ground level (Donaldson-Feilder et al., 2014). Hence, the ability to understand the effectiveness of this policy for those who needed it most was very limited.

2.4.3 Introduction of a statutory duty of candour

In keeping with the need to cultivate more open organisational environments, the government also published the *Patients First and Foremost* document which included proposals for a new duty of candour, as a prerequisite for organisations registered with the Care Quality Commission (DoH, 2013). This was one of the key elements Francis (2013) touched on when calling for open cultures within the Health and Social Care services (CQC, 2015a). The *2015 NHS Constitution* went a step further by detailing plans for a statutory duty of candour, which identified a range of steps to instil open cultures within the health service (DoH, 2015c). By the end of 2015, all Health and Social Care providers in England were required to implement this duty of candour, and it has now become an expectation within all Health and Social Care organisations (DoH, 2015c). The Government's decision to introduce candour as a statutory duty can be perceived as another top-down attempt to implement an initiative which was meant to shape day-to-day ground-level interactions among employees. As in the case of the government's policies on openness and transparency, the degree to which candour among frontline staff could be regulated at the governmental level, given the complexity of health and social care organisations and the number of employees working within them, is questionable.

2.4.4 Updated NHS whistleblowing procedure in England

Another policy initiative to emerge in response to organisational failings and the subsequent post-Francis Reports was the publication of the *NHS whistleblowing procedure in England*, by Powell (2015). This document was aimed at outlining what government policies on whistleblowing in England were at the time. This document also detailed the new elements to be added to the whistleblowing procedure which were aimed at establishing clarity on the process of whistleblowing and creating safeguards for those who do blow the whistle (Powell, 2015). The introduction of more transparency within the whistleblowing process, such as by defining the terms under which the law protects an employee and highlighting additional safeguards, were all responses to calls made by reports which were responding to organisational failings (Pyper, 2016).

Nonetheless, the effectiveness of these new processes and safeguards and their ability to impact on the individual employee's decision to blow the whistle was unclear because this policy was another top-down initiative which did not account for individual organisational differences (Schein 2004; Morrison, 2011). Through my analysis of government briefing papers such as Pyper (2016) and Powell & Mackley (2017), this was another policy which, I argue, did not offer any suggestions as to how positive working environments could be created to reduce the informal fear among employees of voicing themselves or whistleblowing, created by the organisational environment.

2.4.5 The Freedom to Speak Up principles

With the focus of the debate shifting toward the need to better empower employees to voice themselves, the government introduced *The Freedom to Speak Up* principles which, along with the enhanced whistleblowing policies, were aimed at supporting the raising of concerns (Francis, 2015; Powell & Mackley, 2017). This was something which Francis (2015) highlighted in his report and subsequently recommended as an effective way forward. These principles were implemented and rolled out to every primary care provider by NHS England (2016) in line with the changes made to the whistleblowing policy. The aim was to enhance training for staff who raised concerns, introduce local whistleblowing guardians and provide help to whistleblowers to find alternative employment (Powell & Mackley, 2017). According to NHS England (2016), the new speaking up principles along with the enhanced whistleblowing policy resulted in a process which made the raising of concerns simpler and

more effective for staff at all levels. Freedom to Speak up Guardians were also appointed in all NHS Trusts to facilitate the process by which employees voice themselves (Powell, 2015).

At the policy level, the combination of the Freedom to Speak Up principles with the government's enhanced position on whistleblowing worked well. At the organisational level, though, the effectiveness of implementing a one size fits all policy initiative such as speaking up principles within an organisational context as varied as the Health and Social Care context was questionable (Baines & Cunningham, 2011; Donaldson-Feilder et al., 2014).

Furthermore, if the fear of speaking out which authors such as Cavendish (2013) and Keogh (2013) talked about were present within an organisation, the likelihood of individuals proactively seeking out guardians would be limited. Rather than attempting to operate in an environment of fear, the efforts of guardians should have been directed towards the cultivation of open organisational environments (Jones, 2016). Ultimately, I argue that it is only with the existence of open environments that employees can be enabled to seek out such guardians in the first place (Donaldson-Feilder et al., 2014).

2.4.6 Increased oversight by professional regulators

The government also published a document which was explicitly aimed at improving culture change within the NHS, called *Applying the lessons of the Francis Inquiries* (DoH, 2015a). This document highlighted some of the new governmental initiatives aimed at culture change post-Francis, such as changes to the Care Quality Commission Board, which was responsible for inspecting hospitals (DoH, 2015a). External to the organisation, the government also announced that professional regulators, such as the General Medical Council and the Nursing and Midwifery Council, would be introducing 'consistent responsibilities' for individual health professionals. This would enable professional bodies to take action against employees who were not honest about errors with their patients (DoH, 2015a).

From the perspective of the government, this was seen as going one step further than the statutory duty of candour to give professional bodies the power also to act. In doing so, it was proposed that this would help in the cultivation of open cultures. Such changes, I argue, could also be seen as counterproductive to cultivating open cultures if employees who were already working in

organisations underpinned by fear would now face the possibility of being punished by their professional body (Cavendish, 2013; Francis, 2013). Rather than encouraging openness, such forceful policy tactics may result in more closed cultures which extend beyond the confines of the organisation into the professional bodies. Over time, this would remove another avenue which employees may have used to express themselves previously. Indeed, as the majority of these recommendations have come from government-initiated reports, it's essential not to consider such recommendations as totally objective as they would be operating within a predefined context, thus unable to comment on important issues outside their scope (Goodwin, 2019).

2.5 Ineffective governmental policy agenda towards voice culture

In an effort to address the host of recommendations emerging from post-Francis Reports, the government initiated several policies geared towards tackling voice cultures detailed above. Although the government would argue that such policy initiatives went a long way towards grappling with closed organisational cultures and promoting employee voice, it is evident from continued failings (Kirkup; 2015; Gosport Independent Panel, 2018) that such policies have not been effective (Mannion & Davis, 2018). Indeed, I argue that post-Francis, the policy initiatives implemented by the government aimed at cultivating open organisational cultures and promoting employee voice have, for the most part, proven to be ineffective. According to Mannion & Davis (2018) although culture is often named as the primary culprit in healthcare scandals, taking such a basic approach relegates the depth and complexities associated with cultures within the Health and Social Care sectors. This approach was most evident in the failings detailed within the *Kirkup Report*, which Kirkup (2015) described as being 'reminiscent' of those specified by Francis (2013) two years earlier. Hence, there is a need to critically appraise such interventions and grapple with how effective they have been at bringing about change (Goodwin, 2019).

2.5.1 Policy level understanding of organisational culture

From my analysis, it is evident that the nature of culture detailed in each report is significantly different, as such, how can government responses claim to be useful if the cultures they are trying to address have manifested in such divergent ways. Such differences, according to Goodwin (2019) resulted in significant problems associated with how culture was deemed to have manifested within the organisations under investigation. Indeed, due to this generic understanding, emanating from the

post-Francis reports, critics (Mannion & Davis, 2018) would argue that such governmental responses have been oversimplified, and have approached as issue as complex organisational culture in a manner which does not allow for effective solutions to be had (Riley, 1982; Schein, 2010).

According to Goodwin (2019), academically, the concept of organisational culture is debated, and very much contested (Smircich, 1983); thus it may not be such a surprise that the above inquires have also approached the notion of organisational culture very differently. This difference in how the nature of organisational culture is characterised and understood, I argue is one of the key reasons why policy initiatives post-Francis (2013), have, for the most part, been ineffective.

Through my analysis, the way failure has been explained during the above investigations, although different, has at the policy level been generalised into a simplified notion of culture. Goodwin (2019) argues that the introduction of culture into the vocabulary used to explain organisational failure has provided an easy but ineffective way of portraying the problem to the public. The consequence of this basic understanding of organisational culture has been I argue that the subsequent policies geared towards solving the issues identified are not effectively equipped to deal with the true complexities associated organisational cultures, especially within the Health and Social Care context (Baylis & Perks-Baker, 2017). With several influential reports (Berwick, 2013; Keogh, 2013) all calling for organisational culture change, the government saw an evident need to establish open organisational cultures within Health and Social care organisations. Below I detail why specifically in relation to culture and voice these initiatives have been ineffective.

2.5.2 Ineffective implementation of organisational culture policy

From the perspective of Mannion & Davis (2018) calls for culture change within such organisations has become a common occurrence without any real critical insight into what this might entail. Although several initiatives such as steps to cultivate open and transparent working environments (DoH, 2014) and the statutory duty of candour (DoH, 2015) were introduced, failings blamed on closed cultures still occurred (Kirkup, 2015). According to Francis (2015), genuine cultural change is an important process, but one which takes time to cultivate and embed within an organisation. I argue that the policy agenda post-Francis aimed at bringing about wholesale culture change was unable to appropriately grapple with the size and complexity of Health and Social Care organisations (Baylis & Perks-Baker, 2017). Furthermore, the oversimplification of culture change and the lack of

practical consideration given to culture change within such policy documents has its argued (Mannion & Davis, 2018), perpetuated continued failings (Francis, 2015; Baylis & Perks-Baker, 2017).

Although the 'one size fits all' policy agenda (Baylis & Perks-Baker, 2017) recognised the issue of closed organisational cultures, I put forward the argument that the government has been unable to account for the organisational differences associated with national-level closed cultures (Killett et al., 2013a). It was this inability to account for organisational differences and establish open organisational environments which, I argue, caused continual failings in both the Health and Social Care contexts typified within the Kirkup Report. Kirkup (2015) suggests that the government initiatives which proceeded the Francis Report were indeed ineffectively implemented and thus did not bring about open organisational cultures, thereby contributing to the failings he investigated.

Most recently, the independent inquiry into organisational failings at the Gosport War Memorial Hospitals-Portsmouth Hospitals NHS Trust uncovered 'cultures of euthanasia' underpinned by a general belief in clinical freedom, and staff who were still unwilling to speak out (Gosport Independent Panel, 2018). Three years on from Kirkup (2015), and five years on from Francis (2013), arguably lessons on how best to cultivate open organisational cultures within the Health and Social Care context are still pervasive (Department of Health & Social Care, 2019). This latest report demonstrates I argue, the ineffectiveness of government policies aimed at culture change. Indeed, it is noticeable that all the above reports have also been unable to assess the extent to which culture change would bring about improvements. Although all such reports have called for culture change, a critical evaluation of the effectiveness of such changes is something which, thus far, is also lacking within the above reports (Mannion & Davis, 2018).

2.5.3 Ineffective employee voice initiatives

As well as the ineffectiveness of the programme to implement organisational culture change, it is possible to argue that initiatives aimed at promoting employee voice were also ineffective. In responding to the post-Francis Reports, the government initiated several policies such as a new whistleblowing policy, freedom to speak out principles and guardians and the removal of gagging clauses from employee contracts (Powell, 2015; NHS England, 2016a; Pyper, 2016). Such initiatives were aimed at bringing about open organisational cultures which the House of Commons Committee

responsible for reviewing complaints referred to as bringing about 'significant changes' in the development of open organisational cultures' (House of Commons, 2015). This viewpoint was also supported by NHS England (2016) and NHS England (2016) when commenting on culture change within the Health and Social Care service. After a detailed exploration of these policies, it is possible to take a contradictory position and argue that although such policies were seemingly positive, they were not effectively implemented.

An example of this can be found in the report conducted by Tingle (2014), which established that although employees were talking more about openness, transparency and candour, they still did not feel confident to voice themselves at work. Moreover, even though this consultation took place one year after the *Francis Report* and the government policy initiatives relating to employee voice, according to Tingle (2014), staff still felt unable to voice their anxieties to senior managers or voice their opinions. Such acknowledgements by staff, I argue, demonstrate the ineffectiveness of policies at the time in bringing about real change to the way employees voice themselves on the ground level. Allcock et al. (2015) put forward the perspective that such policies failed to bring about real change because of their lack of impact on the daily interactions between employees or group dynamics on the ground (Donaldson-Feilder et al., 2014). Rather, government initiatives such as DoH (2015a) instructing professional regulators to punish members who are not honest about errors with their patients were conceived, which were more likely to stifle employee voice.

With growing calls (Goodwin, 2019) to critically evaluate if indeed inquiries into organisational failings such as those detailed at the start of this chapter are actually having a positive impact on solving issues associated with culture, this analysis indicates that for the most part, they are not. Goodwin (2019) argues that over the past 20 years, a significant amount of time, expertise and money has been directed towards solving the issues of culture within the Health and Social Care context, yet still, failings occur similar to those who have come before (Kirkup, 2015). If this is the case, Mannion & Davis (2018) puts forward the perspective that questions need to be asked as to the extent to which people within such organisations want to bring about culture change. Thus far, efforts have been top-down, with little attention given to those tasked with bringing about culture change think it is a worthwhile endeavour (Pyper, 2014). Indeed, those wishing to bring about such change Mannion & Davis (2018) argue, would require a 'sophisticated understanding' of the context

within which the culture is taking place, further reinforcing the point made by (Baylis & Perks-Baker, 2017) as to the complexity of Health and Social Care cultures.

2.6 Distinctive characteristics of closed organisational cultures

In undertaking a review of the above reports into organisational failings, and the subsequent post-Francis reports, it has been possible to identify distinctive characteristics of closed organisational cultures which are both external and internal to Health and Social Care organisations (Francis, 2015). Such characteristics have also emerged from the literature, which has served to give us a better understanding of the external and internal characteristics of organisations which bring about closed organisational cultures. By exploring both groups' characteristics within the Health and Social Care context, I argue that it will be possible to fully understand the processes which lead to the formation of closed organisational cultures.

2.6.1 Characteristics external to the organisation

From a review of the literature, it is possible to identify the turbulent political and economic context which although existing externally to an organisation has a significant impact on closed organisational cultures within the Health and Social Care industries (Appleby et al., 2014; NHS England, 2018). I argue that the macro-level pressure put on organisations (Karwowski, 2019), contributes to their unwillingness to disclose information which may harm their funding or reputation. This was something Francis (2003) pointed to in the case in Mid Staffordshire when the management team was applying for foundation status. Additionally, the increased role professional bodies are being asked to play by the government in regulating their employees has also contributed to an environment in which employees are becoming more reluctant to speak out due to fear of punishment from both their employer and professional bodies (DoH, 2015a). Although these characteristics are external to the organisation, their impact is very much felt within the organisational environment; thus, they require our attention when attempting to understand the role of closed cultures within Health and Social Care organisations (Mannion & Davis, 2018).

2.6.2 Characteristics internal to the organisation

Internally, there exists what Flynn et al. (2014) have referred to as a 'cocktail' of factors which have contributed to the cultivation of closed organisational cultures. Issues around low pay

(Kingsmill, 2014), prolific turnover rates among health professionals (Dayan, 2017), and the continued rise in zero-hour contracts (Skills for Care, 2017) are just some of the internal characteristics which have contributed to closed organisational cultures within the Health and Social Care context. Although such characteristics can be seen as being varied, they do possess inter-linking factors which demonstrate the complexities associated with the understanding of organisational cultures within any context, especially one as diverse as Health and Social Care (Skills for Care, 2017; NHS England, 2018).

For the purposes of this study, explicit attention will be given to internal organisational characteristics, which the literature suggests contribute to the cultivation of closed organisational cultures (Francis, 2013). This focus is in keeping with the study's philosophical position and methodological stance, both of which I will detail in chapter four (Johnson & Duberley, 2015). In focusing on internal characteristics, I argue that it will be possible to link all identified internal characteristics to the cultivation of closed organisational cultures (Deal & Kennedy, 1982).

2.7 English Care Homes context

From a review of the literature, it is possible at this point to put forward the position that it is, in fact, the Social Care sector which requires the most political and researcher attention (NHS England, 2016b; Baird & McKenna, 2018; Thorlby et al., 2018). Furthermore, within this sector, it is possible to propose English care homes as organisational environments which are most disproportionately predisposed to the cultivation of closed organisational cultures (Skills for Care, 2017; Baird & McKenna, 2018; the King's Fund, 2019). Hence, this next section aims to explore the economic and political context of English care homes, and in doing so provide clarity on their characteristics which I propose have disproportionately predisposed them to the cultivation of closed organisational cultures.

2.7.1 English care homes

The English social care sector is comprised of several different services, with half of all social care services in England provided in care homes (Skills for Care, 2017; Baird & McKenna, 2018). This equates to 1.5 million people within the sector, demonstrating the vast nature of this sector (Skills for Care, 2017). Care homes are organisations that provide services predominantly for older adults

(Mackintosh, 2016; Baird & McKenna, 2018). Prior to the 1990s, care homes consisted mainly of small private for-profit operations, and Local Authority run provision (Baines et al., 2014a; Baines & Cunningham, 2015; Skills for Care, 2017). This is another of the significant differences between care homes and Healthcare provision in England, and one which is seemingly more profound within care homes as compared to other Social Care operations (Baird & McKenna, 2018). Indeed, the profit motive of care homes brings with it an additional layer of complexity when attempting to grapple with its culture (Baines et al., 2014a; Baylis & Perks-Baker, 2017). Since the 1990s, the landscape has changed significantly and is now predominantly comprised of a handful of large 'financialised' chain companies (Mulligan, 2014; Burns et al., 2016; Horton, 2019). This internationalisation of care homes and their overexposure to market forces has meant that the care home market remains very volatile. According to Mulligan (2014), it is the pursuit of high levels of profit through complex financial instruments which has exerted additional pressures on the care home market.

Although care homes make up around 50% of the social care sector, according to Skills for Care (2017) and Jarrett (2016), they account for 76% of the total number of jobs, indicating how important the care home industry is to the social care sector. Skills for Care (2017) and Jarrett (2016) both put forward the view that as the demographics of English society continue to change towards an ageing society (Argyle et al., 2017), the care home industry is projected to expand in scope and importance (Horton, 2019). More so considering the fact that the majority of residents consider the care home their permanent place of residence (Skills for Care, 2017) thus, as the sector continues to grow, the relationship care homes have with the market will become even more critical. Additionally, from an exploration of the literature on care homes, I argue that more research exploring important considerations such as the impact of organisational culture on employee voice is needed within this industry (Thorlby et al., 2018).

2.7.2 Economic context

At the economic level, governmental shifts towards the privatisation of care homes have, according to Burns et al. (2016), resulted in a large number over-exposing themselves to private debt (Karwowski, 2019), and sophisticated capital financing (Huws, 2012; Horton, 2019). Such financial instruments became more widespread during the austerity of 2008 and the subsequent governmental cuts to Local Authority funding (Baines & Cunningham, 2015; Costa-Font, et al., 2015;

Burns et al., 2016). This funding shortfall between the cost of delivering social care services and government payouts, according to Mackintosh (2016), was between £104 and £152 per week. It was this which Burns et al. (2016) and Mackintosh (2016) both pointed to as putting additional pressure on care homes to take on debt-based finance (NAO, 2014). The reliance on debt-based financing has impacted the industry according to Horton (2019), especially with the proliferation of larger-scale operators entering the industry, bringing with them a considerable amount of ‘financialised capital’ (Burns et al., 2016), geared only towards profitmaking (Jarrett, 2016; Horton, 2019).

With statistics from the Competition and Markets Authority indicating that more than 75% of Local Authority funded care homes are at risk of failure, the trend towards more privatisation, according to Thorlby et al. (2018), seems inevitable. This is likely to have an impact on those who call such care homes their home, and the impact such profit-orientated organisations (Karwowski, 2019) will have on the cultures which exist within such organisations, and the ability of their employees to voice themselves is thus far unknown. This is something which will be explored further during this study. From the above reports into organisational failings and the links made between failings and closed cultures, the need for more research on culture and voice within care homes is evident (NHS England, 2016a).

2.7.3 Political context

Politically, care homes have faced a turbulent time over the past decade, with a number of critical reports published on the delivery of care (Cavendish, 2013) and financial mismanagement (Burns et al., 2016). Political decisions to privatise the sector have meant that at the time of this review only 3% of care homes in England are owned by local authorities (Thorlby et al., 2018). The government’s decision to cut Local Authority budgets, especially after 2010, also led to cuts in spending within the sector (Thorlby et al., 2018). This, according to Cottell (2017), has meant that currently, there are over 4.2 million people aged 75 and over who live in areas with insufficient care provision. In addition, according to the King’s Fund (2018), there is a £1.44 billion funding gap in Local Authority spending on social care, which requires immediate attention. Such figures are in stark contrast to the healthcare context, which continues to receive a significant amount of political attention, and with that, financial support.

With Brexit set to disrupt an already fragile sector (Fahy et al., 2019), particularly in relation to the recruitment of care workers and nurses, the sector is set for more turbulent times ahead (Costa-Font, 2017; The Kings Fund, 2018). This perspective has been substantiated by The Carer (2019) who estimate that Brexit will affect at least 60,000 care sector workers, and polemically there could be 380,000 fewer social care workers by 2026. Despite political calls for enhanced care delivery within homes, Baylis & Perks-Baker (2017) puts forward the perspective that the political will and coordination needed to achieve such care provisions have thus far not been forthcoming. Moving forward, efforts must be made to highlight the importance of care homes and the need for greater research within the industry (Baird & McKenna, 2018; The Carer, 2019).

2.7.4 Characteristics of care homes which disproportionately predispose them to the cultivation of closed organisations cultures

From a detailed exploration of the English care home sector and the organisational factors which underpin its operations, it is possible to put forward the following perspective. Organisations which reside within the care home sector are characterised by distinctive features which when combined result in them exhibiting characteristics which, I argue, disproportionately expose such organisations to the possibility of developing closed cultures (Schein, 2010; Francis, 2013; 2015; CQC, 2015b). By detailing each of these distinctive features commonly found within care homes, and demonstrating how, from the literature and published reports, they could facilitate the cultivation of closed organisational cultures, it will be possible to substantiate this position. The exploration of these distinctive features or ‘wicked problems’ (Burns et al., 2013), it is argued, will provide an additional basis from which to justify this study’s aim to focus on investigating the role of organisational cultures on employee voice within the care setting (Chisholm et al., 2018).

2.7.4.1 Lack of leadership

From a detailed exploration of the literature into care home organisations, and reports into organisational failings, one of the key contributing factors of closed organisational cultures is the lack of effective and proactive leadership within care homes (Centre for Policy on Ageing, 2012; Havig & Hollister, 2018). Research by Miller et al. (2010) identified a lack of leadership as the most significant factor in efforts to bring about culture change, which Baylis & Perks-Baker (2017) agree with, commenting that effective leadership is important in influencing employees positively and shaping

care home environments. This is also the view of Weiss & Morrison (2018) who argue that proactive leaders also promote employee voice.

Scott et al. (2003b) and Lopez (2006) both put forward the perspective that within the care home context, a lack of effective leadership structures is to blame for the creation of an environment in which employees are unwilling to voice themselves. This, over time, leads to a situation in which employees not voicing themselves becomes the norm (Allcock et al., 2015). All of which reflects the research on leadership carried out by Havig & Hollister (2018), thus, I, therefore, put forward the argument that a lack of leadership is a significant influencer in the cultivation of closed organisations within care homes.

2.7.4.2 Low levels of professionalised roles

According to Killett et al. (2013b), care homes are known for having a very low skilled workforce which has resulted in workers having unspecific job descriptions which vary from one care home to the next (Humphries et al., 2016). This has resulted in an ever-increasing number of tasks becoming associated with care work which, as Baines & Cunningham (2011) argue, means roles cannot be specialised, thus reducing the quality of care provision being offered (Thorlby et al., 2018). As a result, the likelihood of mistakes is higher, and with a lack of any professional body providing oversight, such mistakes, particularly among care workers, go unreported (Baines & Cunningham, 2011; Moeini et al., 2019). Indeed, Francis (2015) acknowledged the role professional bodies play in cultivating open cultures among members and promoting the voices of members (Thompson, 2009). Hence, it is possible to argue that the low levels of professionalised roles within care homes do contribute to the cultivation of closed organisational cultures.

2.7.4.3 Inadequate qualification

One of the main reasons for the lack of professionalised roles within care homes, according to Dayan (2017) and Surr et al. (2019) is the lack of faith in employee qualifications within the care sector. This problem is not confined to care workers, since, according to Hasson et al. (2014); the quality of training given to nurses who work in care homes is also an issue. The disjointed nature of training systems has resulted in inadequate qualification within the sector according to Dayan (2017), which had also been perpetuated by substandard education and induction of new staff by care homes. Willis (2012), and Argyle et al. (2017) both argue that this has diluted the quality of training

and the skills possessed by care workers within care homes. According to Humphries et al. (2016), 37% of care home workers have no training when starting their jobs. This, coupled with the lack of accreditation (Skills for Care, 2016), has resulted in a lack of professionalism within care homes (Dayan, 2017).

According to Moeini et al., (2019), this lack of training was not limited to care, staff, managerial staff also require training, particularly in communication skills. A lack of quality training and qualifications (Surr et al., 2019) also means such staff are not educated about new policies relating to issues such as whistleblowing or voicing themselves within their organisations (Department of Health, 2015). Although steps have been taken within the social care context to address this issue post-Francis (Argyle et al., 2017), from the literature, it is evident that more is needed to educate frontline staff about employees to voice.

2.7.4.4 Low pay

It can be argued that the above characteristics have perpetuated what Cavendish (2013) and Jarrett (2016) both refer to as chronically low pay levels within care homes. According to Willcox (2017), frontline care workers are, for the most part, paid less than NHS workers, with earnings averaging at approximately £6.72 per hour (Skills for Care, 2017). With the above report by Kingsmill (2014) identifying that a large section of the workforce was being paid below the minimum wage, it is certainly the case that better pay helps to create a culture of feeling valued, which according to Thorlby et al. (2018) is closely linked to improved morale. According to Horton (2019), a significant contributing factor is the financialization of care homes which puts pressure on the pay of care staff to look after the interests of shareholders. With minimal financial incentives (Baines et al., 2014a), the likelihood of employees speaking out or risking their jobs by going against the care home is more unlikely than among employees with more financial security (CQC, 2018). Such closed organisation cultures of silence can then perpetuate a climate of fear that can become the norm within such environments (DoH, 2014).

2.7.4.5 Low social status/ morale

Another characteristic of closed organisational cultures prevalent within care homes is the low social status and morale of care staff (Horton, 2019), which Carr (2014) argued impacts on the calibre

of employees who are attracted to work within the care homes. According to Sinclair et al. (1993), organisational cultures come about as a result of social interaction between members of that organisation, which are influenced by external factors. This entails societies' perception of care work filtering through into, and to varying degrees shaping, the interactions members of the group have with each other, which would impact on group cultures (Smircich, 1983). With care work having low social status, this would inevitably influence how staff interact, and the subsequent cultures which emerge (Sinclair et al., 1993). The resulting low morale, Demos (2014) argues, leads to staff disengagement from the working environment, thereby impacting on the cultural dynamics of groups within care home environments. Over time, this would have a detrimental impact on efforts to create open working cultures (Demos, 2014; Schein, 2010), and according to Weiss & Morrison (2018) also impact on employee voice.

2.7.4.6 Staff turnover

According to The Carer (2019), the predictable knock-on effect of having such low pay and low social status within care homes is a level of staff turnover which is the highest within the social care sector, equating to approximately 27% of the workforce each year (Skills for Care, 2017). The most recent analysis by the King's Fund (2019) indicates that one in 11 care worker roles are currently unfilled. Such prolific turnover rates, according to Thorlby et al. (2018), create an enormous problem for care continuity, which has an impact on care quality (Killett et al., 2013b). Horton (2019) argues this issue has been catalysed by the financialization of the care industry and the fact that the industry now treats care works as being 'disposable'. According to Humphries et al. (2016), this has increased the competition among homes and the NHS to recruit the best quality care workers, with most going to the NHS due to better pay. Research by Skills for Care (2017) indicated that in the past 20 years, turnover rates have seen a year-on-year rise. This indicates that high turnover rates are a persistent problem within the sector which needs addressing (Dayan, 2017). Such prolific turnover rates limit the ability of groups within care homes to create commonly held assumptions as large numbers of the group are continuously leaving, thus establishing strong open cultures also becomes more difficult (Davies & Mannion, 2013).

2.7.4.7 Agency staff reliance

The persistently high turnover rates detailed above lead to chronically low staffing levels, which Kennedy (2014) argues has become the norm within some care homes. According to Pyper & McGuinness (2013) and Skills for Care (2017), this has caused an increased reliance on zero-hour contracts, thus increasing the number of part-time workers within care homes. Such high numbers of part-time staff is something which Griffiths et al., (2017) refers to as a false economy in that it inflates the true numbers of workers within the sector. Pyper & McGuinness (2013) see this as giving rise to the increased reliance of care homes on agency staff. According to Thorlby et al. (2018), this is a problem which is of particular significance within care homes. Such staff, for the most part, do not know the residents they are working with or the cultural norms of the organisation and group functionality becomes disrupted over time (Pyper & McGuinness, 2013). Because agency staff do not have any lasting ties with the care home, incentives to voice out are very limited, thus further perpetuating silence within such organisations, and in doing so, contributing to the perpetuation of closed cultures (Francis, 2015; Surr et al., 2019).

2.7.4.8 Low skilled migrant workforce

Statistics provided by Skills for Care (2017) indicate that the care home sector of the social care industry has a disproportionately high level of low skilled migrant workers compared to other Health and Social Care sectors. Such workers originate from cultures in which employee voice at work is not a priority or desirable, which according to Simonazzi (2009) may affect the culture on employee voice within an organisation. That is, if a large number of employees are from cultural backgrounds in which voicing themselves is not socially accepted, doing so within an English care home setting would also be difficult, especially if a number of such employees work within the same organisation and establish such assumptions within their new working environment (Schein, 2010). The Centre for Policy on Ageing (2012) put forward the perspective that the cultural background of staff is a significant barrier to their willingness to voice out, which therefore contributes to closed organisational cultures.

2.7.4.9 Union membership

Low levels of trade union membership within the care homes according to Skills for Care (2017) means that a significant proportion of employees do not have any external body to represent them if they are having a dispute with their organisation (Royal College of Nursing, 2013; Skills for Care,

2017). This lack of unionisation, coupled with the fact that a large majority of health care workers are not professionalised, results in union membership among workers in care homes being significantly lower than among their healthcare counterparts (NHS England, 2018). A lack of collective voice, I argue, would have an impact on how employees choose to voice themselves within their organisation if they do not have a support base to fall back on (Francis, 2015). I, therefore, argue that low union membership among this group of workers has contributed to closed organisational cultures within care homes as it is one less avenue from which to voice.

2.7.5 Combined characteristics of care homes

From an analysis of the distinctive characteristics of care homes which I argue predispose them to the cultivation of closed organisational cultures, it has emerged that such characteristics are not standalone units, but rather part of an interconnected system. As such, within the care home context, there is a tendency for these homes to have a combination of the above characteristics at any one time (Killett et al., 2013a; Skills for Care, 2017; Thorlby et al., 2018). Indeed, a close analysis of the sector indicates that it is commonplace to have care homes with a combination of the above characteristics, thus the possibility that they possess a culture that stifles employee voice, I argue, is increased (Francis, 2015; age UK, 2018; Baird & McKenna, 2018).

The impact of such combined characteristics would be felt at all levels of the organisation (Davies & Mannion, 2013), and influence all elements of care home life, including the ability and willingness of employees to voice themselves (Demos, 2014; Burns et al., 2016). I, therefore, argue that it is essential not only to identify these characteristics but also understand how they link together within care homes. From this position, it is possible to put forward the perspective that it is the combined nature of such characteristics which is ultimately responsible for care homes being disproportionately predisposed to the cultivation of closed organisational cultures. In contrast, other Health and Social Care organisational contexts may have some of the above characteristics, but based on the literature do not tend to possess as many as care homes and thus are less likely to manifest the outcomes of such combined characteristics.

2.7.6 Analysis of 25 'inadequate' CQC care homes

To further substantiate this position, I undertook a content analysis of CQC inspection reports into 25 English care homes classified by CQC as being 'inadequate' (CQC, 2016). This analysis explored the connections between the characteristics detailed above, and the reason why these 25 care homes failed their inspections, all of which have been detailed in *appendix one*. Through my analysis, links were found between the above characteristics and the reasons the care homes were deemed inadequate by CQC.

For example, among the five care homes that failed their inspection based on their service not being safe, a lack of staff in the homes was a key trend to emerge from all five care homes (*see appendix one*). According to Kennedy (2014), care home recruitment levels are among the lowest in the care industry, which has been catalysed by chronically low pay within the (Cavendish, 2013). In the one instance in which staffing was deemed to have been adequate, it later emerged that it was an agency staff who was not training for delivering the type of care required. This, I argue, links back to the low skilled workforce and reliance on agency staff within care homes as detailed above (Skills for Care, 2017).

There was a similar situation with the five care homes which failed due to their service not being effective (CQC, 2016). Staff working over their shift hours to cover shortfalls (The Carer, 2019), a lack of ongoing supervision from management (Humphries et al., 2016), and a lack of quality service were among the reasons why these care homes failed (Dayan, 2017). In relation to the care homes which failed due to their service not being well-led, the prolific turnover of management staff (the King's Fund, 2019), poorly maintained working environments perpetuated by a lack of leadership (Allcock et al., 2015), and a lack of morale among staff (Carr, 2014) were the reasons given for these care homes being deemed inadequate by CQC (2016).

Through my analysis, it is possible to argue that all of the reasons for the above care homes being deemed inadequate by CQC (2016) can be directly linked back to the characteristics of care homes which disproportionately predispose them to the cultivation of closed organisations cultures. The abilities of such care homes to 'unlearn' (Robyn, 2019) such characteristics are over time and cultivate open cultures are unknown. This being so, it is possible to argue the position that care

homes provide an appropriate organisational context in which to conduct a study which focuses on better understanding the influence of organisational cultures on voices of employees (Schein, 2010; Morrison, 2011), and the role closed organisational cultures play in limiting those voices and contributing to the care home failings detailed above (Francis, 2015; CQC, 2016).

2.8 Summary

From an analysis of the literature relating to the English Health and Social Care sectors over the past decade, this chapter has been able to gain a better understanding of the role that closed organisational cultures (Francis, 2013) and a lack of employee voice (Francis, 2015) played in failings which have plagued both sectors (Berwick, 2013; Clwyd & Hart, 2013; Demos, 2014). Through an analysis of the post-Francis Reports, and the government responses to these reports, I argued that policy initiatives aimed at addressing closed organisational cultures and promoting employee voice were for the most part ineffective (Pyper, 2016; Baylis & Perks-Baker, 2017). Among other reasons, the understanding of the nature of organisational culture at the political level has been ill-equipped to appropriately address culture change in practice (Mannion & Davis, 2018). I further argued that it is necessary to move away from the 'one size fits all' simplistic policy agenda (Baylis & Perks-Baker, 2017) which had led Kirkup (2015) to describe his findings as being 'reminiscent' of the failings detailed by the Francis Report (2013) two years earlier (Goodwin, 2019).

Through the analysis of the specific characteristics that led to the failings in both Health and Social Care organisations, I identified care homes as possessing characteristics which I proposed disproportionately predisposed them to the cultivation of closed organisations cultures (Baines & Cunningham, 2011; CQC, 2016; Skills for Care, 2017). My subsequent analysis concluded that it was the combination of these characteristics within a care home setting which contributed most to the cultivation of closed cultures. Furthermore, my analysis of 25 failed care homes indicated that the reasons underpinning their failure were all linked to the characteristics I had previously identified (CQC, 2016; Baird & McKenna, 2018; the King's Fund, 2019). Hence, moving forward, the focus of this study will be to explore the influence of organisational cultures on employee voice within the care home context (Schein, 2010; Morrison, 2011).

Chapter Three

Organisational culture and employee voice

3.0 Introduction

This chapter aims to further our understanding of organisational cultures and employee voice by exploring their origins and debates within the management literature. Through a review of the literature, I will establish my position on organisational culture and employee voice, which I will argue both complement my philosophical and methodological stance (Johnson & Duberley, 2015; Schein, 2010). Concerning organisational culture, I will detail the different approaches to organisational culture within the management literature before focusing on culture within care homes both nationally and within the international arena. At this point I shall detail my decision to employ the organisational culture model proposed by Schein (1984; 2004; 2010), and the principles which underpin this model and argue why its an appropriate model for exploring care homes.

On the concept of employee voice, I will highlight the factors within the literature that influence employee voice within the care home context. By examining my position on organisational culture and employee voice, I shall identify voice culture as being the critical element of investigation within this study. Finally, through a review of the literature, it will be possible to highlight the research gaps which my research questions aim to bridge.

3.1 Defining organisational culture

The concept of organisational culture, according to Davies et al. (2000) and Schein (2004), has its origins within the anthropological literature. The term 'organisational culture' first appeared in the academic context-specific around 1978, since then, the concept has become a widely used terminology which, within different disciplines, has taken on an array of meanings (Smircich 1983, Davies et al., 2000, Schein, 2004). The ramifications of such diversity in perspectives mean its application is very much context-specific, thus making the concept of organisational culture very difficult to generalise across or even within disciplinary lines (Hatch 1993; Scott et al., 2003b; Dixon-Woods et al., 2014). Within the management context, Schein (2004) describes organisational culture as an abstraction which is pervasive. On this which basis, I argue that our ability to understand better this 'pervasive' concept will subsequently allow for a better understanding of the influence cultures

have on employee voice within the care home context (Schein, 2004, p. 8; Adelman, 2009; Francis, 2015).

In relation to specific definitions of organisational culture, the plethora of positions held within the management literature (Deal & Kennedy, 1982; Arogyaswamy & Byles, 1987; Hofstede, 1998; Sinclair et al. 1993; Davies et al. 2000) means there is a host of differing definitions. For example, from the perspective of Deal & Kennedy (1982), organisational culture represents the social glue which binds an organisation together, providing members with formalised rules about organisational expectations. Arogyaswamy & Byles (1987), meanwhile, argue that organisational culture centres on the existence of implicit, shared and transmittable understandings regarding values and ideologies at a point in time of any organisation.

Although there exists a host of differing definitions on organisational culture, for the purposes of my study organisational culture is

‘a pattern of shared basic assumptions that have been learned by a group as it solved its problems of external adaptation and internal integration. Such solutions have subsequently worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems’ (Schein, 1984; 2004, p. 17).

I put forward that this definition gives clarity on the position this study will take, which is important when undertaking fieldwork (Schein 2004). Scott et al. (2003b) explore this in detail and comments on the far-reaching consequences associated with the way a researcher chooses to define organisational culture for any subsequent study. Hence, such definitions must complement all other components of any study, such as the philosophical, methodological and analytical process, which is something I argue this definition does (Smircich, 1983; Scott et al., 2003b). Indeed, according to Goodwin (2019), culture is defined within the healthcare field as the ‘prevailing beliefs, values, assumptions and attitudes of a community, and their translation into patterns of behaviour, organisational routines and rituals’. I put forward the view that such a definition aligns itself with the definition this research study aims to draw on.

According to Schein (2004), his definition suggests that our ability to understand the processes that establish an organisational culture is of the utmost importance if the culture of an organisation is to be genuinely understood (Schein 1984; 2010). Due to the complexity of the research context of care homes (Baylis & Perks-Baker, 2017), an approach that allows for a real understanding of an organisations culture is of particular importance. The inter-related stages approach put forward by Schein, I argue, does this, and therefore provides an appropriate tool with which to analyse organisational cultures within care homes.

3.1.1 The contested nature of organisational culture

Picking up on the notion that the concept of organisational culture commands a plethora of differing positions, through my review of the literature, two competing schools of thought on the fundamental nature of organisational culture have emerged (Smircich 1983; Bate, 1984; Allaire & Firsirotu 1984; Schein, 2004; Mannion & Davis, 2018). These competing schools of thought may seem on the surface to have minimal differences in their approach to organisational culture, but in practice (Bate, 1984), have a significant impact on how organisational culture is researched within any organisational context (Smircich, 1983; Scott et al., 2003b). It can be argued (Goodwin, 2019), that the contested nature of organisational culture played a significant role in the inconsistencies associated with how the inquires detailed in chapter two went about exploring organisational culture. Consequently, it is essential not only to explore both schools of thought but to justify the position which this research takes and highlight the impact of this decision on the study.

3.1.1.1 Organisational culture as a root metaphor

One school of thought regards the role of culture within an organisation as something which defines the whole character of an organisation (Smircich, 1983; Whelan, 2016). As such, according to Mannion & Davis (2018), within this school of thought, culture is something an organisation is. Within this perspective, according to Davies et al. (2003), cultures can be seen as existing in, and reproduced through, the social interaction of members of that organisation (Sinclair et al., 1993). This school of thought represents what Riley (1982) and Scott et al. (2003b) see as the interpretive approach to organisations, in which organisations are seen as being a culture, thus representing the manifestations of members' consciousness. It is this consciousness which produces the cultures and

because they have emerged from human consciousness Smircich (1983) argues that they cannot be readily manipulated by management.

According to Smircich (1983), there are three main streams within this school of thought. The cognitive perspective stream approaches organisational culture as a system of shared knowledge and beliefs among members of a group (Agar, 1982). From the perspective of those who approach organisational culture symbolically, culture is a system of shared meaning which through the interpretation of themes can be realised by a researcher (Hallowell, 1955; Manning, 1979). And from the third stream, which is the perspective of structural and psychodynamics, culture is a manifestation and expression of the mind's unconscious operation (Rossi & O'Higgins, 1980). Culture within this perspective would be researched through the realisation of people's unconscious manifestations so as to reveal their hidden mindset, thus giving an insight into the culture they are part of (Turner, 1977; Manning, 1979).

The above streams all encompass what Smircich (1983) refers to as a belief in culture being a root metaphor, and that being so, would see organisations as an expression of those within it and society. Hence, a researcher's agenda within this school of thought would be to interrogate how organisational cultures come into being, and what that means for the organisation (Smircich, 1983). Taking this perspective on organisational culture, it is argued, would provide insights into how employee voice is realised and understood, but it would not be able to enhance our understanding of the relationship between employee voice and organisational culture or enable us to identify the organisational characteristics which facilitate both open and closed cultures. From this analysis, it is evident that the position taken by this school of thought does not complement or align with my agenda for this study, which according to Smircich (1983) and Burrell & Morgan (2016) is important when conducting research.

3.1.1.2 Organisational culture as a critical variable

The second school of thought approaches organisational culture as something an organisation has (Mannion & Davis, 2018). Thus organisational culture is an attribute which can be associated with an organisation (Allaire & Firsirotu 1984, Davies et al., 2000). Burrell and Morgan (2016) would place this position within the functionalist stance on organisational culture and regard organisational culture as

akin to other organisational attributes such as the structure (Riley, 1982). This means that it is possible to subsequently isolate, describe, and manipulate such attributes to meet the needs of an organisation (Barley, 1983; Davies, et al. 2003). If culture is something an organisation has, then it becomes a variable and, according to Smircich (1983), there are two streams when it comes to perceiving culture as a variable. The first sees culture as an independent variable, and the second as an internal variable.

According to Smircich (1983), when culture is treated as an independent variable, it is imported into the organisation through the membership as a result of their actions and attitudes (Slocum, 1971). Approaching organisational culture in this way would, according to Smircich (1983), lead to exploring factors associated with organisational effectiveness which is of significant interest to multinational organisations.

When organisational culture is perceived as an internal variable, there is a recognition that organisations are culture-producing organisms, and social instruments which produce distinctive internal cultural artifacts such as rituals, legends, and ceremonies (Deal & Kennedy, 1982; Tichy, 1982; Smircich, 1983). An analysis of these two streams indicates that they differ significantly in terms of their perspective on organisational culture, which would have ramifications for any subsequent study (Burrell & Morgan, 2016).

3.1.1.3 Organisational culture as an internal organisational phenomenon

For the purposes of this research study, I will adopt as an internal variable the position that organisational culture is something an organisation has. As such, an organisation's culture can be realised through the objective exploration of others' inter-subjectivity (Cummings & Schmidt, 1972; Davis, 1981; Deal & Kennedy, 1982; Schein, 1985). This stream acknowledges that subjective interpretations by workers can influence how such workers go about functioning, but the emphasis of investigation within this stream is on the elements which develop within organisations. This emphasis aligns itself with the emphasis of this study, its agenda, philosophical and methodological positions (Riley, 1982; Smircich, 1983; Allaire & Firsirotu, 1984).

This alignment, I argue, not only furthers the robustness of the study, but it will also allow for patterns and informal relationships within the care home context to emerge (Smircich, 1983; Schein,

2010; Nevalainen, M. et al., (2018). In the previous chapter, a critique of government policies aimed at cultivating open cultures and promoting employee voice was undertaken. On that basis, it is only right that the outcome of this study offers ways forward in efforts to improve policies on establishing open cultures and promoting employee voice within the care homes. With this in mind, the chosen position on organisational culture for this study, I argue, allows this agenda to be fulfilled (Blumer, 1954; Riley, 1982; Smircich, 1983).

3.2 Culture in care homes

From an analysis of the literature in chapter two, and further exploration of the contested nature of culture at that start of this chapter, it has become evident that care homes offer a unique environment in which to explore organisational culture (Mannion & Davis, 2018).

In relation to care homes, qualitative research scholars over the years have recognised the need to adapt conventional approaches to accommodate what Thorne et al. (2016) see as a unique environment. Thus, it is essential not to simply accept generic definitions of organisational culture evident within the management literature when attempting to understand this phenomenon within care homes. From an examination of the literature, it has become apparent that a fully formed definition of culture-specific to care homes represents a gap in the literature (Phelps & Campbell, 2012; Aveyard, 2014).

Definitions of culture have been forthcoming within the healthcare context, with authors such as Mannion & Davis (2018), putting forward the notion that culture within healthcare context centres on the concepts of embedded and accepted care pathways, clinical practices, and communication patterns. Such thoughts are generalised by Mannion & Davis (2018) under the umbrella of “the way things are done around here.”, which offers an all-encompassing perspective on culture within the healthcare context. This approach to culture mirrors that of Goodwin (2019), who defined culture within the healthcare field as the ‘prevailing beliefs, values, assumptions and attitudes of a community, and their translation into patterns of behaviour, organisational routines and rituals’. I argue that such a definition aligns itself with the definition this research study draws on. Additionally, it furthers the idea that such definitions are intended to capture the full breadth of a healthcare operation, thus not leaving any room for the possibilities of subcultures.

3.2.1 Justification for researching culture in care homes

Although the above definitions do offer an insight into culture within the healthcare context it is the case that our understanding of culture within the care home context is thus far, limited (Phelps & Campbell, 2012; Aveyard, 2014). Moreover, and building on chapter two in which I proposed that care homes are disproportionately predisposed to the cultivation of closed organisational cultures, I argue that if this is the case, research to understand cultures within care homes better is a worthwhile endeavour (Baird & McKenna, 2018; the King's Fund, 2019). This is especially the case, as we continue to see more research and political attention focused at the healthcare context, further limiting our ability to explore context phenomena such as cultures within care homes (Thorlby et al., 2018; the King's Fund, 2019).

Furthermore, I argued in chapter two that one of the major reasons why governmental policy initiatives have failed to bring about culture change despite continued failings is that they were unable to effectively account for the micro-level aspects of an organisation's culture (Schein, 1983; Donaldson-Feilder et al., 2014). Additionally, I argued that the oversimplified approach the government took in its attempts to understand an issue as complex as organisational culture did not allow for effective solutions to culture change to be had (Riley, 1982; Schein, 2010). If this is the case, and it has previously been established that the literature is thus far limited on the micro-level aspects of a care homes culture, I argue that efforts to bring about culture change within care homes will remain a problematic area.

Consequently, I put forward the argument that as the environment most predisposed to the cultivation of closed organisational cultures (McKenna, 2018; the King's Fund, 2019) our ability to better understand cultures within the care home context is of the utmost importance. Indeed, due to the distinctive characteristics of care homes detailed in chapter two, it is possible to argue that micro-level considerations associated with cultures may be unique to care homes. This provides due justification as to why this study will focus on the influence of care home cultures on employee voice and not other forms of cultures (Thorlby et al., 2018; The Carer, 2019). Thus, conducting research which is specifically focused on culture within the context of care homes would contribute to our understanding of care home cultures and help bridge a gap in the literature.

3.3 The role of care home organisational culture in the international context

In the US, a broad movement seeking change in the culture of nursing homes emerged in 1997 with the establishment of a professionals' network to promote resident-centred care (Banaszak-Holl et al., 2013). This movement gave momentum to a body of research that has grown over the years to develop several frameworks for understanding care home cultures (Frey et al., 2015). This "culture change movement" (Miller et al., 2013; Frey et al., 2015) aimed to deinstitutionalise the nursing home environments move them more to an individualised person-centred approach. Underpinning this approach was a desire to create a system which better valued its employees and flatten the hierarchical structures which were prevalent within such organisations (Miller et al., 2013). From the late 1990s, the principal aim of this movement was to go beyond superficial changes and implement fundamental changes within nursing homes in America (Rahman & Schnelle, 2008). From its inception, there were differences in approach, but essential principles such as empowering frontline staff and residence were considered fundamental aspects of the culture change movement (Chapin, 2010).

To bring about such change, there have been moves over the years to increase the involvement of residents in care initiatives and give staff more power and establish managerial approached which accommodate collaboration and decentralised decision making among others (Rahman & Schnelle, 2008; Banaszak-Holl et al., 2013; Miller et al., 2013). According to Banaszak-Holl et al. (2013), culture change initiatives propose to improve care by addressing the lack of managerial supports and prevalent stressful work environments in the industry. Chapin (2010) puts forward the perspective that it was the over-institutionalisation of the eldercare industry, which catalysed this moment as it recognised the need for culture change. Tyler et al. (2014) argued that such changes encompassed both physical and organisational changes. According to Tyler et al. (2014), physical changes to the environment of nursing homes constituted steps such as removing visible single of authority like nursing stations. Organisational change on the other hand according to Tyler et al. (2014), was geared towards a fundamental shift in the way care was delivered within such organisations, primarily through the cultivation of a 'homelike feel' within care homes.

3.3.1 International approaches to organisational culture

Within this body of work, the predominant approach to culture is from a philosophical position that it is a critical variable; thus, it can be manipulated and changed (Mannion & Davis, 2018). Such approaches to care home cultures do not account for the complex ground level environments in which cultures manifest (Riley, 1982; Schein, 2010). The central strand of the approach centres on the notion that organisational culture is a fully manipulatable attribute of an organisation (Allaire & Firsirotu 1984, Davies et al., 2000). This might go some way to explaining the methodological approaches which are normally deployed when exploring culture within such contexts, which tend to be large scale quantitative or mixed methods, focusing on large sample sizes such as surveys (Miller et al., 2013).

To explore culture change issues, this movement has over the years, drawn on several culture change models to further their investigations. Models such as the Eden Alternative, Resident-Directed Care, The Regenerative Community, Restraint-free/Individualized Care and The Household Model (Chapin, 2010; Banaszak-Holl et al., 2013). From the perspective of Chapin (2010), the main aim of these approaches was to increase residence involvement and cultivate a feeling within such organisations that everyone, including staff, is an integral part of the company. According to Banaszak-Holl et al. (2013), such methods have been effective at bringing about radical change within nursing homes and driving the culture change movement.

Despite this, authors such as Rahman & Schnelle (2008) have drawn our attention to the fact that culture change interventions are not without their limitations, pointing to their mostly untested evidence of success after the methods have been deployed within nursing homes. Such evidence Rahman & Schnelle (2008) argue, have a tendency to generalise information which was captured at only one timepoint, thus not accounting for the continuous nature of organisational cultures, particularly within complex environments such as nursing homes (Mannion & Davis, 2018). Additionally, this lack of rigorous oversight has resulted in an environment in which unproven innovations and approaches to culture change have been deployed within a large number of these organisations, which Chapin (2006) argues does not account for the unique characteristics needs of nursing homes. Rahman & Schnelle (2008) argues that the implementation of such innovations would have brought no positive results but would have wasted a significant amount of money and time.

Culture change research within this movement has though, brought forth some crucial insights according to Banaszak-Holl et al. (2013), whose study found that market-focused cultural values were the predominant culture within the industry. This could be seen as reflecting the English care home sector, which is also very much market-driven, and heavily reliant on financialised capital (Burns et al., 2016; Hulse et al., 2019). Culture change research in this area has also highlighted the importance of stakeholders in planning and decision making, and the need for context-specific training initiatives targeted at specific staff within nursing home organisations (Rahman & Schnelle, 2008). All of this is welcomed and indicates that within the international context, the culture change movement in nursing homes, especially in America, has contributed to our understanding of culture within this context. Within the English care home context though, such in-depth exploration of organisational culture remains limited, especially from the vantage point of understanding the influence of care home culture on employee voice.

3.4 Schein's theory of organisational culture

To this end, this study aims to draw on the model of organisational culture put forward by Edgar Schein as the framework with which to investigate the influence of organisational culture on employee voice within care homes (Schein, 1985; 1991; 2016). After exploring the international context, it is evident that there exist numerous culture change models which could have been deployed for this specific study (Chapin, 2010; Banaszak-Holl et al., 2013; Miller et al., 2013; Frey et al., 2015). Indeed this body of work (organisational culture movement) has conceptualised organisational culture in a specific way, but this study will approach it with the use of Schein's theory on organisational culture. Primarily, this is due to the fact that this study does not seek the formation of new models or innovations which would be deployed within other care homes (Chapin, 2010; Frey et al., 2015). Neither does it seek to change the culture within the care home researched (Miller et al., 2013). The aim of this study is to better understand care home voice cultures, that is, the relationships between care home cultures and employee voice. Thus, the deployment of Schein's theory on organisational culture has been deemed to be the most appropriate for this endeavour.

3.4.1.1 Characteristics of Schein's approach to organisational culture

Schein's approach to organisational culture is underpinned by four fundamental characteristics which, Schein (2004) argues, provide the scope needed to effectively explore the complexities associated with any organisational context. The first characteristic put forward by Schein (2004) relates to the notion of culture as having structural stability. This refers to the processes needed for interactions and sharing amongst a group of people to occur within an organisational context (Wilkins & Ouchi, 1983; Schein, 2010). Structural stability is an important component in the process of transmitting ideas and the transmission of what Wilkins & Ouchi (1983) refer to as historical information about the group to new members (Schein, 2010). This perspective is in line with the characteristic of culture put forward by Bate (1984) when highlighting the importance of shared patterns of behaviour followed by members, which points to the collective nature of culture, that is, the unification of a collective group through a shared purpose.

Schein also details culture within organisations as existing as a taken for granted element of that organisational environment, thus being enacted subconsciously without actors being aware of doing so (Schein, 2010). These characteristics highlight what Schein views as culture being a normalising force within working environments; hence, it is difficult for actors to consciously reflect on which actions reproduce that organisational culture because the processes of that group's culture have become normalised to its members. From the perspective of Francis (2015), such norms brought about closed cultures in which employees voicing out was seen as going against the norms of the organisation, which ultimately resulted in preventable deaths.

The third characteristic explored by Schein (2010) centres on the notion that after its development, the proceeding culture covers all aspects of the group's functioning, thus the established culture governs all group actions within that organisational context. This is something which Harrison (1972) would refer to as an organisation's ideology and can be seen as going beyond the unconscious elements of the last characteristic. This is because such ideology includes distinctive elements which give individual members a sense of belonging to a specific group. This would extend to other elements of the organisation, such as rituals and values, which integrate into a whole coherent organisation (Tichy, 1982; Schein, 2010). Kirkup (2015) noticed this phenomenon while compiling his report and blamed the 'lethal ideological culture' at Trust for the resulting deaths.

The last characteristic centres on the notion that an organisation's culture is a product of social learning and is perceived by Schein (2010) to be the most important. This idea is reflected in Schein's definition of organisational culture in which there is an emphasis on the importance of 'shared assumptions learned by a group' (Schein, 2004). Bate (1984) reflects this position by characterising the establishment of organisational cultures as being transmitted by the process of socialisation. Indeed, a closer analysis of Schein's definition shows how important the notion of social learning among group members is within this definition, for the establishment of cultures (Schein, 2010). What has become evident from an analysis of the four characteristics put forward by Schein (2004) is that there is a strong overarching perspective from Schein that the establishment of organisational culture is something which happens over time and through a process of learning. This may go some way to explaining the ineffectiveness of the government's policies on organisational culture change post-Francis (2013), but also giving us a greater insight into what to expect when researching care homes.

3.4.2 Schein's three levels of organisational culture model

Schein's approach to organisational culture is underpinned by his *three levels of organisational culture* model, which I argue represents the most robust model from which to critically investigate the influence of organisational cultures on employee voice (Schein, 2010). This is a view shared by Scott et al. (2003a), who refer to this model as being the most useful framework for cultural analysis. Schein's model centres on the notion that organisational culture is very complex and its exploration requires some different levels of analysis (Barley, 1983; Schein, 2004). Only after one has been able to appropriately analyse the elements of an organisation's culture, which reside at each level, is it possible to establish a good handle on the nature of the culture which makes up any organisation (Scott et al., 2003a). To this end, the three levels approach of Schein's model is specifically geared towards allowing for a detailed analysis of cultures within organisations such as care homes (Schein, 2004; 2016; Griffiths et al., 2017).

3.4.2.1 Artifacts level

According to Schein (2004), the level of the artifacts represents the visible structures of a group's culture, such as the climate of the culture within which a group resides. Such examples include language and environment (Gregory, 1983). Schein (1984) posits that although this level of a group's

culture is easy to observe, it is very difficult to decipher and make accurate interpretations of the actors' meaning behind their actions.

Indeed, being able to observe something does not automatically enable you to be able to understand its meaning from the perspective of those who are enacting it (Schein, 2010).

As Smith & Simmons (1983) and Schein (1984) both explain, it is problematic to base one's understanding of a specific culture simply on the observable artifacts. Rather, only through investigation over a prolonged period of time within a specific organisational environment is it possible to attain an accurate understanding of a group's culture, which is an aim of this study.

At the level of the artifacts, observable characteristics of the environment would include such as the physical and behavioural actions of members of the culture (Schein, 2004). Within the care home setting, these may include such diverse issues as dress codes for different members of staff which are used to differentiate position or seniority (Carr, 2014). Standard ways of running services and the steps which are followed in this process or methods of performance assessment or delivering care to patients, all of these may differ according to the cultural characteristics of that specific care home organisation (Schein, 2004; Willis, 2012). Davies & Mannion (2013) argue that the most visible manifestations of the artifacts level of Schein's model would relate to such as the physical layout of a building, staff rotas, dress codes and the process for handling residents.

3.4.2.2 Espoused beliefs and values

To achieve a deeper level of understanding of any care home's organisational culture, it is important to analyse the espoused values, norms, rules and goals that provide the day-to-day operating principles by which members of the group guide their behaviour (Schein, 2004). One of the key elements of the espoused beliefs and values level, according to Schein (2004), is the notion that it is based on the process of social validation. That is, the confirmation of shared beliefs and values through shared social experiences, whilst those who do not conform run the risk of being thrown out of the group (Schein, 2010). This element takes us back to the fourth characteristic of organisational culture put forward by Schein (2010) when commenting about the social learning nature of an organisation's culture.

According to Schein (2004) and Davies & Mannion (2013), the beliefs and values at this conscious level will predict much of the behaviour that can be observed at the artifacts level. Despite this, there is an acknowledgement by Schein (2004) that this prediction may not always be in line with what members of a culture do. For example, a care home may say that it values its residents and that it has the highest standards of care provision, but its CQC report in that regard may contradict what it says. Espoused beliefs only come about if solutions to a specific problem work reliably over time; then they are transformed into assumptions as mentioned in Schein's definition of organisational culture. Espoused beliefs can be contradictory in that they may claim to do things which oppose each other. In the care industry, this may be the provision of the highest quality care at the lowest cost (Skills for Care, 2017).

3.4.2.3 Basic underlying assumptions

To get to that deepest level of understanding of an organisation's culture and decipher the patterns of behaviour of members, an analysis of culture must delve deep into the basic underlying assumptions of that culture (Smith & Simmons, 1983; Schein, 1983; 2016). Such assumptions, according to Schein (2004), are the taken for granted solutions to problems within a specific group; such solutions have themselves become part of that group's non-debatable reality; thus they become very difficult to change (Riley, 1982; Schein, 2016). Schein (2004) argues that to be able to understand the culture within an organisation, it is important to understand the basic assumptions which govern that specific culture; by doing so, it will be possible to understand the other levels of a group's culture (Smith & Simmons, 1983).

Only after this has been achieved is it possible to gain an understanding of the deeper levels of a group's culture. According to Sinclair (1993), the emergent patterns of an organisation's culture are a learned and shared set of responses to the environment that have become deep-seated. According to Schwartz & Davis (1981), it is very difficult to change the culture of an organisation because if the observed characteristics are as a result of the group's culture, then such characteristics are rooted in deeply held beliefs and values. This being so, calls for culture change within the care home context from reports such as Willis (2012) and Demos (2014) and the top-down policy initiatives introduced by the government post-Francis have, it is argued, all been ineffective at bringing about change

because they have been unable to influence deep-rooted assumptions within such organisations (Schein, 1983; Baines & Cunningham, 2011).

3.4.3 Subcultures

With Schein's (1984) definition of organisational culture underpinned by the notion that culture is formed through differing groups, it is important at this stage to explore the literature relating to the formation of multiple cultures. From its origin in sociology and anthropology, the concept of organisational subculture has been associated with groups with common characteristics embedded in a set of shared norms and beliefs, which, for the most part, are not intentionally formed (Trice & Beyer, 1993; Davies et al., 2000; Killeth et al., 2012). The complexity associated with subcultures is reflected by Boisnier & Chatman (2002), who detail subcultures as being as diverse as the range and variety of existing organisational cultures. This characterisation of subcultures reveals how important it is to consider their existence and complexity within the context of care homes (Scott et al., 2003a; Mannion & Davis, 2018).

Within the management literature, researchers have adopted two broad positions for studying organisational subcultures. The first defines subcultures relative to an organisation's overall cultural patterns, especially its dominant values (Davies et al., 2000). From this perspective, subcultures can be seen as simply supporting, rejecting or coexisting alongside the values of the dominant culture (Davies et al., 2000).

The second position perceives subcultures as existing as a result of differing occupational, departmental, clinical or other affiliations within the working environment (Gregory, 1983; Davies et al., 2000). This perspective adds more complexity to the concept of organisational subcultures by not simply categorising what the subculture does in relation to the main culture within the organisation, but rather exploring the influence of job roles in shaping subcultures (Gregory, 1983).

Despite the existence of these two perspectives, Davies et al. (2000) state that it is highly likely that within an organisational environment both positions on subcultures would exist and are known to be particularly prevalent in the healthcare context. From my analysis of the above reports and investigations into care home organisations, it is evident that both frameworks were evident in the depictions given as to how closed cultures emerged within the organisational environment (Carr,

2014; Demos, 2014). That being so, for the purposes of this study, no specific subculture frameworks will be adopted, but rather, this study will align itself with the pivotal and peripheral values position of subculture put forward by Schein (1988).

3.4.3.1 Pivotal and peripheral values

From Schein's observations of organisations, he was able to identify that across organisational and membership boundaries, specific values carry more significance than others for differing groups. From these observations, Schein (1988) differentiated between *pivotal and peripheral* values as a way of capturing how organisational subcultures come into being. Pivotal values are those central to an organisation's functioning; members of an organisation are required to adopt and follow these pivotal values and may even be rejected from the organisation for not doing so (Schein, 1988; Boisnier & Chatman, 2002). Within the care home context, such values would, according to CQC (2018), include the delivery of safe and effective care to residents in a caring well-led environment. When analysing reports into care home failings, it is normally failings in pivotal values which bring about such reports and subsequent calls for culture change (Willis, 2012; Kingsmill, 2014).

On the other hand, Schein (1988) views peripheral values as being desirable but normally not believed by members of the organisation to be essential to functioning. Members are encouraged at the organisational level to follow peripheral organisational values but are generally not rejected from the organisation for not doing so (Schein, 1988). According to Boisnier & Chatman (2002), the degree to which members of an organisation conform to peripheral norms can vary considerably. It is this fluctuation in the extent to which members of an organisation conform to peripheral norms which enhances the possibility of subcultures developing (Tichy, 1982). From the perspective of Davies & Mannion (2013), large organisations are susceptible to fragmentation of the organisational culture and the establishment of organisational subcultures. With the proliferation of large care home chains in England (Burns et al., 2016), the role of subcultures in influencing employee voice is relevant to the care home context.

3.5 Employee voice

This section aims to explore the second key concept identified through my review of the Health and Social Care literature in chapter two. The concept of employee voice is contested within the

management literature, due to the nuances associated with the concept, particularly in the organisational setting. Through an analysis of the management literature, it has been possible to identify multiple definitions relating to employee voice (Van Dyne et al., 2003; Dundon et al., 2004; Wood & Wall, 2007).

According to Dundon et al. (2004), the concept of voice has had specific resonance within the academic literature, with the notion of giving employees a say in organisational management becoming popularised in the 1970s and 1980s. From the perspective of Bashshur & Oc (2014), employee voice is not simply speaking or communicating within an organisation's context, but rather, it is an attempt to change the status quo within an organisation.

3.5.1 The contested nature of employee voice

From a review of the management literature, two schools of thought have developed on the role of employee voice within the organisational context. The first portrays employee voice as a concept which involves actors proactively speaking up to influence change (Dixon-Woods et al., 2019). This stream can be linked with other concepts associated with employee voice, such as speaking out and whistleblowing (Van Dyne et al., 2003; Jones & Kelly, 2014). The second stream relates employee voice to a process by which employees take part in organisational decision-making, which is sometimes related to other concepts such as internal voice (Van Dyne et al., 2003).

Apart from the two broad streams associated with employee voice, there exists other literature which explores the perspectives of voice among different groups of workers within an organisation. According to Ruck and Welch (2012), there are differing perspectives on the relevance of employee voice within and between different organisations. For example, according to Morrison (2011), employee voice is generally seen by management as being predominantly negative, but Morrison (2011) also points to evidence which shows that employee voice can be perceived positively. Work by Ruck and Welch (2012) suggests that differing perspectives on employee voice also exist at lower levels of organisational structures. Their research found that even at lower levels of organisations, a significant percentage of employees were indifferent to the relevance of employee voice within their organisation. This research by Ruck and Welch (2012) shines a light on the fact that perspectives on the notion of employee voice are not unanimously positive at any level of an organisation. Therefore,

it is important to understand the contextual specificities of employee voice within any organisation and the factors which contribute to this (Ruck & Welch, 2012).

Indeed, the factors which result in individuals voicing out within an organisational context represent another stream within the management literature. Morrison (2011) contributes to this literature and suggests that when an employee voices out, this results from a deliberate decision to do so, which involves them considering both the positive and negative consequences associated with that act (Weiss & Morrison, 2018). To this, Morrison (2011) adds that the primary rationale for most employees to voice themselves is the desire to benefit the organisation or unit in which they work. Despite this desire to benefit the organisation, there are a number of factors influencing an employee's willingness or perceived ability to voice (Adelman, 2012). This is a view which was echoed by post-Francis Reports in the previous chapter and demonstrates the practical complexities of employee voice within organisations (Martin & Waring, 2013; Francis, 2015).

For the purposes of this study, both streams will be considered as a way of providing flexibility to the study and allowing it to be guided by the findings. Indeed, this is a position to which Van Dyne et al. (2003) would ascribe as they see voice as a multi-dimensional construct, thus in need of exploration from different perspectives. As the position of this study is to consider both streams, for the purposes of this study the following definition of employee voice put forward by Adelman (2009, pp 134) will be adopted:

Employee voice is the optional provision of information, to someone with the authority to act.

The broad definition employed by this study is aimed at avoiding restriction of the study's ability to explore the concept of employee voice within the confines of care homes and account for the perspectives of both streams discussed above. Adopting such a broad definition will allow perspectives on employee voice to develop with the research (Eisenhardt & Graebner, 2014). The contested nature of employee voice within the management literature, I argue, means that using a simple definition limits the potential restrictions this study will encounter when collecting data on issues relating to employee voice (Van Dyne et al., 2003; Morrison, 2011).

3.5.2 Factors influencing employee voice

Apart from the differing schools of thought on employee voice, an analysis of the literature has highlighted three broad factors that are known to impact on employees' willingness or ability to voice themselves (Adelman, 2012). Organisational context, behaviours of leaders and individual employee differences are, according to Adelman (2012), the most important factors to consider when attempting to understand the role of employee voice within any organisational context. Through an exploration of these factors, it will be possible to relate them back to the characteristics of closed organisational culture detailed in the previous chapter and assess if indeed any linkages exist. If so, how does this further our understanding of employee voice and the establishment of closed organisational cultures within the care home context?

3.5.2.1 Context

From an analysis of the management literature, the organisational context in which employees find themselves has a significant impact on their willingness or the degree to which they think they can voice themselves. Work by Morrison (2011) indicates that employees look for cues regarding whether or not their work context is a favourable one for them to voice out. Such cues would include reflecting on what has happened to others who have voiced out on similar issues and using that to guide one's behaviour. This perspective relates to research by Ronnerhag & Severensson (2019), who found that leaders who provide communications channels which are perceived to be trusted by staff enthruse voice. This was evident in the above post-Francis Reports in which employees referred to what had happened to other employees as a factor influencing their choice on voicing out (DoH, 2014; Tingle, 2014).

According to Morrison (2011), the physical proximity between an employee and the person they want to voice to also plays a significant role in determining whether they will voice themselves or not. This point can be related to the role played by organisational status in influencing culture and voice within care homes (Carr, 2014). Employees are known to be less likely to voice themselves to those with higher status positions as opposed to those lower down the organisational ladder (Morrison, 2011).

3.5.2.2 Behaviours of leaders

According to Morrison (2011), one of the most important factors influencing an employee's choice to voice out is based on the behaviour and relationship they have with their immediate manager. Morrison (2011) points to research which demonstrates the relationship between the behaviour of managers and the frequency with which employees voice themselves to them. This can be linked back to the recognition by CQC (2016) and Baylis & Perks-Baker (2017) that leadership within care homes is critical for their effective operation. Furthermore, according to Allcock et al. (2015), the degree to which leaders are open to employee voice does have a significant impact on an employee's willingness to voice out, thus demonstrating the direct link between leadership and voice. If an employee believes that action will be taken by a leader as a result of their voicing out, they are more likely to do so (Morrison, 2011; Whelan, 2016; Ronnerhag & Severensson, 2019).

3.5.2.3 Individual differences between employees

The last main characteristic to emerge from the literature relates to individual differences between employees. According to Morrison (2011), although organisational context and management play a significant role in influencing an employee's willingness or ability to voice out, it is evident from the research that some individuals voice out more than others under the same conditions. From an analysis of the literature, several authors have put forward perspectives as to why this may be, but according to Morrison (2011), there are five key individual factors. The first relates to how positive an individual is about their work; more positive staff are more likely to be engaged and thus raise issues, which is something Donaldson-Feilder et al. (2014) picked up on. Also, staff who are more willing to engage with others, according to Morrison (2011), tend to be more willing to voice themselves. Morrison (2011) claims that gender differences between employees, differing cultural backgrounds and longevity of service within an organisation all play a role in influencing an individual's willingness to voice. Although the above does not represent an exhaustive list of factors that influence an employee's ability or willingness to voice, they do sensitise this study to some of the potential factors to look out for during fieldwork.

3.5.3 Employee voice theory

Theories around employee voice litter the management literature and vary from positions which advocate for employees to be involved in a broad range of issues relating to the organisation to those advocating for a total absence of participation within the organisation (Wood & Wall, 2007). For the

purposes of this study, the three-part framework on employee voice developed by Van Dyne et al. (2003) will be drawn on to help in our understanding of employee voice within the care home context. ProSocial, defensive and acquiescent voice will be explored and related back to the care home as a way of offering some explanations of employee voice within this context.

3.5.3.1 ProSocial Voice

To differentiate from the two broad narratives of employee voice detailed above, Van Dyne et al. (2003) use the terminology of prosocial voice to denote work-related ideas or views of employees that are organisationally orientated. That is, this type of voice within an organisational context is, according to Van Dyne et al. (2003), intentional, and proactive in its intention. Furthermore, this type of voice is seen as being other-orientated, that is, its primary focus is to have a positive impact on others such as the organisation (Van Dyne et al., 2003). This view on prosocial voice as a tool for positive change is aligned to the position taken by Francis (2010), when he called for the proactive promotion of employee voice, and later (Francis, 2015) when he advocated for employees to have the freedom to speak up as a way of improving care quality and bringing about positive change within the health and social care context.

3.5.3.2 Defensive Voice

In contrast to prosocial voice, Van Dyne et al. (2003) use the term defensive voice to refer to employees within an organisation who voice themselves as a way of self-protection. Defensive Voice is self-protective, that is, according to Schlenker and Weigold (1989), characterised by individuals within an organisation taking what they perceive to be safe, secure decisions. From this position, individual employees within an organisation would be voicing themselves in a way which brings less personal responsibility. Furthermore, employees who enact defensive voice are known to attribute outcomes to external factors, such as blaming others and shifting attention on issues (Van Dyne et al., 2003); thus protecting themselves from potential punitive consequences resulting from discussing problems relating to their organisation. Defensive voice was evident within the reports into organisational failings detailed in chapter two. Indeed, the Berwick Report recommended the need to create working environments free from a culture of blame and denial, which was identified as being a significant contributing factor in the healthcare failings Berwick (2013) identified. A culture

of blame and denial can be seen as the normalisation of defensive voice within such organisations; thus over time, it becomes part of the organisation's culture (Francis, 2013; Schein, 2010).

3.5.3.3 Acquiescent Voice

The final form of voice relates to what Van Dyne et al. (2003) refer to as acquiescent voice, which in turn relates to the verbal expression of work-related ideas when an employee feels a sense of resignation. During this time, employees would express their opinion or provide information to the organisation in a way which relates to a sense of not being able to make a difference within an organisation. According to Van Dyne et al. (2003), acquiescent voice is most prominent when employees feel a sense of low self-efficacy to affect any meaningful change within their organisation, in which case they are more likely to voice themselves in agreement and in support of the predominant viewpoint. Unlike prosocial voice and defensive voice, which are both proactive, acquiescent voice is less proactive, and rather centres on what Van Dyne et al. (2003) refer to as pluralistic ignorance. That is, employees, express agreement with specific issues or ignore them, rather than expressing their own opinion. This was highlighted by Francis (2013) in terms of what he saw as the normalisation of poor quality care and silence within the hospital, both of which contributed to patient deaths (Dixon-Woods et al., 2019).

From the above three-part framework on employee voice, it is evident that not only is the concept of employee voice contested in relation to its fundamental meaning (Jones & Kelly, 2014), but also differs in relation to how voice is actually used and the intentions behind its use within an organisational setting (Van Dyne et al., 2003). What has become apparent, I argue, is that the complexities associated with the concept of employee voice within the care home context have until now remained under-researched. Moving forward, I put forward the perspective that more research exploring such complexities within care homes is needed (Van Dyne et al., 2003; Skills for Care, 2017). This is something which this study aims to do, in order, I argue, to enable us to understand better the role employee voice plays within differing care home cultures (Skills for Care, 2017).

3.6 Employee voice and employee silence

On the surface, voicing out and withholding information may appear to be opposites, but it can be said that they sometimes overlap, such as when employees choose to express themselves by saying

nothing (Van Dyne et al., 2003). According to Morrison & Milliken (2003), this is because, within an organisational context, silence is seen as being what employees offer if they choose not to voice themselves. From an analysis of the literature, it is evident that the motives to voice or remain silent within an organisation vary (Van Dyne et al., 2003). Hence, I argue that it is important to keep all possibilities in mind when undertaking such research. This study will thus seek to understand participants' perspectives on employee voice rather than imposing a predetermined framework on how employee voice should be approached within the study (Schein, 1985; Van Dyne et al., 2003).

From an analysis of the literature, it is evident that the most significant factor influencing employee silence is the fear of punishment (Morrison & Milliken, 2003; Weiss & Morrison, 2018). Within the care home context, this is something which several of the above reports have highlighted as being a contributing factor to closed organisational cultures perpetuated by fear (Cavendish, 2013). At the group level, Morrison & Milliken (2003) argue that members may choose silence over voicing their opinion as a way of maintaining consensus and cohesiveness in the group. This perspective sees silence emerging as a result of social pressure rather than a fear of punishment as the majority of the literature suggests (Morrison & Milliken, 2003). Indeed, investigations into closed organisational cultures (DoH, 2014) did make links between the existence of group-level cultures of silence within Health and Social Care organisations and a climate of fear within such organisations. I argue that the evident connections between voice and silence indicate it is right that both concepts are considered during my study as a means of better understanding employee voice within care homes.

3.6.1 Whistleblowing

Apart from employee silence, the other key concept to emerge from the management literature is the notion of whistleblowing (Jones & Kelly, 2014; Lewis & Vandekerckhove, 2018). As in the case of employee voice and silence, the notion of whistleblowing is a very contested one and is known to encompass a number of differing narratives. Within the literature, whistleblowing can refer to staff reporting concerns to external agencies such as regulators or the police (Near & Miceli, 1995). It can also, according to Jones & Kelly (2014), represent the reporting of concerns internally within an organisation to colleagues such as managers or supervisors. Such differences in the narrative associated with whistleblowing demonstrate its contested nature within the management literature.

Within the care context, the difficulties faced by whistleblowers are nothing new according to Lewis & Vandekerckhove (2018) and have over the years resulted in employees who have blown the whistle being perceived as a villain within their organisation (Waring, 2016; Powell & Mackley, 2017). Indeed, one of the key recommendations to come out of the Francis Report was his call not only to encourage healthcare staff to raise concerns or blow the whistle but also to provide them with the security to do so (Francis, 2013; Powell & Mackley, 2017). Despite the risk, several high-profile whistleblowing incidents have led to public exposures of poor-quality care, such as in the case of Bristol Royal Infirmary (Waring, 2016). Whistleblowers were also responsible for initiating a number of the CQC inspections into the 25 inadequate care homes detailed in chapter two (CQC, 2016). Thus, I argue that whistleblowing remains an avenue for employees wishing to voice themselves despite the risks (Department of Health and Social Care, 2018). On the other hand, Weiss & Morrison (2018) take the view that employees who voice out actually enhance their job prospects by being perceived as confident and competent, demonstrating the complexities associated with this concept within the literature.

Within care organisations, whistleblowing has been seen as linked to organisational cultures; for example, Waring (2016) found that whistleblowers were seen as going against collegial norms and values of their profession. I argue that such collective perspectives would make it difficult for care workers to voice themselves in this way and be difficult to detect at the policy level (Waring, 2016). From an analysis of the Government documents put together by Powell & Mackley (2017), it is evident that policymakers did see a direct link between efforts to foster open organisational cultures and the need to protect whistleblowers within the Health and Social Care context. With whistleblowing emerging as an important consideration when exploring the concept of employee voice within the management literature, it is only right that whistleblowing is considered within the scope of this study as a form of voice utilised by employees.

3.7 Organisational culture and employee voice

Through an exploration of organisational culture and employee voice within the management literature, it has been possible I argue to establish a better understanding of the current debates around culture and voice within this body of work. Furthermore, this exploration has enabled us to highlight the complexities associated with these concepts, and in doing so demonstrate their

contested nature within the literature (Cummings & Schmidt, 1972; Schwartz & Davis, 1981). At this point, it is essential to clarify the position of this study concerning culture and voice. Thus, this section provides this clarification, and in doing so, establishes clarity on how culture and voice will be approached throughout this research.

3.7.1 Voice culture

For this study, culture is seen as being separate from voice, but there is an acknowledgement that one does influence the other. Indeed, throughout chapters two and three, culture has been approached as a phenomenon which is different from voice, and this is how it will be perceived throughout this study. The definition of culture taken by this study was detailed at the start of this chapter and followed the definition put forward by Schein. There are, though, two additional definitions which should be clarified at this stage. The first is closed organisational cultures, which was defined in chapter two as *'an organisational environment in which employees feel unwilling or unable to speak out'* (Davies & Mannion, 2013; Francis, 2013; Flynn et al., 2014). The second definition is that of open organisational cultures, which for this study is defined as *'an organisational environment in which employees feel able to speak out, and have their voices listened to and acted on'* (Francis, 2010). The above definitions provide the parameters within which these terminologies are used.

When these two definitions are brought together as a collective, I will refer to this as a voice culture. Thus, this study concerns itself with voice culture in that the aim is to explore the state of voice cultures within care homes. In exploring voice culture within care homes, there is an acknowledgement that voice and culture are two separate phenomena, but there exist overlaps between them. Although these concepts are different, one does influence the other, thus why this study aims to explore what the specific influences of care home cultures are on employee voice. This study is about exploring how we can cultivate care home organisational environments which have open voice cultures (Francis, 2013).

For the purposes of my study, a review of the literature was undertaken to explore the research landscape relating to the influence of care home cultures on employee voice (Fingeld-Connett & Johnson, 2013). Since my analysis of the literature and governmental policy documents spanned the

past decade (2008-2018), the same period was used to explore the research landscape. From my analysis, it became apparent that indeed qualitative research into the influence of organisational culture on employee voice within the care home context represented a gap in the literature (Phelps & Campbell, 2012; Aveyard, 2014). This lack of literature provides additional justification as to why it is essential to undertake this study into voice culture within the care home context.

3.7.2 Research landscape

Studies such as Jones & Kelly (2014), have previously focused on silence within organisations, and the role inaction by those with authority has on shaping an employee's willingness to whistle blow. Although the culture of the organisation did feature in this paper, Jones & Kelly (2014) did not make an explicit attempt to investigate the influence of organisational cultures on employee voice. Furthermore, this paper focused its attention on the healthcare context, but with no mention of care homes.

A study by Adelman (2012) focused on the influence leaders had on shaping employee voice, again within the health care context. This study did recognise the important role played by organisational cultures, but the focus was very much on the influence of top leaders. Again, this study did not investigate the influence of an organisation's culture on employees' willingness to voice out.

A broader exploration of the literature has identified studies such as that of Burke and Cooper (2013) who established links between employee voice, organisational performance and individual psychological health. Research by Mishra (2014) focused on gaining a better understanding of employee voice in organisations by exploring factors such as the motives underlying voice, and the situational factors that increase employee voice behaviour. Mishra (2014) also identified the negative implications of silence for patients, workgroups and organisations as a whole. Despite most of these studies being conducted within the healthcare context, none of them has focused on the influence organisational cultures have on employee voice.

The need for more research within the care home context has already been highlighted by commentators such as Dayan (2017) in chapter two. What has become evident as a result of my review into care home cultures and employee voice, is that across the board, there has been a lack of attention in this area. In chapter two, I detailed the lack of political and economic attention given to

the social care sector, and the predisposition of care homes to closed organisational cultures (Baird & McKenna, 2018; the King's Fund, 2019). In this chapter, we have highlighted the complex and contested nature of culture and voice and identified that care home research within this area is minimal. As such, this research study will endeavour to fill this gap in the research literature by focusing on exploring the influence of organisational cultures on employee voice within the care home context (Schein, 2004; Morrison, 2011; Francis, 2015).

3.8 Research Questions

From an analysis of the literature on employee voice and organisational culture which has focused primarily on the care home context, it has been possible to establish five research questions which will drive this study (Aveyard, 2014). These five research questions are underpinned by the following overarching research question '*what is the status of voice cultures within the care home context*'? This overarching question provides the driver for the five key research question below, which will be posed to participants during this study. The below research questions have emerged from the literature and together aim to help bridge the gap in the literature relating to the influence of care home cultures on employee voice.

3.8.1 Question one: how do care home employees understand the term 'employee voice'?

As a contested concept within the management literature, I first aim to explore how employees perceive the concept of employee voice (Adelman, 2009). By so doing, it will be possible to understand individual perspectives on employee voice better and establish themes and links between groups of employees as to how and why they perceive voice in a specific way. From the above literature (Van Dyne et al., 2003; Morrison, 2011), it is evident that perspectives on voice differ significantly, thus understanding these variations within care homes would be a valuable contribution to the literature. A further rationale for this research question is that by exploring trends between different perspectives on employee voice, it will be possible to establish the characteristics which relate to how specific groups understand employee voice.

3.8.2 Question two: how do care home employees understand the term 'organisational culture'?

The second key concept to emerge from the review of the literature, and one which is also very much contested, is organisational culture (Schein, 2004). From the literature, especially relating to the need for organisational culture change in chapter two, Mannion & Davis (2018) identified that there is a real lack of understanding as to what culture is or what it means within the health service. This is also the case within the care home context, with no care home literature critically exploring what organisational culture means within the care home context. Hence, I aim to explore participants' understanding of organisational culture as the second key question in this research (Scott et al., 2003b; Dixon-Woods et al., 2014).

By exploring how employees understand the concept of organisational culture, it will be possible to gauge the extent to which perspectives on organisational culture influence how it is shaped and the extent to which it influences employee voice within the care home. Furthermore, it will be possible to locate any differences in perspectives and explore why within an organisation, such differences exist and interrogate their origins. This will also add to our understanding of what organisational culture means within the care home context, which thus far, is yet to be explored.

3.8.3 Question three: what are the care home cultural characteristics and factors which facilitate employee voice?

Through an analysis of post-Francis Reports, I was able to establish the notion that in an effort to cultivate open organisational cultures, it is necessary to take account of environmental factors. (Dixon-Woods et al., 2014). Although there is an acknowledgement that such characteristics would be context-specific, highlighting them and understanding their contribution to the overall culture has emerged from the literature as being of the utmost importance. Therefore, the third key question to be explored centres on the characteristics of an organisation which facilitate employee voice. In chapter two, I concluded that the majority of the government initiatives aimed at promoting employee voice have been ineffective because of their lack of impact on the daily interactions between employees or group dynamics on the ground (DoH, 2014; Baylis & Perks-Baker, 2017). Indeed, within the care home context, it is still unknown what cultural factors facilitate employee voice; thus, efforts to remedy the issue within this context will continue to be problematic (Allcock et al., 2015). This question aims to go some way in establishing frontline perspectives on voice, and thereby to contribute to developing future policy initiatives within this care home.

3.8.4 Question four: what are the care home cultural characteristics and factors which mitigate against employee voice?

In chapter two, I identified care homes as being organisational environments which possess characteristics that disproportionately predispose them to the cultivation of closed organisational cultures (Francis, 2015; Skills for Care, 2017; Baird & McKenna, 2018; the King's Fund, 2019). To further our understanding of such characteristics, my next question aims to identify the cultural characteristics within the researched care home, which mitigate against employee voice. From the academic literature on care homes in England, thus far, the detailed exploration of such characteristics and their links to organisational cultures, especially voice culture has not been explored. Thus the inclusion of this research question will I propose, fill an essential gap within the research literature. The addition of this question is also aimed at exploring the extent to which the above characteristics are prevalent within care homes, and the influence such characteristics have on employee voice. This question, I argue, will contribute to efforts to develop strategies to eliminate closed organisational cultures within care homes.

3.8.5 Question five: how can employee voice be elevated to gain greater impact in care home organisational decision-making?

Finally, with my stance on the ineffectiveness of government policies post-Francis, my last key question aims to establish a participant perspective on how employee voice can be promoted within the care home context (Francis, 2015; Skills for Care, 2017). From the literature, it is evident that there is a lack of work exploring the views of care works as to how open voice cultures can be established within care homes, despite being the group within both Health and Social care who are most predisposed to closed cultures within their working environments (Baird & McKenna, 2018; the King's Fund, 2019). Thus, understanding directly from care works how open voice cultures can be cultivated would be a practical contribution to the literature. This question will also explore how employee voice can have a greater impact on organisational decision-making, which would constitute the cultivation of open voice cultures within the care home context. This question will contribute to future recommendations on how best to facilitate employee voice within care homes.

3.9 Summary

Through an analysis of the literature pertaining to the concepts of organisational culture, it has been possible first to define the concept of organisational culture with the use of the definition put forward by Schein (1984; 2004). From this position, the contested nature of organisational culture within the management literature was explored, and I established a philosophical position on organisational culture as a critical variable (Cummings & Schmidt, 1972; Schein, 1985).

The importance of exploring culture within the care home context was then detailed before studying the international body of work on culture change resulting in the identification of multiple culture change models. This was proceeded by an exploration of Schein's theory of organisational culture, which was deemed to be the most appropriate for undertaking this research due to its flexibility.

In relation to employee voice, with the management literature very much contested (Van Dyne et al., 2003), I opted for a generic definition aimed at allowing for sufficient flexibility and scope when exploring this concept in the field. Finally, my decision to explore organisational culture and employee voice within the care home context was justified, and clarification was given on the nature of culture and voice within this study. After exploring the research landscape, gaps in the literature relating to the influence of organisational culture on employee voice within the care home context were identified, leading to the formation of an overarching research question on voice culture which will drive the additional five key research questions within this study.

Chapter four

Methodology

4.0 Introduction

The previous two chapters discussed the Social Care sector and identified a noticeable lack of research on the influence of care home organisational cultures on employee voice (Baird & McKenna, 2018). This chapter thus details the steps I have taken to conduct my study into the influence of care home cultures on employee voice. Through detailing my philosophical approach and theoretical position, it will be demonstrated how such considerations have shaped the case study design of this study (Eisenhardt & Graebner, 2014; Gehman et al., 2018). At this point, I shall detail the research structure and methods deployed to conduct this study and the analytical approach I subsequently took after the data was collected (Schein, 2004; Eisenhardt & Graebner, 2007). Care homes are considered part of a complex organisational context (Skills for Care, 2017). As such, I will argue that my decision to conduct this study in this way offers the best approach to better understanding the influence organisational cultures at the macro level have on employee voice within care homes (Schein, 2004; Eisenhardt & Graebner, 2007; Yin, 2013; Mulligan, 2014).

4.1 Philosophical approach and research design

Gill & Johnson (2010), and more recently Johnson & Duberley (2015), have reiterated the importance of management researchers exhibiting a great degree of awareness of the philosophical commitments they make through their methodological choices during the design phase of any research project (Cook & Campbell, 1979; Benton & Craib, 2011). This is to prevent what Johnson & Duberley (2015) refer to as implicit commitments or 'baggage' being overlooked. Hence, a purposeful attempt to be explicit about my philosophical position is deemed as being of the utmost importance, and something both Gill & Johnson (2010) and Ransome (2010) state contributes to the rigorous nature of the study.

As a result, time was taken at the start of the research process to explore and better understand what I argue to be the most appropriate philosophical position through which to undertake this study (Cook & Campbell, 1979; Guba & Lincoln, 1994; Johnson & Duberley, 2015). The Postpositivist

paradigm detailed below is the framework for the philosophical assumptions which underpin the ontological, epistemological, theoretical and data collection and analysis processes of this study (Guba & Lincoln, 1994; Weaver & Olson 2006; Bryman & Bell, 2007; Gill & Johnson, 2010; Ransome; 2010). Furthermore, it is possible to argue that this philosophical position, which aims for the greatest degree of objectivity, has the potential to contribute to the policy landscape in relation to organisational culture and employee voice within the care home context (Durning, 1999). Therefore, the first section of this chapter explores my philosophical approach; in doing so, demonstrating the philosophical alignment of this study, and how this position has informed the aims of this research (Smircich, 1983; Schein, 1985; Guba & Lincoln, 1994).

4.1.1 Postpositivist approach

This study is located within the positivist philosophical paradigm (Guba & Lincoln, 1994). According to Weaver & Olson (2006), paradigms are forms of beliefs and practices that shape the ways in which research within a discipline is conducted. From the postpositivist stance, it is in today's world untenable to maintain the certainty that absolute truth is discoverable through science (Levers, 2013). That being so, by putting forward a position that centres on an ontologically critical realist stance (Levers, 2013), and an objectivist epistemology (Guba & Lincoln, 1994), this approach is able to offer what I argue to be an appropriate lens with which to explore culture and voice within care homes. Postpositivist approaches have, from the perspective of Weaver & Olson (2006), contributed clarity to nursing research, particularly in relation to structure and methodological choices. Furthermore, Weaver & Olson (2006) have credited the use of postpositivist paradigms within the health context with advancing the understanding of the nature of nursing and thereby helping to guide future practice (Carpiano & Daley, 2006).

4.1.2 Ontological position

Philosophical assumptions are indeed just assumptions, according to Gill & Johnson (2010), and, as Bryman & Bell (2007) argued, are for the most part constructed. Ontology is a branch of philosophy dealing with the essence of phenomena and the nature of their existence, such as what constitutes the real world (Ransome, 2010; Inglis & Thorpe, 2012; Levers, 2013). According to Guba & Lincoln (1994), within the postpositivist paradigm, the ontological position taken would be one of critical realism. This is not to be mistaken for the critical realist social theory name; this is given to the

ontological position of postpositivism (Cook & Campbell, 1979; Levers, 2013). This label refers to the notion put forward (Carpiano & Daley, 2006) that reality must be subjected to the widest possible critical examination to facilitate the process by which one can come to understand it, but yet, it can never be perfectly understood (Guba & Lincoln, 1994; Levers, 2013).

This inability to fully comprehend reality, according to Guba & Lincoln (1994), is due to the limitations of human intellectual mechanisms. In acknowledging the limitations associated with one's ability to fully comprehend reality, the postpositivist paradigm accommodates its pursuit of objectivity through an emic orientated approach (Cook & Campbell, 1979) in which researchers seek to position themselves within close proximity to the truth (Lincoln, 1994). This proximity provides an appropriate ontological position from which to explore culture and voice (Gill & Johnson, 2010; Guba & Lincoln, 1994; Benton & Craib, 2011).

4.1.3 Epistemological position

Epistemology is about how we know if a claim about a phenomenon is warranted or real (Gill & Johnson, 2010; Ransome, 2010), and how theory intends to study what is deemed to be real (Benton & Craib, 2011; Inglis & Thorpe, 2012). Within the postpositivist paradigm, the epistemological position taken would be one of modified objectivity. That is, as the researcher, I would aim to achieve objectivity, but in doing so, I would acknowledge that attaining absolute objectivity remains something which Guba & Lincoln (1994) refer to as a 'regulatory ideal', thus not fully attainable. Therefore, in an effort to gain increased objectivity, after the research process, and moving forward, I would place special emphasis on what Guba & Lincoln (1994) refer to as 'guardians of objectivity'. This would mean considering critical traditions and pre-existing knowledge (Carpiano & Daley, 2006), and the perspectives of research supervisors and the 'critical community' (Guba & Lincoln, 1994) such as researchers during the process of this study (Cook & Campbell, 1979). Through this process, it is possible to argue that a philosophical position which is as objective as possible would be realised, thus enabling me to 'determine how things really are and how things really work' (Guba & Lincoln, 1994; Symon & Cassell, 2012) within the care home context.

In relation to employee voice, this would mean not giving my interpretation of voice to participants, but rather allowing them to tell me 'how things really are' in relation to their understanding of employee voice (Guba & Lincoln, 1994). Additionally, this philosophical approach means that I would

also strive through the deployment of my different methods to ascertain how voice is enacted, or 'how voice really work' within the care home and the units (Guba & Lincoln, 1994). This would mean relying only on first-hand accounts through my interviews, and direct observations to later analyse and make sense of the information gained. Hence, particularly during the observation stage of my data collection, I would only document what I have observed and not my initial interpretation of that observation (Guba & Lincoln, 1994; Symon & Cassell, 2012). The same philosophical principles would be applied to my approach to understanding the care home's culture. On that basis, it is possible to argue that indeed the postpositivist paradigm offers an appropriate and robust framework with which to proceed with a study exploring the complexities of organisational culture and employee voice (Dixon-Woods et al., 2014; Johnson & Duberley, 2015).

4.1.4 Reflexivity and knowledge experience

Although my epistemological position is one that aspires for objectivity, it is at the same time recognised as being a regulatory ideal which can be fulfilled through the employment of guardians of objectivity. (Cook & Campbell, 1979; Guba & Lincoln, 1994). In addition to the guardians of objectivity, considerations of my role as a researcher within the field have also been considered (Bryman & Bell, 2007; Johnson & Duberley, 2007). That is, a purposeful attempt on my part to continuously look back on the impact of my existence within the care home on the data being gathered and analysed. According to Yin (2013), this process also requires me to appreciate the 'cultural baggage' and 'implicit assumptions' (Bryman & Bell, 2007; Burrell & Morgan, 2016) I bring to the care home environment I am researching. This process is something that Johnson & Duberley (2007) refer to as the process of thinking about our own thinking. My decision to incorporate methodological reflexivity (Bryman & Bell, 2007) adds what Symon & Cassell (2012) see as being another layer of rigour to this study. This decision also complements my agenda for developing a clearer understanding of 'how things really are' in relation to culture and voice, and 'how things really work' in the day-to-day (Guba & Lincoln, 1994; Symon & Cassell, 2012).

The fact that I have worked within this company in the past as a care worker would bring particular insider insight into the study (Yin, 2013; Heslop et al., 2018). This experience would enable me to utilise what Borbasi et al. (2005) refer to as the 'contextual benefits' associated with previously working within an environment which is subsequently researched. Such contextual benefits would

include being well-grounded within the cultural environment (Goodrick, 2014), which is an important consideration for this study. Borbasi et al. (2005) contribute to this discussion by pointing out that such benefits rely on the researchers' ability to deploy an effective reflexive strategy. In that case, the choice to employ a reflexivity strategy for this study would assist me in my efforts to attain a closer degree of objectivity (Guba & Lincoln, 1994; Bryman & Bell, 2007), and obtain the contextual benefits detailed by Borbasi et al. (2005). Goodrick (2014) sees such efforts, as being important steps when conducting good qualitative research within the social care context.

4.1.4.1 Daily reflexive diary

The main reflexive strategy employed for this study is the use of a reflexive diary, which Seale (1999, p. 161) argues to be an effective way in which one can account for and regulate one's impact on a research environment. Within my fieldwork, my reflective diary was a useful tool with which I was able to offer some 'confessional tales' (Seale, 1999, p. 161) about the research process with the aim of persuading the reader that all efforts have been made to attain the greatest degree of objectivity (Guba & Lincoln, 1994; Johnson & Duberley, 2015). Through a 'biography' of my reflexive research process (Wong, 2011), it became possible to keep an account and be held to account for any actions I undertook during fieldwork, thus also increasing the methodological rigour of this study (Eisenhardt & Graebner, 2014). I deemed all efforts to increase the methodological rigour of my study as being important because of the added layers of legitimacy subsequent results would have (Bryman & Bell, 2007).

To this effect, I integrated a daily reflexive diary into the process to help me identify and reflect on my cultural baggage (Yin, 2013), and the implicit and explicit assumptions which I held about care homes (Bryman & Bell, 2007). This strategy enabled me to make daily alterations to my own positioning within the research environment, thus bringing an additional layer of objectivity to the study (Guba & Lincoln, 1994). I argue that the daily reflexive diary also enhanced the likelihood of my developing a close understanding of the influence of organisational culture on employee voice. My reflexive diary was kept from the weeks leading up to the study commencing, through the time between each of the case studies and the week after, thus offering a full picture about the processes involved at each stage of the study (Seale, 1999). My reflexive diary was commenced on Monday 12th

of December 2016 and continued up until 21st of April 2017, and was, therefore, able to provide a running reflective commentary covering the full research process.

4.2 The company

The company which oversees the care home researched as part of this study is a 'financialised' chain (Mulligan, 2014, Burns et al., 2016; Hulse et al., 2019), which operates 26 homes within England, UK. These care homes are located across the West Midlands, Yorkshire, the Humber and the North West. The company was established in 1999 as a training centre, and by 2003 it had opened its first purpose-built care home. The company now has over 2000 staff, providing care services for over 750 individuals across England, and is a significant care provider in the UK. Up until July 2016, the company met its day-to-day working capital requirements by utilising the cash reserves of a company called Falcon Capital Investments. By the year ending 31 March 2016, Falcon Capital Investments had generated revenues of £57,440,789. July 2016 saw the organisation introduce new ownership and debt facility structure as it was taken over by an American based organisation with offshore shell companies. Research by Mulligan (2014) indicates that such financial techniques are being utilised by companies within the care industry to maximise profits, which this company has been doing.

According to the company's website, their care homes are registered to provide 'specialist nurse-led care' for adults with a range of different complex needs such as mental ill-health, neuro-disability, learning disability and autism. The company's mission statement elaborates on 'making every day better for everyone we care for and work with'. According to the company's website, the ethos of the organisation is underpinned by four factors: enthusiasm, perseverance, a desire to have fun, and a willingness to challenge. The company's head office plays a significant role in the daily running of individual homes, with important decision-making powers residing with the head office and not the individual homes. Thus, the power each care home manager and staff may have to shape the individual environment and influence its culture may be controlled by the head office to some extent (Willis, 2012; Silver et al., 2018).

4.2.1 The care home

The care home case studied provides nursing and personal care for to 82 younger adults, according to the most recent Care Quality Commission report published in October 2016 (CQC, 2016).

According to the care home's business plan, the home provides 'specialist, high-quality care for service users'. This care home's philosophy centres on an aim to 'help people achieve their full potential irrespective of illness or disability'. The home also claims to 'strive to provide a high standard of 24-hour person-centred care', with staff also striving to preserve and maintain the dignity of individuals. From an analysis of the business overview document provided by the home, it is evident that the home prides itself on 'striving' to provide the best possible care it can. The home implemented its aims through plans aimed at treating each service user as an individual and providing them with a tailored care experience.

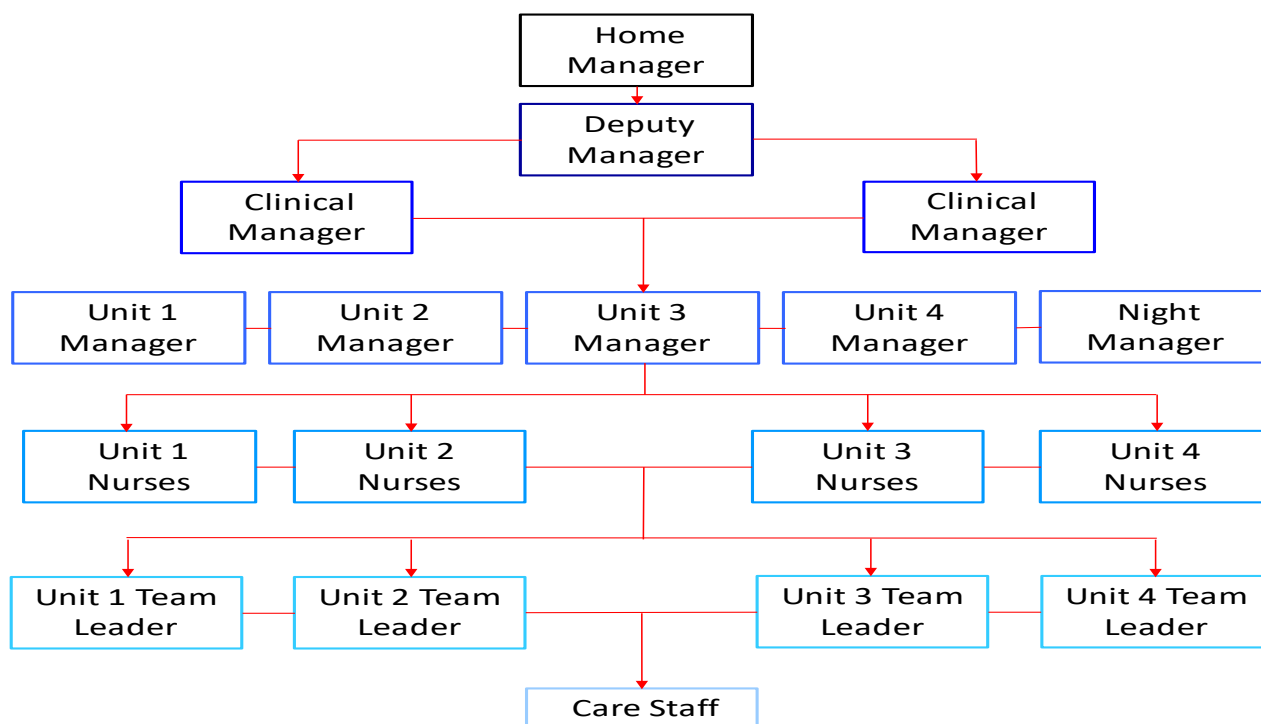
This home employs over 100 full-time members of care staff, five fulltime kitchen staff, ten domestic and four maintenance staff. In the 24 months leading up to this research study, the home had three different home managers, two deputy home managers, three operations managers and five clinical managers, indicating a very high managerial turnover. The impact and consequences of this rapid turnover of managerial staff formed one of the sensitising concepts that I would later explore during my case studies (Johnson & Duberley, 2015). In this care home's most recent inspection by CQC, the home was rated as 'good' on all inspection categories apart from 'is the service being well-led?' The home did not have a manager in place at the time of its last inspection before the case study (CQC, 2016). This inspection reported staff felt there was 'a lack of consistency in the management of the home', and that this had impacted on the care home's ability to effectively communicate across units (Moeini et al., 2019). This was an important discovery in the run-up to this study, and, I argue, demonstrated that the focus on voice and communication within the care home context was already an issue affecting the staff.

4.2.2 Hierarchical structure of the care home

The visual depiction of the care homes hierarchy as detailed in *Diagram Two*, offers an insight into where specific members of staff are positioned within the 'official', formalised structures of this care home. *Diagram Two* has been adapted from the home's own organisational chart and focuses on those members of staff who are of relevance to this study. For the purposes of this study, the participants included a member of staff at each level of this hierarchy, apart from the physiotherapist and the deputy manager (who had been moved to another home during the period of this research study). According to Davies & Mannion (2013), the hierarchy of healthcare organisations is important

because those with more power for decision making may also have more power to oppose culture change if it does not serve their interests. That being the case, the role of the organisation's structures in shaping the home's culture and influencing the voice of employees would also be explored with participants at all levels of the home's hierarchy.

Diagram 1: Care Home Hierarchy



4.3 Approaches to organisational culture

In chapter three, I discussed the contested nature of organisational culture and employee voice within the management literature (Smircich 1983; Bate, 1984; Allaire & Firsirotu 1984). As in the case of the extensive variation in definitions associated with organisational culture, there also exists an exhaustive list of approaches to exploring organisational culture within the management context. Furthermore, it is possible to align some of these approaches to the care home context. This section first explores some of these approaches, before focusing on the approach put forward by Schein, and justifying why this approach was adopted to form the basis of the structure of this research.

4.3.1 Martin

Martin (2001) is one such theorist who offers an approach to studying organisational culture. According to Martin (2001), organisational cultures can be grouped into three theoretical perspectives, namely, integration, differentiation, and fragmentation (Maximini, 2015; Whelan, 2016). The Integration perspective focus on the perception that all cultural elements within an organisation are consistent and reinforce each other as such, any deviation from this are seen as shortcomings in the organisation's culture (Martin 2001, p. 95).

The differentiation perspective focuses on organisational cultural manifestations that have inconsistent interpretations. This perspective relates to situations in which there may be contrasts between what is said and the actions acted out within the organisation such as healthcare managers setting policy but not following it (Martin, 2001).

The fragmentation perspective, on the other hand, conceptualises the relationship among cultural manifestations as 'neither clearly consistent nor inconsistent' (Martin, 2001). In the fragmentation perspective, a cultural consensus is issue-specific, as such, can differ from topic to topic thus according to Boisnier & Chatman (2002) can be seen as further perpetuating the creation and existence of subcultures within an organisational context.

Together, Martin (2001) argues that this approach to organisational culture provides a framework in which it is possible to explore all aspects of an organisation's culture.

4.3.2 Schneider

The work of Schneider (1999) on organisational cultures offers another approach to investigate the role of cultures within organisations. The model put forward by Schneider (1999) attempts to merge what is an extensive array of organisational models in order to establish a 'generally accepted and universal model' of organisational culture (Schneider, 1999). In this attempt, Schneider (1999) detailed three culture models, namely the cultivation culture, collaboration culture, and the competence culture.

According to Schneider (1999), the cultivation culture is a system of beliefs or expectations that the organisation and its employees ascribe to in order to realise what it deems important within that organisational context. This model thus relies on the organisation having unquestionable trust in its members and their willingness to succeed (Schneider 1999, p. 82; Van Dyne et al., 2003).

The collaboration culture according to Schneider (1999), centres on the notion that it is possible to put a group of people together, build them up as a team and enthuse them to be able to use each other's resources, thus emphasising the need for a collective approach to organisations. According to Maximini (2015), examples of such organisations would be hospitals and healthcare organisations which requires a high degree of collaboration among staff to succeed.

The competence culture, according to Schneider (1999), is based on a man's need to achieve, and to do better than others. This culture model emphasises the need to be superior or the best, valuing competition not only in its attempt to be the market leader but also for its own sake (Maximini 2015). Together, Schneider (1999) would argue that these three perspectives on culture cover all dimensions on organisational culture, thus offering a universal model (Maximini, 2015).

4.3.3 Schein

With authors such as Schneider (1999) arguing that their models of organisational culture are representative of the management literature, it would be easy to get lost in the claims and counterclaims about the superiority of specific organisational culture models. According to Riley (1982) and Schein (2010), one of the key weaknesses associated with cultural models is that they have a tendency to oversimplify the complexities related to culture (Rahman & Schnelle, 2008). Hence, Schein argues that such models are at risk of providing cultural categories which are incorrect concerning what they attempt to investigate. By prematurely focusing on only a few dimensions of an organisation's culture, Schein (2010) argues that the majority of culture models limit the degree to which depth and complexities associated with organisations can be uncovered (Riley, 1982; Schein, 2010, p. 175). Schein (2004) also puts forward the perspective that the majority of approaches within the management literature do not allow for shared group feelings to be identified, thus limiting a researcher's ability to understand the group dynamics which are instrumental in the development of a culture.

4.3.4 *The integration of pivotal and peripheral values into Schein's three levels of organisational culture model*

I argue that an effective effort to understand the voice culture of an organisation requires an all-encompassing approach, particularly within a care home environment, which Schein's model offers (Schein, 2004, p. 9; Skills for Care, 2017). The above limitations of other cultural models, I argue

provided due justification as to why this study will proceed with the use of Schein’s model of organisational culture. Thus, this model was chosen as the blueprint on which to structure this research study.

In chapter three, I detailed the key characteristics underpinning Schein’s approach to organisational culture, one of which was his focus on the importance of cultural groups within an organisational environment (Schein, 1983). It is possible, therefore, to envisage situations in which an organisation would have more than one group culture operating within its confines (Tichy, 1982; Schein, 2010). From this position, it is possible to argue that when multiple groups of people within an organisation choose to follow pivotal and peripheral organisational values to differing extents, their experiences of that organisation will be different (Davies & Mannion, 2013). Over time, such groups develop differing assumptions about organisational life which come about as a result of their encountering and overcoming differing experiences, with the resulting assumptions forming the basis of that group's culture (Schein, 2010). Because the formation of that culture is not fully aligned with the organisation’s pivotal and peripheral values, it is argued that such cultures represent organisational subcultures (Schein, 1988; Boisnier & Chatman, 2002).

Diagram 2: Organisational Culture and Subculture Analytical Structure

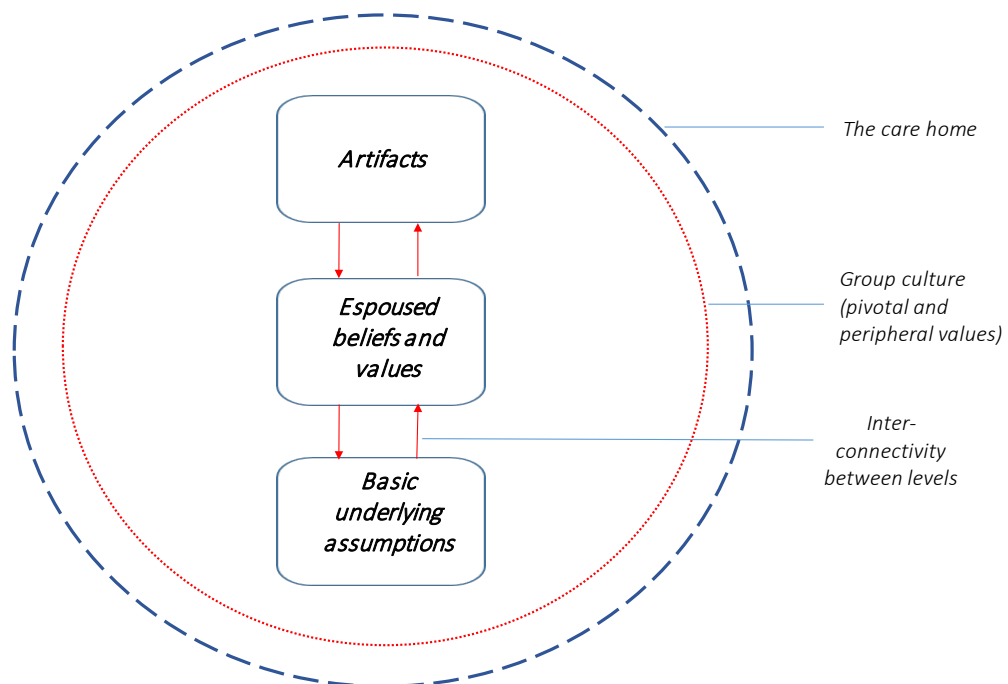


Diagram one above provides a visual representation of my *organisational culture and subculture analytical structure*. I posit that the analytical framework that I have developed for this study is able to accommodate all aspects of a care home's culture, including the existence of subcultures (Schein, 1983; Baird & McKenna, 2018). Hence, this framework will form the base from which I shall analyse the voice cultures present within the care home I research for this study. This framework will also be used to structure my analysis; thus, I will be able to report back in the same way and structure in which the data was gathered.

4.3 Case study design

In this next section, I discuss my rationale for using the case study method in this study. Before gaining access to the care home, one of the key considerations was the development and deployment of an appropriate research method specific to this care home context (Eisenhardt & Graebner, 2014; Gehman et al., 2018). This is necessary due to the complexities detailed in chapter two associated with researching organisational culture and employee voice within the care home context (Skills for Care, 2017; CQC, 2018). Based on Graebner's (2014) argument, a qualitative methodology would be best placed to facilitate this study because it would enable me to delve deeper into participants' understandings of concepts such as employee voice, and gain a true appreciation of 'how things really are' in relation to the voices of employees and the role played by organisational cultures in shaping voice within the care home (Guba & Lincoln, 1994). Such an approach, Guba & Lincoln (1994) argue, would also allow close and in-depth focus on the everyday way things are done within the care home, and how employees use their voice within these contexts.

4.3.1 A three-stage case study design for two units within one care home

After careful consideration of the different approaches to conducting research within the literature, the choice to deploy a multiple-case design was reached before the start of the study (Bryman & Bell, 2007; Yin, 2014). Although single case studies are known to produce very descriptive content (Yin, 2013), it is argued by Eisenhardt & Graebner (2014) that multiple case studies are best suited to this type of study as they deliver a more robust position from which to build theory relating to the influence of organisational culture on employee voice (Yin, 2013; Burrell & Morgan, 2016). Moreover, multiple case studies are recognised to be more entrenched in empirical evidence, in

instances in which a researcher has multiple cases, the analytical power of such studies also increases (Eisenhardt & Graebner, 2014; Yin, 2014; Gehman et al., 2018). Therefore, I argue that this case study design is best placed to address all the research questions detailed in chapter two, but also complements my philosophical position detailed at the start of this chapter.

In relation to care homes, qualitative research scholars over the years have recognised the need to adapt conventional approaches to accommodate what Thorne et al. (2016) see as a unique environment. Hence, an in-depth case study of two of the units within the care home was undertaken. The aim of this was to harness the analytical rigour proclaimed by Eisenhardt & Graebner (2014), to ascertain the influence of the organisation's culture on employee voice within each unit of the same care home. Furthermore, conducting and then comparing and contrasting multiple case studies is very effective for exploring a range of micro-level components at play within the different case studies (Schein, 2004), and contributing new perspectives (Eisenhardt, 1989), around cultures and voice within care homes (Bryman & Bell, 2007; Schein, 2004). My additional decision to implement a process of theory building from the comparative case studies not only reflects the lack of research within this area (Baird & McKenna, 2018; Thorlby et al., 2018), but also the complex context in which the study is being conducted (Eisenhardt, 1989; Burns et al., 2011).

4.3.2 Choice of case study sites

The researched care home was at the time of the study divided into five separate units, providing care services for 'younger adults between the ages of 18-65 years old' (CQC, 2016). At the time of my case studies, only four of the five units were in operation. Two of these unit's support people with complex physical disabilities, including critical care needs. The other two units provide care for people with differing mental health illnesses, some of whom may exhibit challenging behaviour (CQC, 2016). For the purposes of this study, one unit providing care for people with mental health illnesses (CS1) and one providing care for people with complex physical disabilities (CS2) were selected as study cases. Due to the fact that it was not feasible to case study all four units given my time constraints and available resources, the decision was made on Monday 30th January 2017 between myself and the care home to case study the two units which were identified as being the most diverse in relation to the client group and work environment. This decision was made after gaining access because it was not possible to make it before, due to the fact that the specific care home to be

researched changed, thus the structure was not known. However, this did not have any impact on the methodological approach of the research. Indeed, having diversity within the two-unit cases studied was essential in gaining a breadth of perspective on my research questions detailed in chapter three.

Focusing on the two units (two case studies) enabled me to work within my time constraints and explore the cases in-depth (Eisenhardt, K.M., 1989). This was an appropriate decision, particularly when taking into account the complex nature of culture formation as detailed by Schein (2004) and discussed in previous chapters. In addition, according to Eisenhardt (1989), approaching the study in this way would illuminate a range of cultural factors and voices within the organisation. Reflecting on the choice of units, the range in diversity between the units extended from the size of the units, the type of care they delivered, to the demographics of permanent staff on the units. This diversity was also picked up when analysing the staff's service records, with the respondents differing significantly in age and duration of service within the two units.

4.3.3 Unit one context (case study one)

The first unit to be case studied was unit one; this decision was made jointly with the CNM who deemed this unit to be in her words 'ready for you to explore'. According to the Business Plan, this unit was a 14-beds unit providing care for clients with 'mental health, and behavioural diagnosis'. From my initial inquiries into the unit, I was able to establish that the unit at the time of this study had 12 fulltime care workers, which included two full-time team leaders, four full-time nursing staff and 1-unit manager, who was also a registered nurse. On average, this unit had 4-5 care staff and one nurse on duty during the day and 2-3 care staff at night with one nurse. The ethnic diversity of unit one was evident in observations during my time on the unit, the following extract taken from my daily reflective log details my initial contact with members of staff on unit one, and provides an insight into my initial impression of the unit.

Researcher: *'On reflection, it was a strange day, obviously me being within that working context has changed the behaviours of some staff to an extent. Most noticeable would be that of the unit manager, who from my perspective was keen to please me and give me a good impression from the outset. (Daily reflexive diary on 6/2/17)*

My perspective of unit one from the outset was a very positive one, but it was evident that my presence on the unit would change the way participants went about their day-to-day work and potentially their voice as well. I used my daily log and reflexive diary to detail such observations, and I argue that this process of continuous reflection enabled me to adapt to the working environment of unit one and conduct my research effectively throughout my time conducting CS1 (Johnson & Duberley, 2015).

4.3.4 Unit two context (case study two)

After I had finished gaining data on unit one, and undertaken some preliminary analysis, I then conducted CS2. From an analysis of the home's Business Plan, this unit had 17 beds, which provided care for adults aged 18-65 with predominantly physical disabilities. On that basis, the unit was described as being an 'intensive care unit'. At the time of my study, the unit had around 26 full-time care staff, which included one full-time team leader, three full-time nursing staff, and 1-unit manager who was also a registered nurse. On average, this unit had 8-9 care staff and two staff on duty during the day and 4-5 care staff and one nurse on at night. The cultural and ethnic divergence from unit one was very evident, with a significant number of white, middle-aged women working on unit two, most of whom had been working on the unit for over ten years. The following extract gives an insight into the context of case study two from my first day of conducting research.

Researcher: 'Meeting with CNM who introduced me to the unit manager of unit 2. She was upbeat about the research study and sold it to the unit care workers very well. Called a meeting and told them to pass it on that it is a positive study meant to help improve things for staff.' (Case study two daily log on 21/3/17)

Like in the case of unit one, the unit manager of unit two (CS2-UM1) was very welcoming and accommodating. Other members of staff thought they could use my research to their advantage. I did not know what this meant at the time, but there was a hope on my part that it meant they would be very open and willing to discuss topics relating to my study. In chapter six, I will detail the subsequent information I uncovered about the working environment of CS2 in relation to its culture and the role of employee voice on the unit.

4.4 Research methods

With my above design detailed, and context established, the next section of the methodology chapter aims to explore the data collection methods employed. In keeping with my research questions that aimed to understand participants' perspectives on voice and culture, it was appropriate to utilise a data collection methodology that would allow for the collection of rich qualitative data (Eisenhardt, 1989). Qualitative data collection tools have, according to Borbasi (1996), being an effective way of conducting complex health research over the years and furthering our understanding of organisational issues. To ensure the most effective use of the qualitative data collection process, I decided to deploy a three-stage data collection tool comprising non-participatory observations, document and artifact analysis, and semi-structured interviews. The next section of this chapter first explores the process of my gaining access to the care home and navigating my role as a researcher, before exploring each of the methods deployed for this study.

4.4.1 Gaining access to the care home

The process of gaining access to a research site is, according to Borbasi et al. (2005), a social one constructed between the researcher and the people being studied; thus, the process cannot be easily prescribed within the pages of a textbook. Instead, each context is very different and requires a tailored approach, which takes account of the specific context in which the organisation resides. This was the case for my study, and due to the sensitive nature of care homes, I had initially found it difficult to gain access to a care home. One such attempt is detailed in the below extract taken from my reflexive diary.

***Researcher:** The first care home to be approached for access was based in London and was identified by a former colleague of mine who knew about the type of research I was aiming to conduct. After informing the manager of the care home, the colleague contacted me to inform me that it “may” be possible to undertake my study in that care home. Several attempts were made to contact the care home, but no response was ever received. (Daily reflexive diary on 12/12/16)*

According to Schein (2004), the process by which a researcher gains access to an organisation can be a very complex one. This was the case for me, and after a few unproductive leads similar to the one detailed above, I was finally able to gain access to an organisation. On reflection, in the three cases in which I did not get access, no reason was ever given for the care home in question not wanting to host my research study, so I am unable to comment on this, but my topic area could have been perceived as too sensitive. The extract below, taken from my reflective log, details the process which I undertook in order to gain access.

Researcher: *First, a call was made to the care home in question, and I asked to talk to the deputy manager, who at the time was the most senior person within the home at the point. I decided to ask for a meeting and to discuss things relating to the research in person. (Daily reflexive diary on 4/1/17)*

From the above extract, my access to the researched care home took on several different stages, such as meeting with the deputy manager. On reflection, I think this was to build up trust and for the home to gauge if my study would have any negative impact on the home. In the following extract, I detail my surprise at being granted access to this care home, given that all the previous homes I had approached had turned me down.

Researcher: *I am admittedly surprised as to how willing the (deputy manager) was to allow me to conduct my research within his care home. Looking back, I think the most important thing was giving the home anonymity during the study. He (deputy manager) also asked for official documentation from my supervisors detailing that I would be conducting my research within the home. (Daily reflexive diary on 4/1/17)*

In accessing this care home, the most important consideration for the home was gaining reassurances from me on issues relating to anonymity. The majority of my conversations with the Deputy Manager centred on the issue of anonymity and confidence-building in relation to my true intentions for this study. I was able to overcome the concerns of the Deputy Manager by providing him with a detailed information sheet about the study, which is available in *appendix two*. On reflection, this information sheet was successful in explaining the scope of this study to the Deputy

Manager and subsequently persuading him to sign the consent form, which is available in *appendix three*.

Before starting the research study, I contacted the care home again to clarify all the key components relating to the study. It was at this time I learned that the power dynamics of the home had changed since my last meeting, the Deputy Manager no longer being in charge of proceedings relating to my access to the home. I detail this in the following extract from my reflective diary one week before I was meant to start my first study.

Researcher: *I called and spoke to the new Clinical Nurse Manager (CNM) who was very enthusiastic about me doing the research. She said if I needed anything I should come to her directly now, as if to imply that the deputy manager was no longer of any relevance within the home. It became evident to me at that point that the gatekeeper had changed, and it was up to me to now build up a good working relationship with the CNM. (Daily reflexive diary on 30/1/17)*

The power dynamics had changed because the Deputy Home Manager had been moved to another of the company's care homes to act as a manager while the company found a permanent manager. After making initial contact with the care home, I was able to build up a good relationship with the new gatekeeper (CNM), which Borbasi et al. (2005) refer to as being important in a researcher's efforts to undertake a good study.

The last stage of gaining access to the care home was the first day I entered the home as a researcher. The most significant element of this process was meeting the CNM for the first time. Previously, we had only spoken on the phone, so I was looking forward to talking with her face-to-face, and hopefully building a good relationship. As my only gatekeeper, this was very important to the success of my research study. The most significant line of inquiry to come from the CNM related to whether I had any negative intent regarding the study, which can be seen as relating back to the concerns raised by the deputy manager one month earlier. Apart from this one issue, gaining access to this care home was more straightforward than I had imagined. Moving forward, I was aware that

keeping my gatekeeper on board would be the most important factor in keeping the access that I had been accorded.

4.4.2 Navigating the researcher's field role

In an attempt to strive for the most objective stance possible, my role as the researcher was something which took centre-stage in my reflexive process (Guba & Lincoln, 1994; Yin, 2013). For the purposes of this study, and in keeping with the philosophical approach I had adopted, my role as someone who has worked in care, and as a researcher would be made known to all participants (Gill & Johnson, 2010). Such openness would arguably enable all participants to make an informed choice as to how they would relate to me during my research. Knowing that I was a former care worker, participants would be able to better relate to me because they would feel I could relate to their issues. Although my openness as a care worker could not eradicate my presumptions about care homes, it would open my position up to others within the research environment, thus continuously encouraging me to take account of them. Hence, during this study, I maintained an open approach to my identity while continuously reflecting on how I was influencing participants and their behaviour (Johnson & Duberley, 2007).

I took up what Gill & Johnson (2010) refer to as an 'anthropologically strange stance' on the environment being researched, even though, as in my case, the research environment may be familiar. To maintain this anthropologically strange stance, the key step I took was the employment of my daily reflexive diary, which enabled me to make several changes to my role within the research environment (Seale, 1999). Such changes included my decision to implement a uniform regime, which enabled me to identify as a researcher and not management. My choice of uniform was based on the exploration of pre-existing uniforms within the care home and developing a uniform that overtly identified me as being external to the organisation. After careful analysis of workers' uniforms, I chose to wear black trousers and a black top which I reflected on in the below extract.

Researcher: *Preparing to start my research study on Monday, I think wearing a uniform would be the best thing to do. I don't want to look too formal, but at the same time, I can't look like an employee. I think the black-black combination I came up with after meeting the home manager last week will work well for this study. (Daily reflexive diary on 1/2/17)*

On reflection, my decision to wear a researcher's uniform proved effective in terms of visually identifying me as external to the organisation. The uniform also allowed me to better approach potential participants and openly detail my purpose within their working environment (Johnson & Duberley, 2007). On reflection, I think differentiating myself in this way and informing potential participants that I was not working for the care home had a positive impact on potential participants and their subsequent willingness to participate in the study. It also highlighted the fact that negotiating access is an ongoing process.

Another step I took in navigating my position as the researcher was to hold informal information sessions with participants. This was a chance for me to answer any general questions potential participants may have had about the study. As was the case when I was attempting to gain access to the care home, the most important factor for potential participants was the issue of anonymity. In both CS1 and CS2, I was able to provide potential participants with the necessary reassurance needed for them to feel comfortable enough to take part in the study. *Appendix four* provides details of the observation information sheet given to participants in both CS1 and CS2, and *appendix five* the observation consent form all participants had to sign before participating in the study.

Researcher: *Today, handed out information sheets to the night staff and outlined the rationale for my research. Most important was the need to clarify that everything observed during this study is totally anonymous and that all information as long as it is not relating to abuse of service users would be kept confidential. (Case study one daily log on 8/2/17)*

In both case studies, potential participants were most concerned about confidentiality. This may suggest that there was a significant amount of unease among potential participants in relation to who would have access to the information they provided. At the time, I deemed this to be a good development because I assumed it meant if their confidentiality were protected, potential participants would be willing to disclose valuable information relevant to my study. Confidentiality was also a focus of participants during my interviews, and I felt that the process of taking them through the interview information sheet (*appendix six*) and the interview consent form (*appendix*

seven) was instrumental in winning their trust, which contributed to the rich data analysed in chapters five and six.

Reflecting on my experiences of navigating my role as a researcher, I have been able to identify two problematic areas which I did not account for before starting my study. The first is related to my relationship with the CNM1, who was my only gatekeeper during the entire process of collecting data but was also very eager to gain information on what participants were telling me. The following extract details my dilemma in keeping my access while maintaining the anonymity, which underpinned the ethical integrity of my study.

***Researcher:** Pressure from CNM1 to know what is happening in the unit. During CS1, I would have regular meetings with CNM1 who on reflection was much more helpful than anyone would have imagined her being. She was offering me full access to all the information the home had about employee voice and was also willing to facilitate any meetings I wanted to have with specific members of staff. This, I thought, was very helpful but I couldn't help but feel it was at a 'price'. Indeed, that price was information, which she later asked for, but was not provided with. (Daily reflexive diary on 14/3/17)*

My above dilemma was a difficult one to navigate and something that I had not foreseen, but because the anonymity element of the study was prominent in the information sheets, I was able to use it to my advantage. I did offer CNM1 generic emerging trends, but I was able to circumvent disclosing specific information relating to my study, and I was still given the access needed to effectively complete my research. This example further demonstrates the ongoing ethical dilemmas faced by qualitative researchers in the field.

The second problematic area which I had not accounted for in relation to my position as the researcher centres on something I refer to as the *information burden* of conducting a study. That is, after gaining the trust of participants, they started to disclose sometimes very personal information to me. In additions, some participants disclosed information relating to situations in which they have been punished for voicing themselves by other members of staff who were also participants and with whom I interacted regularly. The process of staying objective and professional in such an

environment, especially when in possession of such information, was more difficult than I imagined, and something that I reflect on in the following extracts.

Researcher: *The personal burden of information is real; I didn't think I would feel like this, but I do feel a deep burden of knowledge now. Some of the information I have been given and the insights I now have weigh heavy on me, more so than I thought. I just got home, and I am writing this in my kitchen, I am just reflecting on what has been a very interesting day. (Daily reflexive diary on 17/4/17)*

Researcher: *On reflection, the notion of taking an objective stance is useful methodologically and enables the researcher to get at information which otherwise may be difficult or compromised. At the same time, it is important to acknowledge that even at our most objective, we are still just humans and, as such, susceptible to being emotionally drained. (Daily reflexive diary on 17/4/17)*

The additional information gained from participants did on reflection provide me with an additional layer of insight into the organisation and its culture. I would also argue that I was able to maintain my stance and objectivity within the research environment, but in the proceeding weeks after my study, I did feel drained. The role of information burden is an issue that I will take into consideration in future studies.

4.4.3 Inductive methodologies

The use of inductive methodologies within management research has, over the years, taken several different manifestations (Glaser & Strauss, 1967) reflecting the changing nature of the field (Gill & Johnson, 2010). With a focus on exploring how organisational cultures within the care home context influence employee voice, this study is best placed to proceed by drawing on inductive methodologies (Bryman & Bell, 2007). That is, this study aims to explore the inter-subjective world of individual care workers in relation to the concept of organisational culture (Schein, 2004) and employee voice (Morrison, 2011); thus the recognition and appreciation of an inductive standpoint is of the utmost importance (Denzin, 1971). Furthermore, it is the case that the employment of an inductive approach not only complements my methodological position but also provides a framework

from which to effectively establish an emic viewpoint which highlights the customs and beliefs around employee voice (Guba & Lincoln, 1994) within this care home. This is something which a deductive approach could not have offered this study (Denzin, 1971), due to its inability to effectively explore the intersubjectivity of individual participants and groups (Bryman & Bell, 2007). Thus, this study proceeds with the deployment of a three-stage inductive data collection tool.

4.4.4 Unstructured, overt non-participatory observations

From an exploration of the literature on qualitative data collection tools, it was possible to identify a number of observational strategies which could have been deployed for this study, such as participatory observations (Borbasi et al., 2005). In keeping with my postpositivist paradigm, there was a need to deploy a data collection strategy that was as objective as possible given the limitations on objectivity discussed previously (Guba & Lincoln, 1994; Johnson & Duberley, 2015). To realise these needs, my observational strategy was guided by the literature and comprised three elements, namely being unstructured, overt, and non-participatory (Eisenhardt & Graebner, 2014). The combination of these three elements, I argue, offered the best way of observation within my research environment while fulfilling my philosophical commitments (Johnson & Duberley, 2015).

Firstly, unstructured observation was selected in order to remove any restriction on what could be observed, and rather follow the data as it emerged (Cook & Campbell, 1979). Indeed, I was guided by the literature in relation to potential areas of observation and by the practicalities of the care home in relation to what was possible to observe, but efforts were made to follow the data as much as possible. Taking this position would allow me to understand and interpret the cultural behaviour within the care home, according to Mulhall (2003). This is because, from this position, I was able to follow participants unhindered through their working day, which is of the utmost importance to a study that aims to understand the influence of organisational cultures on employee voice. This is in contrast to the structured approach which would have limited me to a 'strict checklist of predetermined behaviours' (Mulhall, 2003), without the flexibility needed for a study which is focused on understanding participants' perspectives and interactions.

The next strategic consideration for my observational strategy was the decision to maintain an overt position in my role as a researcher within the care home during my observations (Gill & Johnson,

2010). Again, this is in line with my philosophical position of obtaining the most accurate accounts of participants (Symon & Cassell, 2012; Guba & Lincoln, 1994). That being so, my decision to take an overt position provides what Gill & Johnson (2010) see as the freedom and legitimacy to effectively gather data from different sources whilst continuing to maintain a constant role from the perspective of participants.

In relation to the care home, a covert position would have proved problematic due to the need to conform to the norms of the care home, such as service users' care needs and confidentiality. In addition, the ethical limitations of my study meant I could not proactively interact with service users or enter their rooms. Such limitations would have made it difficult to take on a covert role within the care home and I would have ultimately drawn attention to myself, which would have potentially had a detrimental impact on my ability to collect direct data from participants (Lewis et al., 2013).

Finally, after a review of the literature, a non-participatory position was arrived at which for my observations would enable me to maintain the highest level of objectivity by removing myself from the day-to-day interactions between participants (Guba & Lincoln, 1994; Beck & Polit, 2014). Although I had worked within the company, I had not worked within either of the two units or with any of the participants previously, thus my insider status was limited (Heslop et al., 2018). Non-participatory observations would also enable me, according to Higgs et al. (2008), to dig deep into the manner in which interactions around organisational culture and employee voice were actually negotiated on the ground, which is particularly important within an ever-evolving organisational environment such as care homes (Mulhall, 2003; Age UK, 2018). My observer position strived for the greatest degree of neutrality possible (Beck & Polit, 2014), whilst acknowledging complete neutrality was not possible. Hence, the deployment of this unstructured, overt, non-participatory position, I argue, would make possible my full exposure to the organisation's culture and the day-to-day enactment of voice within each unit.

4.4.5 Document and artifact collection

The second data collection tool deployed as part of this case study was document and artifact analysis (Burrell & Morgan, 1979; O'Connor, 2007). During the case study of each unit, an in-depth documentary analysis of the care home's policies and procedures relevant to organisational culture and employee voice was undertaken. Furthermore, artifacts relating to organisational culture and

employee voice such as posters, leaflets, notifications, websites were also examined (O'Connor, 2007). From a review of the management literature on document and artifact analysis, the purpose of this data collection tool was to expose the espoused, formal, and publicly accessible versions of the home's stance on issues relating to the organisation's culture and the role of employee voice within the organisation (Schein, 1983). Through the analysis of language and artifacts used to enact voice, this tool would be able to explore how interactions around employees voicing themselves manifest (Fitzgerald, 2007). Furthermore, it would be possible to extract ways in which the espoused role expectations of employees relating to employee voice is constructed in these documents, and the extent to which this is subsequently enacted by employees (Burrell & Morgan, 1979).

During the data collection process, the document and artifact analysis tool was deployed before the start of the study on publicly available documentation and artifacts relating to organisational culture and employee voice (O'Connor, 2007). This was to aid my efforts to gain some contextual understanding of the organisation which Eisenhardt & Graebner (2007) state as being an important step in data collection. The documents and artifacts analysed as part of this research study were gained directly from the organisation and represented the organisation's espoused views on issues relating to employee voice and the organisation's culture. There is, therefore, an argument to be made that since such data was not affected by my intersubjective views, this represented an objective approach to data collection (Bryman & Bell, 2007; Johnson & Duberley, 2015).

4.4.6 Semi-structured interviews

The final stage of the case study would involve the deployment of semi-structured interviews which, according to Berg et al. (2004) and Eisenhardt & Graebner (2014), are known to be a highly efficient way of extracting good empirical data within distinctive environments. Thus, the deployment of interviews as the last data collection tool to explore the contested concepts of organisational culture (Deal & Kennedy, 1982) and employee voice (Van Dyne et al., 2003) within a complex environment such as care homes (Skills for Care, 2016) is considered appropriate. Specific to the care home setting, Borbasi et al. (2005) perceive interview as having a therapeutic effect on participants by giving them a chance to speak about their work and lives. This was something which came to the fore during the interview process and was accommodated through an interview debrief session. The themes guiding the semi-structured interviews were derived from the literature and also

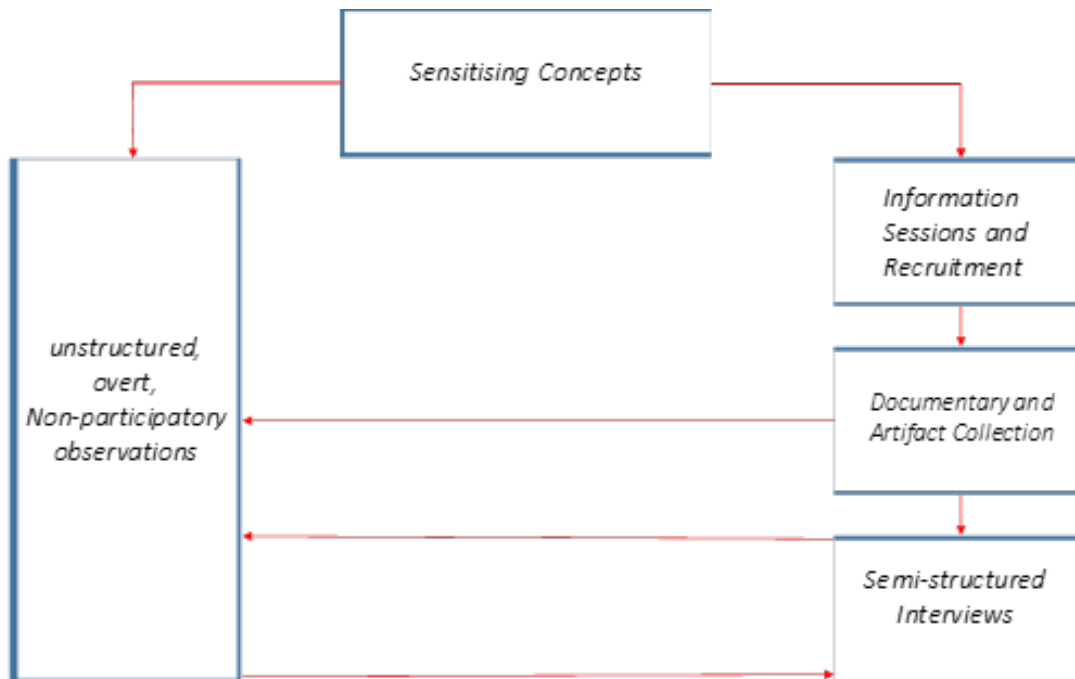
observations made in the field. The interview process was also used to build up relationships and earn the trust of participants, which Borbasi et al. (2005) state as being an effective way of strengthening the quality of the data gained (Guba & Lincoln, 1994).

Through the semi-structured interview process, it was possible to conduct in-depth interviews with participants at all levels of the care home hierarchy and better understand meanings relating to organisational culture and employee voice (Berg et al., 2004; Eisenhardt & Graebner, 2014). Furthermore, Britten (1995) argues that the deployment of semi-structured interviews allows personal perspectives to be gained, and assists in the identification of the types of language used in constructing narratives around culture and voice. This personal perspective would complement the emic philosophical approach I had adopted (Guba & Lincoln, 1994), and therefore aid in the generation of what Borbasi et al. (2005) have stated to be high-quality data. Indeed, I argue that the data gained as a result of the deployment of my semi-structured interview strategy, as in the case of the previous two strategies, did result in the acquisition of relevant data which will be detailed in the subsequent two chapters. *Appendix six* provides details of the interview information sheet provided to all participants who agreed to participate in the interviews, and *appendix seven* the consent form all participants had to sign before the interviews

4.5 Data collection process

This section explores my data collection process, with the use of sensitising concepts as a starting point from which I proceeded with data collection in both case studies. My unstructured, overt non-participatory observations continued throughout the data collection process, whilst my information sessions, document and artifact analysis, and semi-structured interviews took place one after the other. Finally, information gained during my observations was fed into interviews as a way of gaining clarification of specific situations I had observed. Feeding observed information into my interviews was to ensure that I did not misinterpret those situations, therefore, attaching my intersubjective perspective onto them (Bryman & Bell, 2007). This clarification of the observations process, I argue, was an important one as it allowed me to gain participants' interpretations on such situations, thus making the data collection process more objective (Guba & Lincoln, 1994). *Diagram Three* below provides a visual representation of the *Data Collection Strategy Framework* I implemented in both CS1 and CS2.

Diagram 3: Data Collection Strategy Framework for Case Study One and Two



4.5.1 Stage one: sensitising concepts

My first consideration for the data collection process centred on whether the study should be guided by sensitising concepts (Johnson & Duberley, 2015). After careful deliberations, I took the decision to acknowledge and incorporate sensitising concepts into the design of this study (Johnson & Duberley, 2015). Such sensitising concepts did not dictate the direction of my study, but rather only offered initial positions from which to start, after which the study was guided by the data as it was being collected (Eisenhardt & Graebner, 2007; Gill & Johnson, 2010). Sensitising concepts used were gained from examining the home's publicly available documentation such as websites and publications as well as CQC documents on the home. In taking this approach, I was able to quickly ascertain the reliability of such concepts based on the data I was collecting, and it also avoided my initial areas of focus being guided by my subjective perspectives of the units (Guba & Lincoln, 1994; Johnson & Duberley, 2015).

4.5.2 Stage two: information sessions and recruitment of participants

The second stage of my data collection process was an ongoing one which started with the information session I delivered to the home manager to gain access to the care home. At the unit

level, information sessions were held at the start of both case studies as a way of recruiting participants, and also shaping the narrative within each unit as to the purpose of this study. On reflection, this was a good strategy as it resulted in potential participants asking questions, reading the information sheet and understanding that the data collection would be anonymised, which turned out to have been a key recruiting factor for the people involved (Seale, 1999). In both CS1 and CS2, I ran multiple information sessions at different times of the week for both day and night staff so as to engage as many potential participants as possible.

4.5.3 Stage three: unstructured, overt, non-participatory observations

To limit the impact of my observations on participant behaviour, no observational data was recorded for the first three days of observations in either unit (Yin, 2013). In addition, no information was recorded in the presence of participants or on paper. Instead, I took the decision to take down all information on my mobile phone device as a way of removing the formality of the data collection and ensuring that participants felt at ease when they came into contact with me. This consideration came about through my reflexivity and was introduced within the first two days in CS1, during which I noticed that participants were very anxious whenever they saw me writing. The following extract from my reflexive diary gives an insight into my thinking at the time.

Researcher: *I also didn't realise using a pen and paper to take notes would make the workers freak out like that. They seem to act very calmly when they see me on my phone checking emails though, so it's probably best that I use Word on my phone to make all my notes. Hopefully, this will work, otherwise I am at risk of messing the quality of the data up. (Daily reflexive diary on 7/2/17)*

Although participants knew through the information sheets that they were being observed, I noticed that participants in both cases, studies were more relaxed around me when notes were taken on my phone. Due to the unstructured nature of this observation tool (Cook & Campbell, 1979), my only parameters were to ensure that all participants were observed and that I observed every hour of the day at least once during the duration of my time on each unit. I also observed a 24-hour cycle on each unit as a 'reconnaissance strategy' to sample both case studies and identify the specific times of the day in which voice was being enacted, and staff were interacting with each other. From this

sampling, I was able to adapt my observation strategy to accommodate such occurrences and focus more on them. *Appendix eight* outlines the times of the day in both units one and two on which I focused my observations after my initial '24-hour reconnaissance cycle'.

It is important to note that the above times were not always the same and, importantly, variations did occur within these timeframes, which were accounted for during the observations on both units. Furthermore, my observations lasted for the duration of the time on both units and the information gained from this stage did feed into interviews with participants, thus representing a very important component of my data collection process.

In addition to the above, I also undertook seven hours of observations with the Clinical Nurse Manager of the home, specifically focused on gaining additional insights into how management within the home communicated with front line care staff.

4.5.4 Stage four: documentary and artifact data collection

The fourth stage of my data collection process involved additional document and artifact analysis to that used to sensitise my approach to the data collection. This additional analysis was undertaken on those documents and artifacts which I could not get access to externally, such as internal organisational policies and procedures relating to the home's culture and the role of employee voice. The data collection process was undertaken before the start of my interviews as a way of establishing a better picture of the formalised position within this care home before interviewing participants. This was an important consideration, because it enabled me to gauge the extent to which such formalised positions on employee voice were perceived by participants. Because my observations would have already been underway, it also enabled me to gauge the extent to which such formalised positions were being manifested and enacted on the ground.

The collection and analysis of documents and artifacts took place both at the home and unit levels, and for the most part, the same sources were used for both CS1 and CS2. In relation to employee voice and organisational culture, the care home had overarching policies and procedures. Due to this fact, it was possible to take the knowledge gained from this analysis and apply most of it to both units. Looking back on the data collection process, this was the only tool to yield a significant amount of information which was applicable within both case studies. What became important was to

explore how perspectives relating to these documents and artifacts differed or were the same between the two cases. That was another reason why I undertook this stage and completed it before starting my semi-structured interviews. As a result of the process, it was possible to get access to 110 pages of relevant internal documents relating to the care home's culture and employee voice.

4.5.5 Stage five: semi-structured interviews

The last stage of my data collection process was semi-structured interviews with participants. Conducting the interviews last was aimed at enabling me to maximise the potential of gaining the most relevant insight from participants relating to voice and culture. I was able to do this by incorporating elements from both my observations and document and artifact analysis into the interviews. This meant that I had an a very good grasp of the working environments of both CS1 and CS2 before starting my interviews with participants. Thus, my questions could be more directed, and I was able to give participants examples from documentation or observations relating to specific points. Looking back, this strategy enabled me to follow up on specific lines in their entirety and establish a more objective position in relation to my findings as they were all being reinforced by participants.

In relation to unit one, the interviews all took place in the same location, and for the most part, were very organised and facilitated by the unit manager. In unit two, the interviews took place in multiple locations and were less structured due to the working dynamics within the unit and the fact that it was difficult to get specific times to conduct interviews.

Questions relating to employee voice and organisational culture remained the same across both units, but I used context-specific examples for participants to better understand the context of the interview questions. I also had a section at the end of each interview in which I would ask participants specific questions relating to what I had observed or documentation relating to their units. In both case studies, the parameters of such questions were always about employee voice and organisational culture. *Appendix nine* provides information on all the interviews conducted for this study.

4.5.6 Data tables overview

During the data collection process, it was possible to collect what I argue was a relevant amount of information with which to subsequently conduct effective analysis. *Table one* below provides information on the data gathered from all three methods deployed during both my case studies.

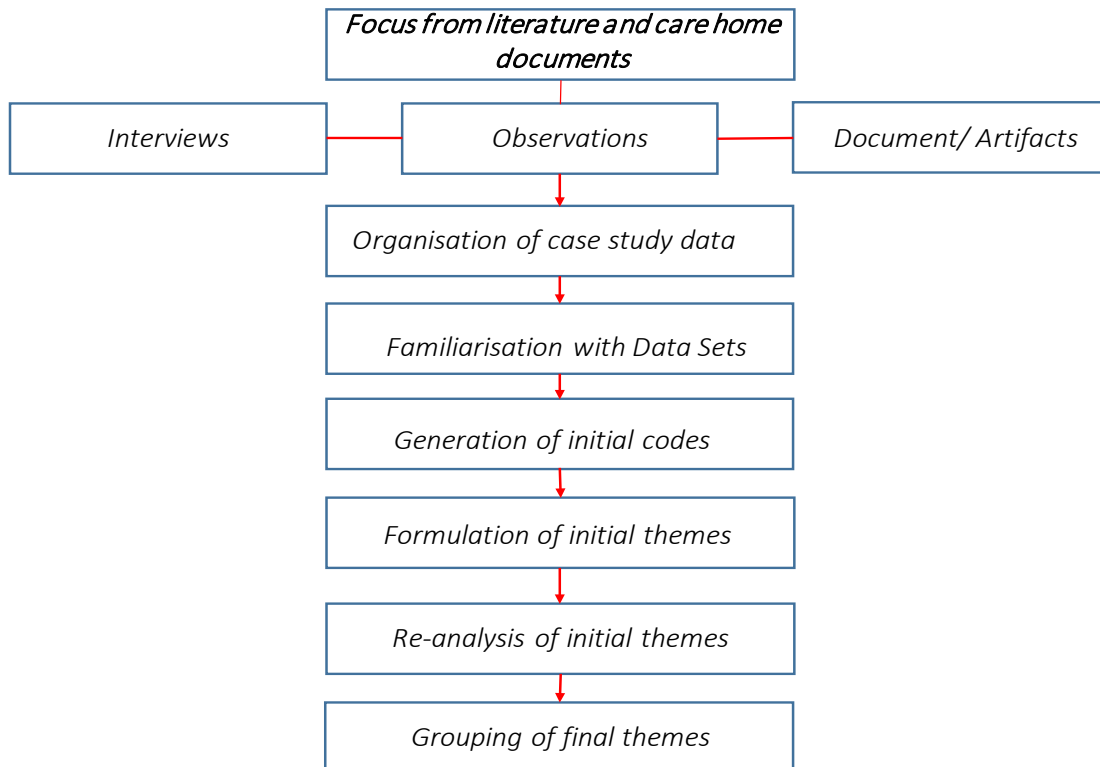
Table 1: Total Data Collected in Case Study One and Two

Total interview time	27:59:40 hours or 1674.74 min
Total number of interviews	30
Total observation time	276:00:00 hours or 16560 min
Total internal documents	110 pages

4.6 Data analysis process

For this study, the data analysis process proposed by Eisenhardt (1989) and Eisenhardt & Graebner (2007) and used by several relevant qualitative studies (Burns et al., 2011) was drawn on to inform my thematic *Data Analysis Framework* detailed below which was used to analyse the data. By analysing and comparing the differences between the espoused position on what was being said and written and what I observed, this analysis framework was able to offer a real-life picture on the influence of the organisation's culture on employee voice within the units researched (Eisenhardt, 1989; Eisenhardt & Graebner, 2007).

Diagram 4: Data Analysis Framework



4.6.1 Data analysis stages

The first stage in analysing my data was to organise all the data collected according to collection method from both case studies. All documentation and interview recordings were then transferred onto my university computer and kept under password protection in keeping with my ethical commitments. After all the data had finally been organised, I undertook an initial analysis of all documents and observation logs from both case studies by carefully reading and rereading them. This was followed by the transcription of all the interviews I had gathered from both case studies. This transcription process also acted as a form of analysis because I was gaining a very good insight into the data and starting to establish key areas of interest. After transcription, initial codes were identified through a thematic analysis of all the data using NVivo. Initial codes were generated from interview transcripts, observational notes and documents and artifacts gained from the care home (Eisenhardt & Graebner, 2007; Gehman et al., 2018). *Appendix eleven* is a table of the initial codes from the data analysis process.

This analysis process resulted in a large number of initial codes being generated which were later reanalysed and thematically grouped together to formulate initial themes specific to each case study

and the care home available at *appendix eleven* (Eisenhardt & Graebner, 2007; Gehman et al., 2018). The requirement for each theme was that it could be found in each of the three data collection methods I deployed, that is, a reference to each theme could be found in interview transcripts, observational notes and the artifacts I gathered (appendix 13-18). These themes were then reanalysed within each case study and at the care home level to identify any overlap or inconsistencies that may have arisen during the initial stages of analysis. The remaining themes were then thematically grouped together and generated six broad final themes, available in *table two*, and which I have subsequently used throughout chapters five and six to form the basis of my findings (Eisenhardt & Graebner, 2007; Gehman et al., 2018).

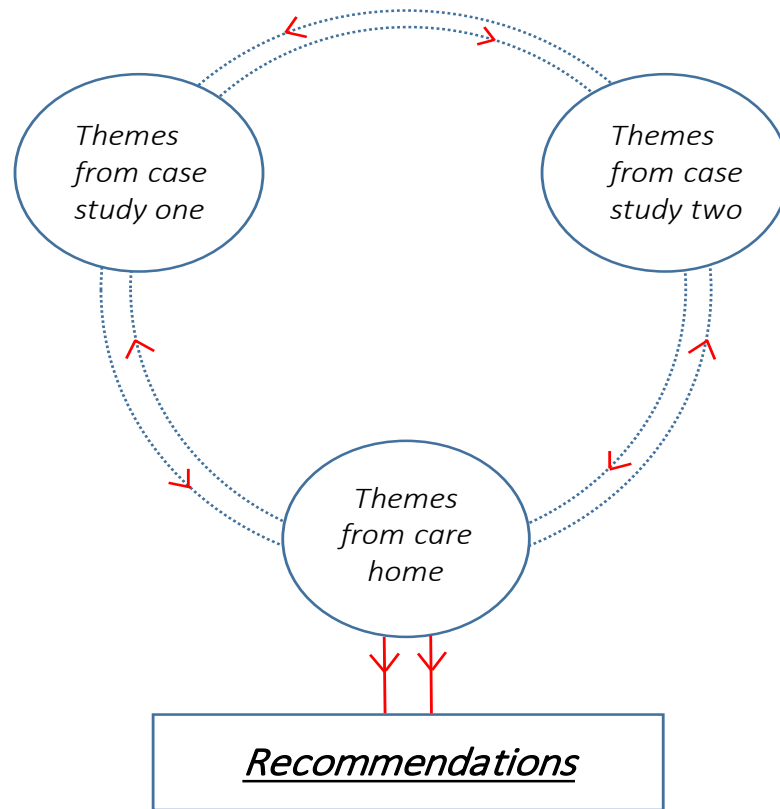
Table 2: Cross Unit Themes

<i>Themes</i>	<i>Location</i>
Theme One: Participants' understanding of voice	Appendix Twelve
Theme Two: Participants understanding of culture	Appendix Thirteen
Theme Three: The care home is not homogenous	Appendix Fourteen
Theme Four: The training environment	Appendix Fifteen
Theme Five: The family	Appendix Sixteen
Theme Six: The cliques	Appendix Seventeen

4.6.2 Cross analysis of themes and generation of participant recommendations

After undertaking the analysis on each unit, I developed the *Cross Unit Thematic Analysis Framework* detailed below to cross-analyse the themes which had emerged from my analysis of both units and the care home. Although the care home was not case studied independently, through my data collection I did obtain data at the care home level such as from interviews with the Home Manager, Clinical Nurse Manager and the Night Manager. I, therefore, decided to keep this data separate from the two units I did case study, but to feed this type of information into my analysis when directly relevant to each specific unit. Through my cross-analysis it was possible to establish recommendations in relation to how voice can be elevated within the care home. The recommendations to emerge from the analysis can be found in *appendix nineteen*.

Diagram 5: Cross Unit Thematic Analysis Framework



This analysis process was guided by the process proposed by Eisenhardt & Graebner (2007), which makes it possible to argue that any information from my analysis would offer an insight into ‘how things really are and how things really work’ (Guba & Lincoln, 1994; Symon & Cassell, 2012) in this care home. Furthermore, I put forward the perspective that such information would enable me to establish a better understanding of the influence of this care home’s culture on the ability and willingness of employees to voice themselves. Finally, I argue that it would also be possible to use this data to inform future policy on culture and employee voice within the care home context (Guba & Lincoln, 1994; Durning, 1999).

4.7 Theorisation

Although this study was undertaken within one organisation, the philosophical and methodological considerations which have underpinned it do provide the potential for theory generated (Eisenhardt, 1989). This process, according to Morse (1994), is part of a process of recontextualisation where theory can be abstracted to new settings, but this would, according to Eisenhardt (1989), rely on emerging theories being compared to existing literature (Morse, 1994).

Theorisation within the post-positivist tradition is nothing new according to Durning (1999), who claims that one area in which postpositivist methods have thrived is in the area of policy analysis where they are well known for producing good quality theories based on the analysis of policies. This recognition is important, as one of the main aims of this study is to contribute new perspectives for the development of policies around open organisational culture and the promotion of employee voice within care homes. Therefore, the use of post-positivism to underpin my philosophical position, I argue, was appropriate for this study. In addition, Weaver & Olson (2006) argue that theories arising from postpositivist paradigm inquiry have over the years also yielded significant theories in the Health and Social Care contexts. I argue that the position I have taken for this study represents an effective one in contributing to efforts to generate theory around culture and voice within the social care context. This analysis did not generate a new theory but did use a new analytical framework to explore care home cultures and put forward recommendations for future policy initiatives detailed in chapter seven (Morse, 1994; Weaver & Olson, 2006).

4.8 Methodological considerations

In detailing the stages undertaken to collect and analyse the data above, it was also possible to take account of all areas associated with this study. The final section of this chapter details the methodological considerations which were accommodated in the development and execution of this research study and which, as I argue, have served to enhance my study.

4.8.1 Ethical considerations

My ethical considerations for this study were in line with those of the University of Sheffield, and the policies and procedures that underpin those considerations. I also took into consideration the policies and procedures of the care home in question. I, therefore, submitted a full ethical application to the University Review Department and sought guidance from supervisors. Through this process, I was able to carefully consider introducing sensitive topic areas in the study and offer a debrief session to all participants. In addition, employees who no longer wished to take part or changed their minds before final publication were assured that their involvement, however small, would be removed from all records and not be included in the final study. Furthermore, all data on participants, such as interviews and observations, were anonymised (Bryman & Bell, 2007).

The consent of the home was first officially sought before the study proceeded; this involved detailing all the ethical processes of the study for the care home manager for approval. Consideration was also given to the fact that residents live within the research environment, so all steps were taken to be respectful to residents, such as not conducting any aspect of the study in private areas of the home such as bedrooms or quiet rooms. Before each case study, information sheets were given out to all participants, and those wishing to participate were asked to sign a consent form before doing so. Finally, in relation to continued consent, participants were made aware that the consent form they signed was also for continued consent and that future publication would result from the data gathered. The most significant concern to emerge from my information sessions on both units was the issue of participant confidentiality, which I was able to fully address through my information sheets which can be found in *appendix two, five and seven*. On reflection, the ethical considerations underpinning this study were ongoing throughout the study and related to the context and methodology being deployed.

4.8.2 Limitations

One of the key limitations of this study was time restriction. Due to the complex environment of care homes (Dixon-Woods et al., 2014; Skills for Care, 2017), and the contested nature of the concepts in question (Cummings & Schmidt, 1972; Van Dyne et al., 2003), it was not possible to spend as much time collecting data in the field as I would have liked. This was down to logistics and the practical time available for this study. On reflection, I do not think this had any influence on the quality of the data collected. Initially, the plan was to conduct more case studies in more organisations, but due to lack of time I made the key decision with my supervisors to aim for depth and detailed insight rather than breadth and to therefore conduct just two case studies in one organisation.

4.9 Summary

In detailing the methodological processes and considerations underpinning my research study, it has been possible to give a full account of all the factors that have contributed to its development. From the exploration of my philosophical and research design approach, I was able to demonstrate how my philosophical commitments aligned with my study design (Cook & Campbell, 1979; Guba & Lincoln, 1994; Johnson & Duberley, 2015). A justification for the use of Schein's theory of

organisational culture proceeded, including the provision of the *organisational culture and subculture analytical structure*, which was based on Schein's theory of organisational culture. This structure was also noted as being the blueprint on which the results of this study would be subsequently reported back. This chapter has also detailed the processes that I undertook to gain access to the researched care home (Borbasi et al., 2005), before providing a detailed insight into the three-stage case study design which I deployed for this study (Eisenhardt & Graebner, 2014). Using my *Data Collection Strategy Framework*, I detailed the various stages of my data collection process and argued that it was an effective strategy for theorisation (Eisenhardt, 1989; Weaver & Olson, 2006), with potential to contribute to future policy initiatives within care homes (Morse, 1994).

Chapter Five

Care Home Culture and Voice

5.0 Introduction

To better understand the influence of the cultures within the care home on employees and their ability to voice, this chapter first aims to explore participants' understanding of these two concepts. After which, the *Organisational Culture and Subculture Analytical Structure* detailed in chapter two will be deployed as a framework with which to explore the culture within this care home (Schein, 2004). Through an analysis of my data, it will be possible to identify cultural characteristics of the care home present at each level of the analytical framework (Aveyard, 2014). Such characteristics will be guided by examples given by Schein when he was case studying Ciba-Geigy and Digital Equipment Group using his framework (Schein, 2004). Through the deployment of the analytical framework, I argue that it will be possible to not only better understand the culture within the care home, but also the factors facilitating and mitigating against employee voice within it.

5.1 Participants understanding of employee voice

In an effort to better understand the influence the culture of this care home had on how employees voice themselves, I deemed it important first to explore how participants across both unit's case studied understood the concept of employee voice. The data distribution of participants understanding of voice is available in *appendix thirteen*; this was also the first theme generated in my analysis of data in chapter four. From the perspective of Ruck & Welch (2012), there are differing perspectives on the relevance of employee voice within an organisation; thus, I deemed it essential to explore this perspective within the care home. Through my *Cross Unit Thematic Analysis Framework*, detailed in the previous chapter, it was possible to identify three key themes relating to participants' understanding of employee voice based on the following research question.

Researcher: *How do you understand the concept of employee voice, what does it mean to you?*

5.1.1 Theme one: employee voice is being listened to

The first theme related to participants perceiving employee voice as a process of being listened to. The following extracts taken from interview transcripts detail this perspective.

Participant: “It means when you are an employer, you have to listen to their concerns and listen to their worries.” (CS2-CA6)

Participant: “To me, it means like your voice being heard on a situation whatever you say to the management.” (CS2-CA4)

Participant: “Employees speaking, and management listening.” (CS1-CA7)

From the above extracts, it is evident that within this care home, there was a group of participants who perceived employee voice as being a process by which employees are listened to. For the above, participants such as CS2-CA6 and CS2-CA4 felt that ‘being heard’ was the most essential component of employee voice rather than what employees were actually saying. From the perspective of Van Dyne et al. (2003), this theme can be linked to a form of prosocial voice, in that the above participants who are trying to voice are doing so over work-related issues (Waring, 2016).

5.1.2 Theme two: employee voice is a dialogue between employee and employer

The second theme to emerge from my analysis was that participants perceived employee voice as a dialogue. That is, it was not a one-way flow of information, but rather a process by which both employees and the employer were engaged in conversations (Dixon-Woods et al., 2019), as the following extracts exemplify.

Participant: “It means that whatever the employee’s concerns are, they can voice it out to the employer and there have to be some measures in place for feedback so that they know that the employer had heard what the employee is saying.” (CS1-N3)

Participant: “I think it’s communication with employees and general things like how the home is run.” (CS2-N1)

Participant: “To me, it means when we are able to communicate our needs, interest and concerns to the people we work for.” (CS1-N2)

The notion of communication is very prominent in the above extracts in which participants such as CS1-N2 talked about employee voice as a process of communicating with ‘them’, and ‘the people we work for’. This example referred to the care home and its management, rather than just being listened to as detailed in the first theme; this theme centres on an exchange of information. This theme is also in line with the views of Dixon-Woods et al. (2019) on employee voice within the healthcare context. It is worth noting that three of the four participants within this theme were nursing staff, compared to all three being care staff in the first theme. This may suggest that different groups of workers depending on hierarchy have different experiences of voicing themselves and as such different perspectives on employee voice.

Indeed, *The Care Home Hierarchy* diagram in chapter four indicates that nursing staff are higher up the care homes hierarchy than care staff. It can, therefore, be argued that this higher status within the home meant that such staff had more opportunity to engage with management (Davies & Mannion, 2013). This position is in contrast to care staff who were at the bottom of the hierarchy and as such may just hope to be listened to rather than perceiving that they would have an opportunity to engage in a dialogue with management (Martin & Waring, 2013; Waring, 2016).

5.1.3 Theme three: employee voice is an expression of one’s views

The final theme relating to participants’ understanding of employee voice related to the notion put forward by some participants that employee voice is the expression of one’s views. These perspectives are detailed in the following extracts from participants.

Participant: “For me, it’s about allowing pathways for people to let them know they have a voice, so if people come from outside, they can share their ideas.” (HM1)

Participant: “Employees can express their thoughts and views about some policies changes without any fear of their manager or immediate supervisor or anything and want to be heard.” (CS1-UM1)

Participant: “Well, that means giving employees a chance to voice their concerns and talk about issues, and when you give an employee a voice, this should also give them empowerment.” (CS2-N3)

From the above extracts, participants perceived voice as an expression of one's views. Furthermore, with two managers and one senior nurse expressing an opinion within this theme, it would suggest that employee voice for those at the top of the organisation is perceived more concerning receiving voice rather than voicing themselves. This perception is the case when exploring the response given by the home manager HM1, who talks about 'allowing paths for people to voice' rather than how he would voice.

What has become apparent is that in our efforts to better understand the notion of employee voice, the perceived position of participants within this care home plays a significant role in shaping how participants perceive employee voice. This perceived position is something which CS2-CA4 comments on in the below extract when asked about barriers to voice within the care home.

***Researcher:** Is there anything the home does, which makes it difficult for you to get your voice heard?*

***Participant:** "Well, like most organisations, if you are lower down the organisation, then your voice will not matter cos you are just a number. Unless you bang your head on the wall, it's just the fundamental nature of the care work." (CS2-CA4)*

From the perspective of CS2-CA4, the position of staff within the care home does influence whether your voice is listened to. From my analysis of participants' perspectives on employee voice, this is the conclusion that I have also reached. From the Health and Social Care literature on employee voice, the notion that the perceived positionality of employees within a care home is directly linked to how employees see their voice is underdeveloped. It is important to note that hierarchy is not the only factor which influences employee voice within a care home setting; indeed, chapter two and three have provided detail on this (Morrison, 2011; CQC, 2016). What this analysis demonstrates is that within this care home, hierarchy was a significant factor for participants, which I explore further in chapter seven.

5.2 Participants understanding of organisational culture

As with the concept of employee voice, I also deemed it necessary to explore participants' understanding of organisational culture due to its contested nature within the management literature (Smircich, 1983; Allaire & Firsirotu, 1984). To do this, I included the following question in

my semi-structured interviews. The data distribution of participants understanding of organisational culture is available in *appendix fourteen*.

Researcher: *I would like to ask you how do you understand the concept of organisational culture?*

Participant: *“Culture is the system which is paraded in a certain place.” (CS1-CA4)*

Participant: *“From my understanding, it’s how you operate on a day to day basis and carried out as a norm.” (CS1-UM1)*

Participant: *“I think it is the way in which the organisation works.” (CS1-N1)*

Participant: *“What happens within an organisation and what is accepted.” (CS1-N3)*

Participant: *“Culture is the way you do things within a certain setting, and I think with culture, we have a very good culture here.” (CS1-CA5)*

In contrast to the contested nature of organisational culture within the management literature (Smircich, 1983), the above extracts from participants’ responses can be seen as following a view that organisational culture represents the ‘*norms of an organisation*’ (Deal & Kennedy, 1982; Schein, 1985). Such definitions, I argue, are essential as they serve as a guide to how participants perceive the concept of organisational culture, which is important in the subsequent exploration of the care homes culture.

5.3 Participants’ perspectives on the care home’s culture

Following on from my initial question on a general understanding of organisational culture, my next question aimed to contextualise that within the working environments of participants. My analysis showed that unlike the responses to the initial question on a general understanding of organisational culture, when applied to the working environment of participants, three broad contrasting themes emerged. The first theme was from a group of participants who perceived the care home’s culture as being positive; the second theme was from participants who perceived the culture as being negative. The third theme was from participants who perceived the care home’s culture as being in flux, influenced by a complex mix of factors, particularly the history of the organisation. The following section of this chapter explores these three themes in detail.

5.3.1 Theme one: positive perspectives of care home culture

The first theme to emerge from my analysis of responses to the above question relates to participants who perceived the culture within the care home as being good to varying degrees. The below extracts represent the positive responses given by participants on perspectives of the care home's culture.

Researcher: *Within the care home environment, how would you describe the culture?*

Participant: *"Yes, I think it is positive, I think it is an interesting time to be in this company, we now have external investment coming in." (HM1)*

Participant: *"I would say it is much more positive than the time I first started." (CNM1)*

Participant: *"Like I said before this place is a good place to work when compared to so many other places I have worked. The maintenance culture is very good as well but I don't think the staff are being looked after as much as they should be." (CS1-N2)*

Participant: *"I think it is a good culture, I think it is moving forward. I think they are trying to renovate the home and trying to get new people to come into the home". (CS2-CA6)*

Participant: *"Yes, I think it is a good place to work. From what I have been told about other care homes, this is one of the good homes to work in." (CS2-CA1)*

After an analysis of the above extracts, it is possible to see that the majority of responses come from senior members of staff within the care home. For example, the first two extracts come from the two most senior people within the care home, who at the time of this study were both relatively new. As such, they were only able to reflect on the home's culture as they know it. But yet, they are both making a conscious attempt to differentiate the culture they are attempting to cultivate within the care home from the past.

On the other hand, other frontline staff also contributed to the narrative that the care home had a positive culture. CS1-N2 attributes this positive culture to the care home being a good place to work. CS1-N2 and CS2-CA6 give the example of renovation and maintenance as being examples of what makes the care home culture good.

What is evident from the above extracts is that although all the participants perceive the culture to be positive, their rationales differ significantly, thus indicating that what constitutes a good culture is down to individual interpretation.

5.3.2 Theme two: negative perspectives of care home culture

The second theme resulting from my analysis was from a group of participants whose perspectives on the care homes culture were negative. The following extracts give an insight into some of the rationales behind the views of this group of participants.

Researcher: *Within the care home environment, how would you describe the culture?*

Participant: *"I feel it is a business and they are here to make money. I feel it is a money-making business; sometimes they don't even want to know whatever is happening, all they need is to bring money and make money, that's the culture really." (CS1-CA4)*

Participant: *"They do have a mission statement and aim to give the best possible care, etc. But they are not delivering them aims because the care is happing, and we give the best care we can give, but we have not got enough staffing to give the best care." (CS1-CA7)*

Participant: *"I think everyone is down at the moment, cos we have had so many management coming in and out of this care home, so people are a bit down. None of the managers get a chance to implement change." (CS2-N1)*

Participant: *"At the minute I would say it is low, our unit. I know it sounds like I am bigging-up the place, but our unit runs very differently." (CS1-CA1)*

Participant: *"Well, to be honest, I don't like this organisation, they are all take and no give. You can do things for them but they don't give anything back. I think they could give us more, I would rather have more in the pay package, to show appreciation." (CS2-CA7)*

As in the case of those participants who perceived the care home as having a positive culture, those who perceive the care home to have a negative culture also differed in their rationale. For example, CS1-CA4 reflected on the business model of the care home as a "money-making business" which from this participant's perspective prevents the home from focusing on employees and residents, which reflects the views of both Horton (2019) and Karwowski (2019) on the impact of financialisation on care homes. A similar narrative was picked up by CS1-CA7, who compares what

the home says they will do (mission state), with what CS1-CA7 sees as the reality on the ground, which is a lack of investment in staffing. The focus on making money is something which CS2-CA7 also picks up on, describing the culture as one of 'all take and no give' and calls for more pay as a way of showing staff appreciation.

CS2-N1 reflected on the fluidity of managerial appointments within the care home, and the impact that is having on the care homes culture, which is something The Carer (2019), picked up on in chapter two. CS1-CA1, on the other hand, is the first participant to differentiate between the care home culture and that of their unit culture, signalling, that within this organisational environment, some participants perceive there to be more than one culture.

5.3.3 Theme three: a mixed perspective on care home culture

Finally, the third theme came from a group of participants whose perspective on the care homes culture was fluid and prone to fluctuation. The below extracts give an insight into their perspectives.

Researcher: *Within the care home environment, how would you describe the culture?*

Participant: *"It can be positive, but again, it can be negative, depending on who is on the management. We had a few managers who made us feel that we are vulnerable and that we can lose our jobs over anything at any time. There was that culture of feeling vulnerable, but at the moment, we don't know who is coming next with the management."* (CS1-CA4)

Participant: *"Difficult one cos we are in a state of flux, but the new management seems to be looking forward, but the head office seems to be having big plans, but they seem to be closing other homes down, I don't get it."* (CS2-UM1)

Participant: *"This is a mixed one because I don't think I have been involved within the organisation as a whole or enough to answer. I have been part of this home for a few months, and in that time, the home has had a full make-over, so I can't really answer that, to be honest."* (CNM1)

From the above extracts, it is possible to get a sense of the mixed picture put forward by both CS1-CA4 and CS2-UM1 concerning the culture within the care home. As in the case of the previous two themes, the rationales for their perspectives, although relating to management, still differ. CS1-CA4

reflected on the practice of previous managers as a factor which negatively impacted the culture, but then offset that with a feeling of uncertainty about the new management and the impact their practices would have on the culture of the home moving forward. What is evident is the vital role that participants at different levels feel management have in shaping the culture within the care home (Davies & Mannion, 2013).

The differing narratives that have emerged from the above themes would suggest that although there seemed to have been a consensus in the understanding of what organisational culture is in general, this consensus does not translate into practice. From these differing narratives and perspectives, it is possible to argue that the notion of a care homes culture is indeed a complex one, reflective the views of organisational culture put forward by Tichy (1982) and Smircich (1983) in chapter three. As such, I argue that the deployment of my *Organisational Culture and Subculture Analytical Structure* was an appropriate one due to its ability, according to Schein (2011), to analyse the complex processes associated with the formation of a group's culture.

5.4 Cultural manifestations within the care home

To undertake this process of applying Schein's model of organisational culture to this care home, I have decided to be guided by Schein's own case studies of Ciba-Geigy and the Digital Equipment Corp. I shall draw on the characteristics of that organisation which Schein used to categorise the culture within these organisations into the three levels of his model (Schein, 2004). The Ciba-Geigy Company, on the other hand, was a Swiss multidivisional, geographically decentralised chemical company (Schein, 2004). Up until the 1990s, Digital Equipment Corp was the number two computer company in the world, with over 100,000 employees and sales of \$14 billion (Schein, 2003). Although very different types of organisations to the care home I researched, my aim is only to be sensitised by the cultural organisational characteristics Schein referred to as a starting point from which to proceed with my cultural contextualisation of the care home (Boisnier & Chatman, 2002; Schein, 2004).

At each level of Schein's model, I shall provide categories and context-specific examples from my data analysis to demonstrate each cultural level within the care home (Boisnier & Chatman, 2002). After mapping the cultural characteristics of the care home onto the three levels of Schein's model, I

argue that it will be possible to identify the nature of the culture, and detail how the differing levels of Schein's model come together to form this care homes culture. According to Hofstede (1998), the exploration of organisational culture is best undertaken by means of inductive processes which can explore perspectives at all levels of the organisation, which is the position taken for both my findings chapters (Guba & Lincoln, 1994; Yin, 2014).

5.4.1 Artifacts

To help in this endeavour, the first level of the care homes culture, which I explored in my analysis of the research data relating to the care home was the artifacts level. According to Schein (2004), the process by which a researcher is able to gain access to an organisation and the steps of entering an organisation for the first time are all valid forms of evidence that describe the artifact level. Through an analysis of the data and reference to the two case studies conducted by Schein three considerations at the artifacts level of analysis were identified. These included entering into the research environment, the observational characteristics of the research environment, and finally the interactions between participants (Wilkins & Ouchi, 1983; Schein, 2004).

5.4.1.1 Entering the care home

Gaining access to the care home involved several steps, most of which have been detailed in the previous methodology chapter. I reflect on the difficulty in securing managerial approval to the care home, the changing gatekeepers and power dynamics within the home (Silver et al., 2018). This section explores my initial entry into the care home and the environmental characteristics which greeted me and how they relate to the artifact characteristics of the organisation's culture.

Monday 6th February was the first day I entered the care home as a researcher, and on entry, I had to sign my name in the guest book and was also given a clocking in card to 'clock' myself into the home as a form of security. From my initial observations of the home's reception environment, the walls were covered with policies and procedures documents relating to the running of the home. I was then escorted to a reception waiting area and waited to be received by the Clinical Nurse Manager (CNM1). The following extract from my daily reflexive diary gives an insight into the process of entering the care home for the first time as a researcher.

***Researcher:** The day started with me having a meeting with the CNM1, I think she just wanted to find out more about what I was doing and more specifically if I had any other intentions for my study than I had previously stated. I was at pains to reassure her that this was not the case. It is easy to think this way, especially when taking into consideration the topic of my research and its context. (Daily reflexive diary on 6/2/17)*

After my initial meeting with CNM1, I had an opportunity to look around the care home; it was evident from my initial observations that this was a very formalised environment. This view was reinforced by all the reception staff and management I came into contact with wearing formalised clothing such as suits. The Home Manager (HM1) and Clinical Nurse Manager (CNM1) were both observed to be wearing suits and having formal door signage on their office doors. Such formality would suggest an organisational hierarchy was very entrenched within this care home, which is in line with the views of Davies & Mannion (2013) and Weiss & Morrison (2018) concerning care organisations as hierarchical organisational settings.

5.4.1.2 Observable characteristics of the environment

One of the most important characteristics I identified when entering into the care home for the first time was the visible presence of a large number of policies and procedure and memorandums posted around the home on notice boards. I made these observations both informal areas of the home such as reception and less formal areas such as staff rooms. Such policy and procedure documents relating to employee voice were gathered and copies made as part of my analysis of the home's artifacts regarding employee voice (Schein, 2004).

Another observable characteristic was the fact that the environment felt light and pleasant, especially in the reception area, doors to offices were observed as being left open even when there was no member of staff present. The environment felt gave a feeling of relaxation to the organisational environment.

As I proceeded through the care home, the number of different doors and combination locks become evident. A locked door separated each section of the home, with both units one and two having different lock combinations to enter the units. Although the units were part of the same

home, I observed that there were many physical barriers between them, which I reflected on in the below extract from my reflexive log.

Researcher: *If I remember correctly, we went through about four different locked doors today to get to unit one, all of them seemed to have a different lock combination as well. I wonder how staff can remember all these different combinations when trying to get from one part of the home to another?* **(Daily reflexive diary on 6/2/17)**

From the above extract, I recall being surprised as to just how many different doors and locks there were between the manager's office and unit one. Furthermore, when exploring around the home later that day, I noticed that there was a considerable distance between unit one and two, which were located on different floors of the care home and separated by about four locked doors, all of which had a different lock combination. This observation, I later reflected, suggested that these units are very different entities and must, for the most part, exist independently of each other. Indeed, on reflection, there was nothing I observed about the environment of the care home, which would have suggested otherwise.

5.4.1.3 Interactions between staff members

From my observations, it was evident that the new top management (HM1 and CNM1) of the home went out of their way to interact with staff by walking around the home on a regular basis. This is something which the home manager commented on as a purposeful act to engage with staff during my interview with him and has been detailed in the below extract.

Researcher: *Are there things which may prevent people from speaking out?*

Participant: *"I would hope not, I think I have done a lot of work in narrowing down the barriers and opening things up. If you are a manager who exposes themselves and walks around, you get more response from talking to the staff on the couch than expecting them to always come to you."* **(HM1)**

This act of walking around the units seems to have been a purposeful policy adopted by the new management team to engage with staff. The home manager talks about getting more responses from

talking to staff informally than through staff having to come to his office, which would be seen by staff as a more formal process. Such actions would suggest that despite the formalised environment of the home, the home manager appreciated the significance of informal interactions with staff, and links to the views of Kendall & Kendall (1993) on the positive role of informal processes within organisations. This position was also echoed by CNM1 in the following extract.

Researcher: *What do you think could be done to improve the quality of the job for frontline staff?*

Participant: *“So every morning before the shift I go around and speak to all the staff and say how are you doing, are you alright, do you need anything, staffing levels. So I purposely go out of my way and ask about staffing and things like that.” (CNM1)*

From the perspective of both HM1 and CNM1, the way they go out of their way to interact with staff was seen as a way of establishing their position within the care home. In addition to this, it can be argued that this was also an attempt at creating an open environment to enable staff to voice themselves directly to management (Donaldson-Feilder et al., 2014). The following extract from CS1-CA1 indicates that the strategy by HM1 and CNM1 of proactively engaging with employees was being noticed and appreciated.

Researcher: *At the management organisational level, do you think the informal communication is useful?*

Participant: *“Yes, I have seen 3 managers and they have all done the informal stuff, but for me, the most recent one is the only one that is getting it cos he is informal but has got a boundary. The CNM is the same as well with the boundary, the current management has the balance right with being the boss and being friendly.” (CS1-CA1)*

The above extract from CS1-CA1 contrasts previous management with the new management which CS1-CA1 sees as getting the balance right when it comes to interaction with staff. Management’s interaction with staff is something which I also commented on during the study and is reflected in my following log post.

Researcher: Home manager on unit asked about my study and has agreed to take part in it. Interesting that the home manager is willing to participate in the study. A constant presence on the units and willing and able to interact with both residents and staff. **(Case study one daily log on 14/2/17)**

I described the home manager as a constant presence on the unit, referring to the fact that when I made this entry into my log it was the not first time I had seen him on the unit. The engagement of HM1 with staff can be seen as reflecting the proactive leadership style advocated by Allcock et al. (2015) when organisations are attempting to establish open working environments.

Apart from this interaction, the main other interaction I observed at the care home level between different members of staff took place for the most part in three distinctive locations. First was the staff room, second was the smoking area, and last the training room (Kenkmann et al., 2017). In the staff room and smoking areas, staff had a tendency to only interact with specific groups of people who worked on the same unit as them. I argue this demonstrated further the disjointed nature of the care home and the lack of integration between the units. This lack of integration was also evident when staff were in the smoking area; I observed staff smoking in what I refer to as 'familiar smoking bubbles'. These were groups of staff from the same unit who would go out and smoke together, huddle up in groups and all come back into the home together. Training sessions were the only other time I observed staff interacting, I shall later on in this chapter explore this in further detail and provide some arguments as to why this was.

5.4.2 Espoused beliefs

According to Schein (1984), although the artifacts level of a group's culture is easy to observe, it is challenging to decode and make precise interpretations of the actors' meaning behind their actions. In an attempt to account for such meanings, we must explore the espoused beliefs or formally expressed goals and values within an organisation (Schein, 2004). The best way to do this is through engagement (Schein, 2004), which is the approach I took through the deployment of semi-structured interviews and non-participatory observations (Mulhall, 2003; Eisenhardt & Graebner, 2014). As a result, three key beliefs at the care home level have emerged. The first centres on how change occurs within the care home, also participants' beliefs about the role of policies and procedures within the

home, and finally, how accessible participants felt management were to them. This section aims to explore all three beliefs to gauge how they contribute to the culture within the care home.

5.4.2.1 Beliefs about where change occurs from within the care home

Through the data analysis process, one of the first beliefs to emerge was the belief that change within the care home normally came from the top. This was part of a wider notion, especially among care staff, that they were powerless to influence real change within the care home (Silver et al., 2018). Although the formally expressed view of the care home was that it listens to employees through formal channels of communication, such views were not shared by frontline participants. As such, there was a disparity between the formalised position and the perspective of frontline staff, which is evident in the following extracts from participants.

Researcher: *From your view, where does change normally occur from?*

Participant: *"I would say from the management." (CS1-TL1)*

Participant: *"Change normally comes from downstairs." (CS1-CA8)*

Participant: *"I think it normally comes from management. We have had so much change, which is not good for an organisation because someone comes and has an idea then they leave and someone else comes who also has another idea, which is not good for the organisation." (CS1-N2)*

Participant: *"If it's big things like safeguarding, then it usually comes down from the management level." (CS1-CA1)*

It is evident, I argue, that from the above extracts there was a notion that change within this care home is top-down and very much centralised in the hands of management. CS1-N2 puts forward this perspective but comments on the negative impact the prolific turnover of managerial staff is having on the organisation. This is particularly the case given the belief that the power to bring about change resides with these individual managers, according to participants such as CS1-CA1 and CS1-CA8. From this perspective, I argue that such beliefs have far-reaching consequences for staff and their willingness to engage in the organisation's processes if they feel they do not have a stake in bringing about any change (Davies & Nutley, 2000). Under this circumstance, the likelihood that an employee would engage in what Van Dyne et al. (2003) referred to as acquiescent silence in chapter three is

enhanced. This form of silence would, within this instance, become the norm and a way by which employees protect themselves from a situation in which they already believe they have no power in decision making (Silver et al., 2018).

This disparity in beliefs is also underpinned by the perspective among frontline staff that the methods used to communicate policy changes are not effective. From my analysis, such methods would predominantly involve official memorandums sent by management to staff. This being so, the perception of ineffectiveness among frontline staff regarding the way in which management communicate with them, I argue, contributes to the disparity in beliefs around where change occurs within the care home. The following extract provides an insight into this perception of ineffectiveness regarding the way in which management communicate with frontline staff.

Researcher: *How do management communicate with staff?*

Participant: *“They write memos or leave a message to the unit manager”. (CA4-CS1)*

Participant: *“It’s a memo stuck to the desk saying when you pick up the phone, you have to follow this..... We don’t need it stuck to a desk for us to see.” (CA7-CS1)*

Participant: *“You see, this is what I have an issue with.... The home manager very rarely comes up to the unit and communicates with his staff, if we do get anything, we get memos. Rather than coming up to the unit and saying what the paper says, he sends a piece of paper round which gets delivered by admin, rather than coming up and communicating with his team.” (CS1-N1)*

CA4-CS1 and CA7-CS1 both talked about managerial communication coming in the form of a “memo”, which is a formal document used by management to communicate to staff within the home. CA7-CS1 believed that this method of communication is derogatory towards staff; with reference to a memo on how to answer the phone, CA7-CS1 comments that “it makes me feel like I am a child”. This, I argue, suggests that such communication methods were seen as being patronising to those for whom they were intended. CS1-N1 also picked up on the notion of how managers perceive frontline staff by stating that the home manager should see frontline staff as “his team”, suggesting this is not currently the case. CS1-N1 believed that managerial methods of communication created a disconnect between management and staff. This disconnect, I argue, also extends to the

perceived role of such communication methods which management deem to be appropriate reflecting what Moeini et al. (2019) found in their study.

Through my analysis of such documentation, I argue that visible mechanisms through which employees could voice themselves were not present within new policies. Thus, I argue that this perceived inability of frontline staff to feedback to management about policy changes has contributed to the disparity in beliefs among management and frontline staff as to where change comes from within the home. I argue that such beliefs can be linked back to the artifacts level of analysis when reflecting on my comments about the formalised feel of the care home environment. Indeed, it is evident that the social validation talked about by Schein (2004) as being a vital component of a group's culture was not present when it came to beliefs around change within the home.

5.4.2.2 Beliefs around the role of policies and procedures within the home

The second key espoused belief to emerge from the data related to the role of policies and procedures within the care home and the extent to which they shape the culture of the care home. From my analysis, it was evident that perspectives relating to this belief were drawn along hierarchical lines within the care home (Davies & Mannion, 2013). Indeed, those higher up the organisational hierarchy were more positive about the role that policies and procedures played in shaping the home's culture. This is evident in the following extract from the top management within the home.

Researcher: *From your view, how would you describe the culture within this organisation?*

Participant: *"They have not got any different cultures from their policies and procedures. The only way on anything is adhering to our policies and procedures."* (NUM)

Participant: *"I would say that it is important that people work within policy and procedures because it protects our residents."* (HM1)

Participant: *"I think it is good, you will have ups and downs, as a whole, the organisation, they are very good in training, policy and procedures and allocation management."* (CS1-UM1)

It is apparent from the above extracts, I argue, that there was a belief among participants that policies and procedures are not only positive but are also important in shaping the culture of the care home. It is worth noting that these participants are all senior members of staff and management, with no junior member of staff reflecting this position. NUM is linking the homes policies and procedures to all aspects of the home's culture. HM1 also talked about the importance of people working within policy and procedures, thus implying how important policies and procedures are to the workings of the care home.

Despite the emphasis placed by management on the importance of policy and procedures to the care home, this was not a view shared by frontline staff. From my analysis, frontline staff did not perceive policies and procedures as an instrument for shaping positive cultures within the home, rather, as one for the suppression of employee voice. The following extract from my interview with CS1-N1 gives an insight into the negative perspectives towards policies and procedures in relation to employee voice held by some participants.

Researcher: *Any examples in the past in which you have spoken out or voiced out against this or other organisations?*

Participant: *"Well I whistle blew when I first started...., cos I had just started working in this home and I was on a unit I had not been on before, and the incident happened at about half-past seven in the evening, so when the shift finished I went back to the unit I normally work on, but my manager had already left, so I did not report it until the following day. Due to me not reporting it till the following day I was penalised for not following the right policy relating to whistleblowing and stuff like that..... Just by me reporting something I seemed to have got the worst end of it rather than the perpetrator"*

Researcher: *Do you think you were disadvantaged by the organisation and they did not take into consideration your resigning for doing what you did?*

Participant: *"Yeah, exactly."*

Researcher: *What did the organisation do to you that you think was as a direct result of your whistleblowing?*

Participant: *"Yeah, well, I had to redo all my mandatory training and my probation was extended by six months." (CS1-N1)*

What the above dialogue demonstrates is how the technicalities of the organisation's policies and procedures are sometimes resulting in employees who voice themselves feeling like they are in the wrong (Killett et al., 2013c). A lack of understanding of the complex process involved in policies around voicing out means that employees are scared off, and therefore proactively choose to remain silent (Van Dyne et al., 2003). The notion of being punished for not following specific guidelines when employees are voicing out is not exclusive to this one participant, but rather seems to be part of the culture within the care home. This is something which CS2-CA6 details in the below extract.

Researcher: *Is there anything the organisation does which makes it difficult for you to express yourself?*

Participant: *“There is, like I have not really encountered it but other people have, and they try to take action, then it backfires on them. They then end up losing their job, or they just keep quiet.”*

Researcher: *Is that something you have seen happen to others?*

Participant: *“Yes it is, they lost their jobs for speaking out.” (CS2-CA6)*

From the above extract, CS2-CA6 believed that there were instances in the past in which employees have lost their jobs for speaking out or being silenced because they did not follow correct protocol or were subsequently deemed to have been in the wrong after voicing out. This reflects the perspective of policies put forward by CS1-N1 previously, and, I argue, demonstrates why employees would choose not to voice themselves.

In relation to employee voice, there was a perspective among frontline participants of a disparity between what policies and procedures claim to do and the realities on the ground. This is something which was expressed by both CS1-CA6 and CS1-N2 in the below extracts.

Researcher: *I would like to find out what you think this organisation does to promote the voice of employees?*

Participant: *“I think policy wise, I think probably yes, but in practice, going to the management I don't feel like they do, not really.” (CS1-N2)*

Researcher: *In your view, is there a disparity between formalised processes and practice on the ground?*

Participant: *“Yes, I would say so.” (CS1-CA6)*

CS2-CA6 believed that there was a distinct disparity between what the formalised processes within the care home state in relation to employee voice and the realities on the ground. Analysis of policies and procedures within the care home indicated that such documents were very complex. Such complexity, I argue, can provide ‘legitimate cover’ for the home in relation to how it responds to employee voice, especially when it relates to voicing out. Such documents do little for employees’ understanding of formalised processes involving voicing out within the home, which is something both CS1-CA6 and CS1-N2 have alluded to above. The disconnect between management and frontline staff on the role of policies and procedures can be seen, I conclude, as further demonstrating the lack of cohesion within the care home.

5.4.2.3 Beliefs around the accessibility of management (the open-door policy)

The final espoused belief was a belief among the management of the home that the home had an open culture and, on that basis, an open-door policy in relation to all staff (Francis, 2010). This open-door policy was seen by management as a tool for staff to voice themselves. Such perspectives from management can be seen in the below extracts.

Researcher: *How do you promote the voices of frontline staff?*

Participant: *“Every minute of the day, the door is always open unless its closed, but that is because someone is voicing their concerns.” (CNM1)*

Participant: *“They (care staff) may not have time to catch up with me, cos the pace of the unit can make it difficult, cos the door is open, so people are coming in and out.” (CS2-UM1)*

Participant: *“I would hope that people within this home know that I have an open-door policy.” (HM1)*

In the above extract, both CNM1 and CS2-UM1 use the terminology of open door to describe their belief that staff are always welcome to voice their opinion whenever they need to. HM1 also uses this terminology, evidently believing that managers are open to the voices of their employees. The open-

door policy was something which all managers I spoke to talked about, but from the below extracts this was not a view shared by frontline staff.

Researcher: *How do you think the organisation promotes employee voice?*

Participant: *“All I know is there are staff meetings, and you are given an opportunity to voice yourself, and there is that feeling that management has opened their doors despite sometimes that feeling that they have not really listened.” (CS1-CA4)*

Participant: *“I think at the minute the clinical manager is very approachable, as compared to the last one who did not have an open-door policy.” (CS1-N1)*

The above extracts indicate that although management talked about having an open-door policy, this is not a belief which frontline care workers shared. CS1-CA4 gives the example of the management door being physically open but getting the feeling that they are not really listening; thus, although the door is open, it is not open to the voices of employees. Staff lower down the hierarchy, especially care staff, saw office doors open but did not have that espoused belief that they could enter through the door and voice themselves (Schein, 2004). Hence, staff would be more likely in such situations to deploy defensive silence mechanisms, rather than proactively voicing themselves as the top management in the home would like to think (Van Dyne et al., 2003).

This disconnect between the perceptions of the open-door policy by management and the perspectives of frontline staff can be linked back to the above belief by frontline staff that change comes from the top of the care home based on what they have observed through care home artifacts such as memorandums. Despite this, I did observe instances in which the home manager and the clinical nurse manager had their office doors open and were interacting with staff inside the office. Furthermore, I did observe several instances in which the home manager (HM1) and the clinical nurse manager (CNM1) would move about the care home with the aim of coming into contact with staff members on both units. At the espoused beliefs level, what is now apparent is that there existed profound fundamental differences between management and frontline staff as to the fundamental nature of the care home and the characteristics of the culture that underpin it. I argue that this further demonstrates how divided this care home is and the lack of unity in its culture.

5.4.3 Basic underlying assumptions

According to Schein (2004), understanding an organisation's culture cannot be complete without exploring and gaining an in-depth understanding of the basic underlying assumptions of that organisation. From Schein's work, it is apparent that only by exploring the basic assumptions level is it possible to fully comprehend the culture of an organisation. From an analysis of the data, it has been possible to identify that it was informal rules within each unit which underpinned the assumptions within the care home. That being so, the critical basic underlying assumption within this care home was the assumption that each unit is fundamentally different, the notion put forward by staff that 'they work differently from us', in this context, 'they' refers to other units within the care home. This assumption was a deeply shared assumption which I analysed as cutting across both units researched (Mannion & Davis, 2018).

Indeed, it is possible to say that this care home was not a homogenous culture, but rather one made up of a collection of sub-cultures found at the unit level. This assumption, I argue, forms the underlying basis of the culture of this care home, and the next section of this chapter aims to explore this in more detail (Schein, 1988; Davies et al., 2000). The data distribution for this assumption is available in *appendix fourteen* and was the third theme generated from my analysis in chapter four. This next section provides some detail from participants which shines a light on this assumption of difference, which is what I argue formed the bedrock of the care homes culture.

5.4.3.1 They work differently from us

According to Schein (2004), assumptions are the taken for granted components of a group's culture. It was evident within this care home that the assumption was that the care home was made up of different parts. In my view, this assumption can be referenced back to the artifacts level through the physical distance between the units, and the number of different locked doors added to this assumption. This created a feeling that physically the units were independent entities with no visible connection between them (Schein, 1988). At the espoused beliefs level, policies and procedures were feeding into this assumption due to the disconnect between managers and staff. Due to this disconnect, I observed that staff within the home had created what I refer to as *informal rules-based hubs* on their units. The aims of these hubs were to insulate staff against what they saw as suppressive care home level policies and procedures and unstable management (Davies & Mannion, 2013). The creation of such hubs, I argue, feeds into the assumption of difference within

the units, further entrenching the unit-based cultures within this care home (Trice & Beyer, 1984; Schein, 1988; Rice & Beyer; 1993). The following extract offers an insight into the assumption that this care home did not have a homogenous culture.

Researcher: *Are there different cultures within the home?*

Participant: *“Ohh yeah definitely, there are definitely different cultures within the home. There is a whole home culture where we all strive towards the same goals, but I believe there are different unit cultures, and different people obviously bring together different opinions and different positives and different negatives.” (CS1-CA5)*

From the above extract, I argue that CS1-CA5 held a deep-seated assumption that the home is, in fact, a combination of different unit cultures. CS1-CA5 also points to the significant role individual members of staff play in shaping the home’s culture. CS1-CA5 defined culture during the interview as ‘*the way you do things within a certain setting*’. It is evident that CS1-CA5 assumes this setting not to be the care home but the unit. CS1-CA5 was not the only participant to put forward this perspective; in the below extracts other participants discuss the fact that different units have different dynamics to them which substantially influence unit cultures.

Researcher: *Do you think this care home has a good culture?*

Participant: *“I think that it does have a good culture, but I do think sometimes that it is like a bad atmosphere on certain units, especially when some members of staff are on. Then on other units, there is a good atmosphere.” (CS1-CA3)*

Participant: *“I think there is a totally different culture between this unit and upstairs, there is sometimes some form of competition between the units, there is some form of antagonism.” (CS2-N2)*

The above extracts demonstrate that across both unit’s case studied, there was a perception that the units were very different. Both CS1-CA3 and CS2-N2 allude to the atmosphere within the units as the main point of differentiation, which suggests that although they are in the same building, they possess very different working environments.

Those at the very top of the care home also shared the assumption that the care home was made up of multiple unit-level cultures, which is demonstrated in the following extracts.

Researcher: *How would you contrast the culture of unit one to unit two?*

Participant: *“Unit one is a very close team, their culture is very together, although this is very positive there are negatives within there. I would say that unit one is totally different from unit 2”. (CNM1)*

Participant: *“You can tell as soon as you get onto the units that there is a difference in the appearance of the units, when we discuss it, unit one is very hierarchical, and unit two is slightly matriarchal but without the hierarchy. There is much more of a we can on unit two and you will on unit two”. (HM1)*

In both instances, the top two managers within the home recognise that in relation to units one and two, there were very different cultures on the units. CNM1 differentiates between the units in relation to teamwork, indicating that unit one was closer-knit than unit two. On the other hand, HM1 focused on hierarchy as the main difference between the two units by suggesting that unit one was more hierarchical than unit two. Although both managers use different characteristics to substantiate their perspective, they are both united in the view that the units are culturally very different. If this was the case, then the next question for me was how these managers thought such cultural differences translated into the role of employee voice within the units. To further this line of inquiry, the following question was posed to both CNM1 and HM1.

Researcher: *How would you contrast unit one and two in relation to employee voice?*

Participant: *“I think some people have confidence in their unit managers, so I think if a health care worker has got an issue, I think on one of the units (pointing to unit one) they would go to their unit manager first, and they would be quite happy with the outcome. But on the other unit (pointing to unit two) they may not be as happy with the outcome and therefore would just want to clarify it or maybe just seek advice.” (CNM1)*

Participant: *“I don’t think it is as open, although it works and we need to have structures and boundaries, I think that unit (pointing to unit one) would benefit from a little more of an open approach to people and their views on change. So it is something I have noted, and I am in conversation with senior management about how we can support that change. But I think*

there is work that is needed around the engagement and work of the team, and how they engage with their unit manager.

I think unit two has certainly much more of a flat structure, I think the unit manager has too much of a laissez-faire approach in how she leads that team. That is something another clinical manager is going to look at changing.” (HM1)

From the above extracts, it is evident that both managers did directly link the cultures on unit one and two with how employees voiced themselves. From the perspective of CNM1, employee voice was down to confidence in the unit manager to bring about change, which is in line with the perspectives of Davies & Mannion (2013). Staff in unit one had more confidence in their unit manager and thus would be more willing to voice directly to that individual than members of unit two, who were more likely to seek external clarification. This would indicate that the personalities of unit managers, according to CNM1, plays a significant role in shaping the culture and voices of staff on the unit.

From the perspective of HM1, it is possible to see that such comments very much related to the power dynamics at play within the informal hierarchical structures of the units. In unit one, HM1 put forward the view that more work was needed to open up the structures within that unit. This indicates that HM1 felt that the structures were not conducive to staff openly voicing themselves. In unit two the opposite was the case concerning the structure of the unit. In both instances, HM1 commented that work would commence to address both the units and their culture.

It has become apparent that the different groups of staff in this care home do not as a whole have any significant shared vision (Killett et al., 2013b), thus I argue this has perpetuated the entrenchment of strong subcultures within the care home (Schein, 2004). My findings indicate that all the above factors have contributed to the assumption that the care home is a combination of multiple unit-based subcultures. The implication of this analysis is that moving forward my analysis will be based at the unit level, and will explore each unit as a subculture to the home (Boisnier & Chatman, 2002). According to Trice & Beyer (1993), subcultures are groups whose common characteristic is a set of shared norms and beliefs, but according to Boisnier & Chatman (2002) are also formed in a very complex way.

5.5 Influences facilitating employee voice: the training environment

From an analysis of all data gathered in relation to voice culture within the care home, it has been possible to identify the training environment as possessing the most significant cultural influence within the care home in terms of facilitating employee voice. From an analysis of my data, it is evident that participants perceived the training room environment as one which not only enabled them to better understand what employee voice was but also gave them an opportunity in which to use it (Demos, 2014; Dixon-Woods, et al., 2019). Examples of the influence of the training environment on employee voice is shown in the below extracts taken from a cross-section of participants within both case studies, and the data distribution is available in *appendix sixteen*.

Researcher: *Where has your understanding or view of what employee voice is come from?*

Participant: *“It has come through training, we do training, and we do whistleblowing. That is how we are told to or shown how to whistleblow, or you are told how to complain if you have a problem and who to go to”. (CS1-CA4)*

Participant: *“When you do your training, and obviously you talk on unit”. (CS1-CA3)*

Participant: *“Well in training we do have that, and we have the whole whistleblowing so I think people do know what they are meant to complain about and report”. (CS1-CA6)*

Participant: *“Training I have found is actually really good, it is one of the best places I have been for training.” (CS1-CA7)*

Participant: *“Most of the voice I understand through training and through how we work. But I understand more through practising it at work.” (CS1-CA8)*

From the above extracts, it is evident that participants felt that the training environment did indeed facilitate their understanding and enactment of their voice. According to CA4-CS1 and CA6-CS1, it did this by educating participants about the complaints processes and how to blow the whistle. The need for such education and training within care homes was something that Skills for Care (2016) and Dayan (2017) argued for in chapter two as being important in creating open cultures, demonstrating the importance of appropriate training for staff (Francis, 2010). As well as gaining an understanding of employee voice, from my data, the training environment was also seen as one in which

participants felt able and willing to voice their issues. This is something which was expressed by participants in the below extracts.

Researcher: *What are your views on the training provided within the care home?*

Participant: *"I feel like it is ok, if I have brought anything up in training it has always been answered."* (CS1-CA3)

Participant: *"I think the training provided is good, I think that I can express myself easily."* (CS1-CA6)

Participant: *"I think the training provided is good, I think that I can express myself easily. I think that the training could be better in terms of the individuals you have to deal with on the units."* (CS1-CA5)

Participant: *"They are excellent with the training in this place. They are always very willing for you to get a refresher even if it is not your turn to do so. They have just started training for diploma 2 and stuff, so they are good for training and give extra training as well."* (CS1-CA1)

Participant: *"It is very good; every year you get updates which are good as well."* (CS1-CA2)

Participant: *"I think the training does help with employee voice".* (CS2-CA1)

All the above participants expressed the view that the training environment was a good one for expressing themselves (Surr et al., 2019). Such comments were noted from participants within both case studies, thus indicating that this perspective was not limited to a specific subculture, but rather a view that ran through the whole care home. I, therefore, put forward the argument that the training environment was one which was able to overcome all the subcultures within the care, which may account for why it facilitated voice so well. In the below extract, I detail my observations during a training session.

Researcher: *Good engagement of staff during the training session and a willingness by the trainer to engage. Indeed, it is evident that training sessions are very good within this home. The willingness and freedom of care workers to voice any concern is very noticeable. (Case study two daily log on 11/4/17)*

The key factor I observed about the training environment which facilitated voice culture was the fact that participants felt able and were willing to voice themselves, thus the training environment became what I refer to as a *'hub of voice and learning'* within the care home. At the time, I made the above comments I had almost come to the end of the fieldwork; thus, I was able to contrast my observations with those I had made in both case studies. Reflecting on this observation, I deemed it essential to better understand the characteristics of the training environment which facilitated employee voice, which I explore below.

5.5.1 Characteristics of the training environment which facilitated employee voice

From my observations, the first significant characteristic of the training environment which I noticed as facilitating voice culture was the fact that all training sessions took place off the units and in a dedicated room. This room was what I refer to as a *'mutual ground'*, which no unit or group of staff had jurisdiction over; thus, it was free from any unit-level peripheral values (Schein, 1988). From my observations of training sessions, it was evident that because this room was free of any unit-level expectations, beliefs or assumptions, the participants I observed felt able to act differently. The training environment thus offered participants from different units a safe and neutral environment in which to voice themselves, free from the rituals, legends, and ceremonies which underpin the cultures on their units (Deal & Kennedy, 1982; Tichy, 1982; Smircich, 1983). It is this freedom, I argue, which enabled participants to interact so freely, as I detailed in the artifact section of this chapter.

The second facilitator of voice culture I observed in the training room environment was the fact that training sessions were made up of employees from all units and all levels of the organisation. Due to the ratio of care workers to other members of staff, there were always more care workers attending training at any one time than any other staff group. What this meant was that because of the ratio of care staff to management in the training room and the absence of any care home or unit level rituals or ceremonies (Deal & Kennedy, 1982; Smircich, 1983), management were not able to impose their organisational hierarchy on other staff. As a result, I observed participants proactively voicing themselves on a broad range of issues not necessarily directly linked to the training topic (Dixon-Woods et al., 2019), showing a willingness to voice themselves and make positive suggestions that reflects the notion of prosocial behaviour (Van Dyne et al., 2003; Rose, 2015).

Another characteristic of the training environment, which on reflection played a significant role in creating an organisational environment which facilitated employee voice, was that most staff did not wear uniforms within the training environment. From my observations, it was apparent that participants who took part in training sessions did so out of uniform. The same applied with all other members of staff, only a few coming to training in uniform, and they tended to be employees who were working that day. The lack of uniform within this environment appeared to create a more relaxed and informal feel in the training room. This lack of uniform was in stark contrast to my observations of the reception area when I first entered the home. This informal and relaxed environment would, I argue, have made it easier for participants to voice themselves by creating an open environment in which to do so (Waring et al., 2013; Francis, 2015).

Finally, the last characteristic of the training environment which apparently facilitated employee voice was the fact that the trainers were individuals who did not have any direct involvement with the two units. Such trainers tended to be external to the care home, a member of the maintenance team, or the home's trainer. I argue that this meant that participants who attended these training sessions were not under any direct or indirect pressure to conform to the cultural norms of their units (Deal & Kennedy, 1982; Schein, 1988). In addition, some trainers would have been perceived as being neutral and trusted as they had no conflict of interest with the units.

The above characteristics of the training environment are arguably important considerations to be taken forward for our understanding of how to better promote employee voice within the care home context. Furthermore, there are lessons to be learned from the characteristics of this environment in the creation of new employee voice policies moving forward and this is something that I shall explore in chapter seven.

5.6 Influences mitigating against employee voice: the legacy of previous management regimes

It was possible through my analysis to establish that within this care home, the legacy of previous management regimes was the key factor mitigating against voice culture. The notion that the care home was gripped by a legacy left by previous management regimes only became evident to me during the second stage of my data collection process, in which I engaged in my observations and

also had informal conversations with participants on issues relating to employee voice. It soon became apparent that within the care home context, events that had occurred under previous management were still having a significant impact on employees in relation to employee voice. Due to this realisation, the following question was included in my interviews.

Researcher: *Do you think the legacy of previous management regimes has had an impact on this home in relation to employee voice?*

Participant: *“Yes, without a doubt, I will give you an example. When I came, people kept saying they said we can’t do this and do that. I would ask them who is they, and the staff would say previous management. I would tell them I am the manager now, and over the past 6 months, I have found a lot of residual things of that nature: saying we can’t do things that way or do things in that way. The best way of changing all that is to engage the team with change, I think that is the best way of doing things. If I am trying to change things within the home, I always want to come at it from a perspective of let’s do”. (HM1)*

Participant: *“Yes, it does, and I think it will take time to build up that confidence within the staff, and I think they have to see that what we are doing is positive. Maybe that will change their attitude, or maybe they will always have that attitude”. (CNM1)*

Those at the top of the care home were very much aware of the impact of previous managers on the care home and employee voice. This was something which HM1 was attempting to change through a more proactive approach to managing the home. The negative legacy of previous management on employee voice was also explored by CNM1 who said it had influenced the ‘confidence of staff’, which according to my argument and Schlenker & Weigold (1989) is an important consideration when exploring employee voice.

It was not only the top management of the care home who talked about the negative legacy of previous management regimes on voice, as this was something which care workers also discussed during my interviews. The following extracts provide an insight into the perspectives of care workers on previous management and their influence on the care home.

Researcher: *Where do you think that fear has come from?*

Participant: "From management, because of things they have said and action they have taken before. They are just scared, the old manager if you did not agree with things, she said she was just getting rid of you. How many people did the old manager get rid of? Do you know what I mean! I think the previous manager up until now has put a lot of fear into people, like if they speak out, they are going to come under some kind of spotlight, and they are going to be tried to be got rid of, so it is easier to keep quiet." (CS1-CA7)

From the perspective of CS1-CA7, the fear instilled in staff by previous managers was a significant factor that influences employee voice. The use of fear in stifling voice is nothing new; indeed, both Morrison & Milliken (2003) and DoH (2015a) have explored this in previous chapters. What is significant is that CS1-CA7 is referring to a contained fear resulting from management who are no longer working in the home. The above extract by CS1-CA7 was such that I felt it was important to follow this line of inquiry with follow-up questions detailed below.

Researcher: What you are saying is, the previous manager, in your view, purposely got rid of people for speaking out?

Participant: "Yes, if they spoke out, and they did not agree with what she wanted, then she found a way of making their lives hell, and they would end up leaving. There were a lot of people who left, and that person, I think, has had a negative effect on everyone else and that has made everyone keep quiet."

Researcher: So, although that manager is no longer here, you think the damage is still evident within the workforce?

Participant: "Yeah." (CS1-CA7)

The above comments, I argue, go to the heart of this issue of previous management regimes and their continued influence within the care home. Furthermore, they demonstrate the long-term impact of fear on staff within an organisation and their subsequent willingness to voice (Berwick, 2013; Francis, 2013). It was not just CS1-CA7 who put forward this perspective, and the below extract provides an insight into how widespread such perspectives of previous management were within the home.

Researcher: *Are there things the care home does which you think prevent people from raising concerns?*

Participant: *“Some managers you don’t feel confident to voice yourself and you think I might be in even more trouble, cos I might be investigated and made to feel worse, so it depends on the manager.” (CS1-CA4)*

Participant: *“Yeah, at times, cos even old management, not new management, you go to them with issues and a lot of the time they will twist it back, and it is your fault, rather than with the problem you took to them.”*

Researcher: *And what impact has that had?*

Participant: *“It just makes you feel like there is no point.” (CS1-CA7)*

Participant: *“We had a manager who did not like people speaking out at all.” (CS2-UM1)*

In all the above extracts, it is evident that participants at all levels of the care home had perspectives that previous managers were indeed responsible in part, indicating why participants did not feel able to voice themselves. In my conversations with the home manager (HM1), I was interested then to know what he had been doing to counter this negative legacy. Through my conversations with HM1, it became apparent that this was an issue at the forefront of HM1’s list of things to address. HM1 argued that his efforts to proactively walk around and engage with staff was one of his key strategies. Following on from our discussion on this issue, I was interested to explore if HM1 thought that his approach was working and having an impact in improving employee voice. The extract from this question is provided below.

Researcher: *Do you think this different approach is having traction on the ground, are care workers noticing a difference?*

Participant: *“Yes, I would hope so, even the senior manager said on a visit that the home feels much more like a different home. And also the feedback I have got is that staff are happier about coming to work, and the retention rate of staff has improved as well.” (HM1)*

Indeed, HM1 did think that his interventions are having an impact on the ground and that he is making a difference to how management are perceived within this care home. I argue that those at the top of the care home did believe that they were having an impact on bringing about positive

change and promoting employee voice within the home. From the below extract provided by CS2-CA2, this is not a view shared by some frontline staff.

Researcher: *Since you started working within this organisation do you feel you are able to express yourself and voice your opinions?*

Participant: *"I don't think the new management has a clue, I think things are just being swept under the carpet, and some people are favourites of the nursing staff and the unit manager. In the past, I had 100% support from the Clinical Manager, but now things have changed, and it is upsetting a lot of people."* (CS2-CA2)

The comments provided by CS2-CA2 indicate that although the perspectives on the legacy of previous management in relation to employee voice are for the most part negative, views on the efforts of the current management team to tackle this issue are very much mixed. I argue that this just further substantiates the assumption my analysis has come to that this care home does not have a homogenous culture (Boisnier & Chatman, 2002). That being the case, steps to address issues such as the negative legacy of previous management regimes on voice will also be met with missed responses, as staff continue to look towards their units for solutions and guidance.

5.6.1 Characteristics of the legacy of previous management regimes

As a result of my analysis, the main characteristic underpinning perspectives of the legacy of previous management regimes was the prolific turnover of management staff within the care home (Baylis & Perks-Baker, 2017). Over recent years, there have been a number of different managers running the care home who have all sought to take the care home in a different direction. This continued flux has resulted in inconsistencies and a lack of managerial stability at the top of the care home. In an effort to regain a degree of stability, frontline staff have sought stability in their own units, because the turnover of unit managers is far lower than that of care home managers. It can be argued that this lack of stability at the top of the care home has contributed to the lack of a voice culture within the care home. This lack of stability relates to the need for structural stability within a group detailed by Schein (2010) as an important consideration when establishing a culture. I argue this was absent within this care home, thus staff sought stability in their units, which over time has also contributed to the strong unit-level subcultures within the care home (Wilkins & Ouchi, 1983;

Schein, 2010; Mannion & Davis, 2018). The following extracts give an insight into the perceived high turnover rates among management staff in the care home.

Researcher: *Do you think this care home is well-led?*

Participant: *"I don't know them, we have had so many managers leave, like in the past two years we have had four managers leave." (CS2-CA1)*

Participant: *"I think everyone is down at the moment, cos we have had so many managers coming in and out of this care home, so people are a bit down. None of the managers gets a chance to implement change." (CS2-N1)*

Researcher: *Is there anything the care home does which you think prevents people from raising concerns?*

Participant: *"I think sometimes it can be the changes in management, I think that is an issue for me. Cos, you can go to management and say something, and they will change something, then new management will come and change it." (CS1-CA4)*

Participant: *"Yeah, and it's like you don't know where you are sometimes." (CS2-CA5)*

All the above quotes would suggest that the prolific turnover of managerial staff within the home has according to participants had a significant impact on all aspects of the care home. CS2-N1 blamed it for the culture of the home, CS2-CA1 for the leadership of the home, and CS1-CA4 for the current state of employee voice within the home. Hence, I argue that this characteristic is a very important one not only in our efforts to better understand the impact it has had on employee voice within the care home but, following on from comments from participants such as CS2-N1, also the culture of the home.

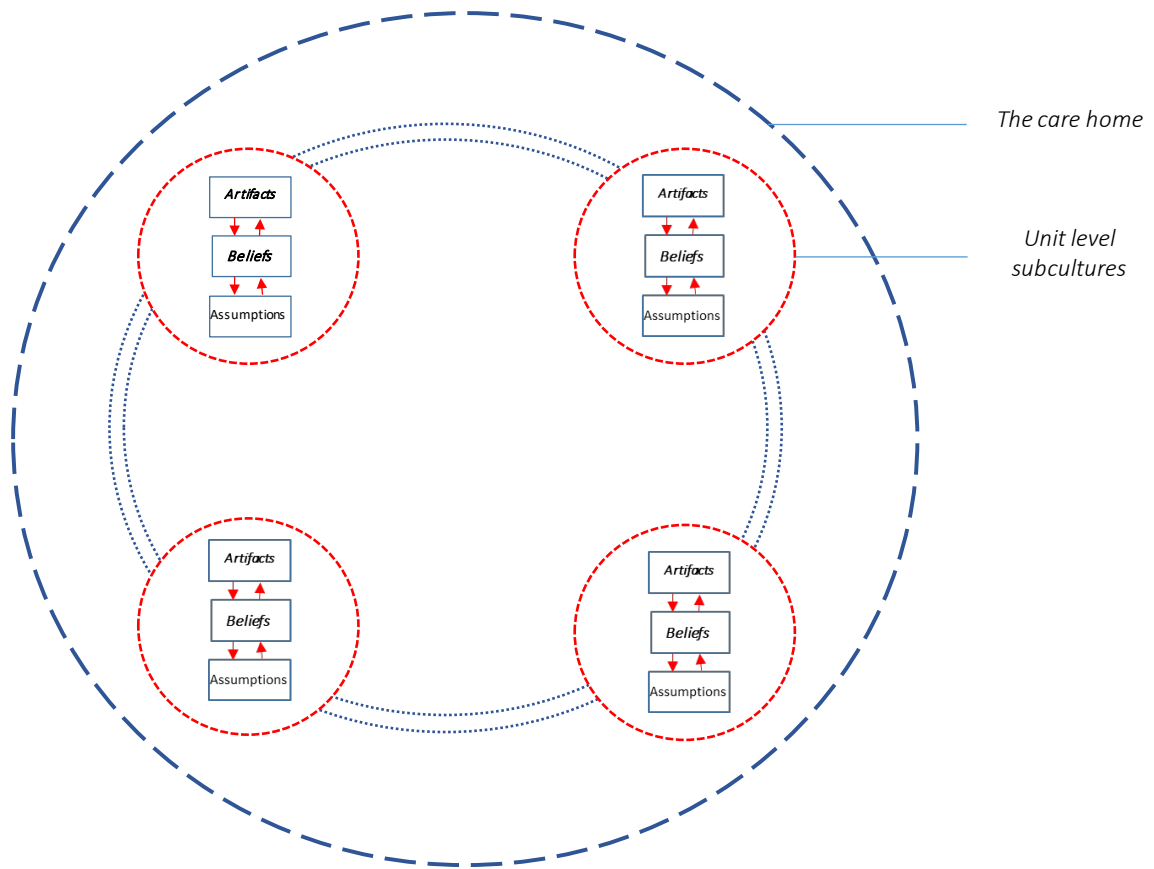
It is evident that the legacy that has been left by previous management regimes has according to participants had a significant impact not only on the culture of the home but also the ability and willingness of participants to voice themselves. Furthermore, the prolific turnover of managers and the perceived inability of managers to communicate effectively has compounded this issue (Dayan, 2017). All this has resulted in a situation in which a large number of participants are sceptical about the role played by managers within the care home, and their ability to effectively promote employee

voice. It is possible to put forward the perspective that despite the efforts of HM1 and CNM1 to proactively engage with staff (Allcock et al., 2015), the legacy left by previous managers still prevailed at the time of this study. In the 24 months since this study was conducted, the care home has gone through three Home Managers, two Caretaker Managers, three Clinical Nurse Managers and 2 Unit Managers on the unit which I conducted my second case study. Evidently, issues around high turnover of managerial staff and the impact it has on the care homes culture and employee voice are still of significance within this care home.

5.7 The care home culture as a collection of unit-level subcultures

Only after one has been able to appropriately analyse the elements of an organisation's culture that reside at each level, according to Scott et al. (2003a), is it possible to establish a good handle on the nature of the culture, which makes up any organisation. This, I argue, has been the case at the level of the care home, and as a result, it has been possible to establish that this care home did not possess a homogenous organisational culture (Trice & Beyer, 1993; Davies et al., 2000). According to Donaldson-Feilder et al. (2014), within a large organisation, there are likely to exist different subcultures. This is also a view shared by Davies & Mannion (2013), who argue that large organisations are susceptible to fragmentation of the organisation's culture and the establishment of organisational subcultures. Through an analysis of the three levels of the care home's culture, it was apparent that the care home's operational reality was one of multiple strong unit cultures. This is in line with the framework of organisational culture put forward by Davies et al. (2000) who argue that subcultures exist because of differing occupational, departmental, clinical or other affiliations within the working environment. In this instance, it was the lack of a home culture and the reliance on unit-level processes which contributed to the unit level culture within the home (Gregory, 1983). *Diagram Six* below provides a visual representation of the *Unit-Based Subcultures* within the care home.

Diagram 6: Unit-Based Subculture



The above diagram depicts what I argue to be the four-unit based subcultures which dominate the care home. Within each subculture, I argue that staff have chosen to establish their peripheral values from this position; it is possible to argue that multiple groups of people within an organisation decide to follow pivotal and peripheral values within their units as a way of countering what they perceive to be a hostile care home environment (Schein, 1984). Over time, I argue that each unit has developed differing assumptions about the care home, and their place within it, which has contributed to the unit-based culture of the care home (Tichy, 1982; Schein, 1984; Davies & Mannion, 2013). Hence, it is right that my analysis of the organisational culture goes further, and explores the culture of this care home at the unit level, which Hofstede (1998) credits with allowing for retrospective cross-analysis. Thus, this exploration will provide the appropriate level of scrutiny of the two units selected to effectively understand the cultural dynamics at play within them and the care home as a whole.

Therefore, the next chapter will explore two of these unit cultures, to better understand them, and explore how each unit's culture influences employee voice.

5.8 Summary

Through my analysis of data obtained from both case studies, it has been possible to gain an insight into the cultural dynamics within this care home and their influence on the voice of employees. An exploration of how participants understood employee voice identified that positionality within the organisational hierarchy was a crucial factor in shaping participants' perspectives. My analysis of participant perspectives on the care home's culture produced three themes around positive, negative and mixed perspectives, which in my view indicated that this care home was disjointed.

Through my deployment of my *Organisational Culture and Subculture Analytical Structure*, it was possible to establish that the fundamental assumption was the care home was not a homogenous culture, but rather underpinned by unit-based subcultures (Mannion & Davis, 2018). It was also possible to detail the characteristics of the care home environment, both those that facilitated and those that mitigated against employee voice, which provided additional cultural insight into the care. Finally, it was possible to put forward my *Unit-Based Subculture Framework*, which I propose as a visual representation of the subcultures dominating the care home. Moving forward, chapter six will analyse the cultural dynamics of the two units researched to understand better the role subcultures play in shaping employee voice in both units (Schein, 1984; Morrison, 2011).

Chapter Six

Unit Culture and Voice

6.0 Introduction

With the emergence of unit-based subcultures as the most crucial consideration influencing the culture of the care home, I shall proceed to undertake a cultural analysis of the unit one and two case studies. To aid in this endeavour, I shall deploy metaphors which have emerged from the data, to facilitate our understanding of the cultures within both units (Morgan, 1983). Through the application of the *Organisational Culture and Subculture Analytical Structure* to both case studies, I argue that it will be possible to gain a better understanding of the cultural dynamics which contributed to the cultures of both units (Smircich, 1983; Schein, 2004). With this information, it will finally be possible to gauge how such cultures have influenced employee voice within both of these units, thus contributing to our understanding of this issue and future policy initiatives in this area.

6.1 Metaphors in use

To aid in our understanding of the cultural complexities associated with both unit one and unit two, I have decided to deploy metaphors as a way of assisting my depiction of the two units (Morgan, 1983). In keeping with my philosophical position, rather than borrowing metaphors from other academic fields (Morgan, 1983), or my knowledge base, the decision was taken to implement metaphors which have come directly from the data (McClintock et al., 2010). I argue that this would represent the observable characteristics of the organisational environment (Morgan, 1983), which would give us a higher degree of authenticity, objectivity and transparency (Cook & Campbell, 1979; Guba & Lincoln, 1994; McClintock et al., 2010). This approach will also help to present a more accurate picture of the culture within each of the units researched (Morgan, 1983).

According to Morgan (1983), metaphors are the basic structural form of experience through which human beings engage, organise, and understand their world. Within an organisational context, this would be how people understand their working world (McClintock et al., 2010). Kendall & Kendall (1993) see metaphors as being very helpful to organisations in attempting to tie their parts together into a meaningful whole. Thus, I argue that metaphors can be seen as an effective tool by which one

can better understand the complex components of an organisation which make up that organisation's culture (Kendall & Kendall, 1993; Schein, 1988).

Through an analysis, I identified one metaphor within each of my case studies. In CS1, the metaphor of *'the family'* will be used to depict the cultural characteristics of the unit. In CS2, the metaphor of *'cliques'* will be used to depict the cultural characteristics of unit two. The next section of this chapter will proceed by applying my *Organisational Culture and Subculture Analytical Structure* to both case studies, and in doing so will critically assess the characteristics of each level which have contributed to the unit's culture (Schein, 1988).

6.2 Cultural manifestations in unit one (case study one): the family metaphor

An analysis of the data has brought to the fore the metaphor of the *family* as an appropriate cultural reference for CS1 from the perspective of participants (Cook & Campbell, 1979; Guba & Lincoln, 1994). The notion of family as a depiction of organisational culture is nothing new; Schein (2011) explored the use of the concept of family during his case studies. From Schein's (1983) depiction of the family as a metaphor, the family has very different meanings to members of different organisational cultures. For example, according to Kendall & Kendall (1993), the notion of the family can provide comfort and friendliness for its members. However, in the case of Schein (1983), it relates to a strong mother or father at the head of the family who sets rules that all members of the family must follow.

Indeed, in the above example case studies put forward by Schein (2004) in chapter three, the notion of the organisation being a family was evident. Despite this, the concept of what a family meant in each context was very different. At DEC, the underlying assumption was that the organisation was a family, and that being the case, members could fight amongst themselves, but they still loved each other and would not lose membership of the family (Schein, 2004). In the case of Ciba-Geigy, the underlying assumption was also that the organisation was a family, but this family was at its best when 'parental authority' was respected, and children obeyed their parents (Schein, 2004). Children within this family system would be taken care of only if they conformed to the family rules (Schein, 1983). These two examples demonstrate that perspectives of family cultures differ; thus the next

section of this chapter aims to analyse each level of the family culture, and provide an enhanced insight into how the family culture has come into being.

6.2.1 The family culture in case study one

The notion that the members of unit one, which was my first case study, were a family was something that became apparent from the outset of my study. The perspectives among participants that the unit was a family was a unanimous one. The family culture was expressed through documentation such as rotas, verbally, during my semi-structured interviews, and through the actions of participants, which I observed during my non-participatory observations. The family culture was also the fifth theme generated, and the data distribution for this is available in *appendix seventeen*. In the below extract, it is evident that participants related the culture within their unit to one of a family.

Researcher: *Within your unit, how would you describe the culture?*

Participant: *"I think because we work as a family and a team, it's like coming to work and the unit manager is my mum, the team leader is my uncle... and my aunt cos we've got a boy, and a girl, and my teammates are like my brothers and sisters. It is like a family unit up there. We kiss and cuddle, we really are a family unit."* (CS1-CA1)

Participant: *"We are like a family, it is a very weirdly put together family on our unit, but we are like a big family, we are just all together. We are all on the same level, we will all help each other out, and we will do favours for each other."* (CS1-CA7)

Participant: *"We do, we feel we are family not told we are family."* (CS1-CA4)

The above extract from all three participants goes to the heart of this notion that the unit is underpinned by a family culture, although a different rationale was given as to why the unit was a family culture. The perspectives put forward by CS1-CA1, that the unit manager is the mother and the team leader the uncle, maps the hierarchy of a family structure onto that of the unit (Martin & Waring, 2013). This structure, I argue, indicates that there is a hierarchy within the CS1, and that the unit manager is at the top of that hierarchy. Within the first few days on the unit, I had already picked out the notion of the family within the unit, and in the following extract, I try to make sense of this, in the moment as events are developing.

Researcher: *The concept of the unit operating as a family keeps coming up within most of the interviews conducted thus far. I don't know why they all use the same word to describe the unit. Evidently, from my observations, the unit manager operates a strict matriarchal system within the unit. I think this goes beyond the matron role normally seen in hospitals. (Case study one daily log on 6/2/17)*

Although the above extract was formed early on in my case study, the idea that the unit was a family culture is something that prevailed through my time on the unit, and, I argue, demonstrates how visible this culture was on the unit. According to Schein (1983), the taking up of perspectives of a family within an organisation can have far-reaching implications for the characteristics of its culture. In this instance, it is evident that the family system furthered by the unit manager does shape all aspects of the unit.

6.2.2 The family's perspective of its unit's culture

To investigate this, I first deemed it essential to explore the perspectives of participants within the unit on the unit's culture. The following question was posed to participants during the semi-structured interview stage of my data collection.

Researcher: *How would you describe the culture in your unit?*

Participant: *"My unit, they are very, very close, the staff are very close, we are family actually, we are not just staff. We look after each other in different ways, it feels very comfortable and quite united". (CS1-CA4)*

Participant: *"Well on my unit the culture is very open, I think we are quite a small unit, actually bigger now, but we are quite a small team". (CS1-CA6)*

Participant: *"Yeah it is a good culture". (CS1-CA2)*

The above responses to my question on the unit's culture were unanimously positive. This, I argue, suggests that on the issue of the unit's culture, participants were united, which was not the case at the care home level when the same question was posed. Furthermore, this unanimity would also suggest that participants share or believe in some common characteristics that brought about the

unit's culture. To explore if this perspective was correct, the same question was put to the manager of this unit, and followed up with additional questions aimed at delving deeper into this positive unanimous position of the workforce.

Participant: "Ooh yeah, it is a positive culture cos someone's weakness is someone's strength; that's my culture".

***Researcher**: Ok, but how has that positive culture developed?*

Participant: "By teaching and coaching them."

***Researcher**: By you?*

Participant: "Me..., or anyone, what I would say is that if someone is complaining about this person, I would show them their own faults. I don't want to take credit for the good culture; it's a group effort." (CS1-UM1)

In the above extract, the manager of this unit puts the positive culture on the unit down to the 'teaching and coaching' of staff. This suggests that there was a purposeful attempt to train staff to behave in a specific way, which is something that will be explored in detail later on. What has become evident for the exploration of participants' views on the culture within unit one is the deeply seated bonds between members of the unit which I argue have formed the basis of the unit's culture (Kendall & Kendall, 1993). To make sense of how this culture has come into being, it is important (Schein, 2004) to delve deeper into the differing levels of the unit's culture as detailed below.

6.2.3 Artifacts

In following my *Organisational Culture and Subculture Analytical Structure*, and with reference to the cases of Ciba-Geigy and the Digital Equipment Corp studies by Schein, I use the same three considerations used at the care home level to analyse the artifacts in CS1 (Schein, 2004). I argue this will maintain analytical consistency, but also that such considerations offer an appropriate way of understanding the artifacts which have contributed to the family culture within this unit.

6.2.3.1 Entering case study one

In my efforts to access unit one as part of my first case study, I underwent a number of steps, which have been detailed in the methodology chapter. The key stages I went through in order to

access the unit included first being debriefed by CNM1 about the unit before being escorted upstairs and introduced to the unit manager (CS1-UM1). The following extract reflects my initial thoughts about being in the unit.

Researcher: *The unit manager made a point of saying that she had told all her staff to be open and talk to me. I didn't think much of that statement at first but a few moments later, I wondered why she felt the need to tell them that. Also, why she felt the need to tell me that she had told them that. Is the default position not to talk unless they have been given permission to do so? If so, what is the status of the information that I am going to get over the next few weeks and am I being sold out before I have even started? (Case study one daily log on 6/2/17)*

From the very first day, I arrived on the unit I started to have concerns about the influence the unit manager had over her staff and their ability to voice themselves. On reflection, my concerns were warranted; the unit manager's approach of 'teaching and coaching' staff seemed to be apparent even at the early stage of being on the unit. From my first impressions, I was worried that the next few weeks of research could be a show put on to impress me, but on reflection I think I was able to work around that and gain a real insight into the family culture within CS1. In relation to that unit's family culture, it was evident at this stage that the unit manager was the most important member of this family.

6.2.3.2 Observable characteristics of the environment

From my observations of the unit environment, it is possible to state that the unit had a very closed feel to it. This was because all the doors were kept closed at all times, and the day-to-day activities on the unit were very regimented, such as meal times and afternoon activities for residents. According to Davies & Mannion (2013), the most visible manifestation of the artifacts level of Schein's model would be factors such as the physical layout of a building. I was able to identify two characteristics of the layout of the unit which, as I concluded, helped the unit manager to promote the family culture on the unit.

6.2.3.2.1 The nursing station

The first characteristic of the unit environment I observed relating to the family culture was the nurse's station. This was a room on each unit used to keep documentation and medication for residents (Kenkmann et al., 2017). From my observation, this room was used by the unit manager as a 'living room' for staff. For example, the unit manager would allow staff to keep their bags and coats in the nurse's station, which I later found out was against official care home policy. I also observed that the nurse's station had a number of the unit manager's items within it, such as a stereo with speakers and a chair. The unit manager would use this to play music during the afternoons I observed and would always sit on her chair. The unit manager also decided to keep the Christmas decorations up only in the nurse's station throughout the whole year as a way of making that space more comfortable. I argue that all of these observable characteristics of the nurse's station were an attempt by the unit manager to create a homely family feel to the nurse's station, which is in line with the family culture of the unit. This is something which I detailed in the below extract.

***Researcher:** One of the things that are surprising is how chilled out the nurse's station is, it feels as if you are at home. The unit manager allowed me to keep my bag and coat in the nurse's station, and it seems to be less of a nurse's station and more of a chill-out station.*

(Case study one daily log on 6/2/17)

6.2.3.2.2 The kitchen cupboard

Another observable characteristic of the unit environment was the kitchen, in which I observed that the unit manager had allocated specific cupboard space just for staff to keep personal belongings and food (Kenkmann et al., 2017). Again, this was against official care home policy; I argue that this was another attempt by the unit manager to personalise a space within the unit to give it a 'family feel'. I observed staff using this personal kitchen space to keep personal cups and food items, which they would use especially during their meal times. During a conversation with CS1-CA4, I was informed that the unit manager had a special cup kept within this allocated kitchen space and that no one was allowed to use that cup apart from the unit manager. As the head of the family, it was evident that the unit manager used informal rules such as this to maintain control and impose her superiority over her staff. This is something which I explore in the below extract.

Researcher: *Today I went into the kitchen to get a drink with CS1-CA4 who informed me about some of the informal rules of the unit which up until this point I had not been aware of, such as the fact that staff had their own kitchen space and the special cup used by the unit manager. It is evident that members of the unit were happy to have such informal privileges, but they also knew who was boss. (Case study one daily log on 8/2/17)*

From the above observations, it is evident that the observable characteristics of the environment within CS1 did facilitate the family culture, which was apparent throughout the unit. Furthermore, I argue that the family feel created within both the nurse's station and the kitchen was an attempt by the unit manager to underscore further the family ethos within staff, thus maintaining her position as head of that family.

6.2.3.3 Interactions between staff members

Through my initial observations on the unit, one of the first things that became apparent was how close members of staff on the unit were. This closeness manifested in a number of ways, such as instances in which I observed staff members kissing and hugging at the start and end of each shift. This act of emotion can be seen as underpinning the perspective of family, which staff kept commenting on whenever I would ask them why they were doing things such as kissing each other on the cheek. This is something that I commented on after observing it happen, as reflected below. At the time I deemed such an act as kissing at the end of the shift as being 'too friendly', but on reflection, I argue that this was a visible way staff showed that they were part of a family.

Researcher: *The interchange between day and night shift seems to be very important in this unit. Care staff tend to on the whole come in slightly earlier and talk among themselves. Staff seen kissing and cuddling each other before going home. This seems a little too friendly to me. (Case study one daily log on 7/2/17)*

Another interaction I noted was that which took place between staff and the unit manager. Over some time, it became clear to me that these interactions were more complex than was initially evident. Although seemingly pleasant on the surface, what became evident was that the unit manager operated a system of informal control. As such, I got the impression that the unit was run

with an undercurrent of control by the unit manager. Staff always seemed to agree with the unit manager and do exactly as she asked without ever asking questions or suggesting alternatives. The following extract details my thoughts around this informal control which the unit manager exerted over the staff on the unit through the way she interacted with staff.

Researcher: *There is a sense of ‘we know who is boss and she knows she is boss’. Thus far, I am unable to really understand its impact on voice if any, but there does exist a power dynamic at play within this context. (Case study one daily log on 6/2/17)*

Researcher: *Reflecting on today’s observations, I do think that there is an undercurrent of fear on the unit and that the majority of staff go along with things without complaining, and only give their views when they are asked to, rather than when they want to. (Daily reflexive diary on 7/2/17)*

This form of control, I argue, was very subtle, and went beyond what would be expected within an organisational context. I suggest that as the mother of the family, the unit manager was able to invoke ‘parental authority’ as was the case with Ciba-Geigy and use this to gain extra control over staff on the unit (Schein, 2004).

Through my analysis of the unit’s culture at the artifact level, what has become apparent is that a number of artifact level considerations exist, which can be directly linked to the family culture within this unit. According to Schein (1984), although the artifacts level of a group’s culture is easy to observe, it is very difficult to decipher and make accurate interpretations of the actors’ meaning behind their actions. Therefore, the next section of this analysis aims to explore the beliefs level of the unit’s culture, and in so doing to further our understanding of the family culture within CS1.

6.2.4 Espoused beliefs

In an attempt to better understand the family culture within CS1, I have been able to identify three espoused beliefs which underpinned the culture within this case study. Because these beliefs underpin a subculture within the care home, all of the below have come about through informal policies, rules, values and goals which are unique to this specific unit (Schein, 1983). I argue that it is these rules and goals which have over time resulted in the family culture within this CS1. On that

premise, this section aims to explore all three beliefs, and in so doing indicate how they contribute to the family culture presented within case study one.

6.2.4.1 The unit manager has a policy of moulding staff

The first espoused belief held by some participants within the unit was the belief that the unit manager, through a number of different processes, had a policy of 'moulding staff' into working in accordance with the family norms and values. Previously we have explored the notion put forward by the unit manager that the positive culture detailed by staff on the unit is as a result of "teaching and coaching them", with 'them' referring to staff who work on the unit (Sinclair, 1993; Morgan, 1980). This policy of coaching staff is something that through my interactions with participants has emerged as an important stage within the process of developing the family culture within the unit (Schein, 2004). I argue that this system of 'teaching and coaching' staff is a system the unit manager uses to indoctrinate new members of staff into her vision of the unit as a family and also to continually coach old members about what is expected of them as members of the family (Kendall & Kendall, 1993). In the below extract, the unit manager uses the terminology of moulding to refer to this process of teaching and coaching her staff.

***Researcher:** 'Moulding' within this context, I believe, refers to a process in which the unit manager influences you to work according to her way of doing things. This goes far beyond the requirements of the job; rather, it is a 'training course' in how to work for her and conform to her rules and regulations. Most of such rules and regulations are informal and based around informal communication mechanisms and recognising her superiority on the unit.*

(Daily reflexive diary on 7/2/17)

In my efforts to better understand the moulding of staff in relation to the unit manager, I reflected very early on into my observations that I perceived it as being a 'training course' on how to function on the unit. Indeed, this would still be the case, and I would argue that this training course was geared towards teaching staff how to behave as part of the family.

The notion that the unit manager uses her process of moulding staff as a way of indoctrinating them into the family was also explored by CS1-N1 in the following extract.

Researcher: *From conversations with members of staff everyone seems to say the same thing about the unit manager, is that normal, or has that come from the moulding you talked about.*

Participant: *“Well it depends on what they are saying”.*

Researcher: *Was it very positive.*

Participant: *“Well yeah, it probably has come from the moulding, don’t get me wrong, the team themselves upstairs enjoy working where they work. The unit manager manages the unit very well but it is not the way I would manage a team”. (CS1-N1)*

In the above extract, CS1-N1 acknowledges the fact that the family culture on the unit has come about as a result of the unit manager ‘moulding’ staff. Although the staff on the unit were happy, argued CS1-N1, such a system was not how CS1-N1 would run the unit, suggesting that CS1-N1 did not totally agree with this method. In the following extract, I put a follow-up question to CS1-N1 aimed at clarifying what CS1-N1 meant when using the term moulding.

Researcher: *You have used the word moulding, from your view, it describes a system in which the unit manager creates what she expects of a carer and expects that alone?*

Participant: *“Yeah”.*

Researcher: *but your laid-back approach gives more autonomy to the carers?*

Participant: *“Yeah”. (CS1-N1)*

Indeed, we both had the same interpretation of this terminology; furthermore, the reason why CS1-N1 did not adopt this approach was that CS1-N1 argued that the ‘laid-back approach’ CS1-N1 had adopted was best suited to giving staff more autonomy and, I would argue, potentially more voice. In the below extract I ask the unit manager about the culture on the unit, and the response does indicate that CS1-UM1 acknowledges the use of this system on the unit.

Researcher: *What about the culture in your unit as the unit manager, is it a positive culture?*

Participant: *“Ooh yes, is a positive culture cos someone’s weakness is someone’s strength, that’s my culture. No specific job for anyone, they work on it, they know their weaknesses and work together”.*

Researcher: *Ok, but how has that positive culture developed?*

Participant: *“By teaching and coaching them.” (CS1-UM1)*

I argue that the unanimous responses that I was given at the start of this chapter in relation to the culture within CS1 came about to a large part as a result of the unit manager's moulding of staff. The belief that the unit manager moulds staff is reflected at the artifacts level of this analysis through the authoritative feel the unit manager projects through the family hierarchy system on the unit and the visible way in which members of staff on the unit interact with each other through hugging and kissing at the start and end of each shift to visibly demonstrate their closeness. Hence, I argue that this system of moulding staff is not just a belief, but a significant component in understanding the unit's culture.

6.2.4.2 We work as a small close team

The second belief to emerge from the data was that the unit operated best as a small team. This was an informal policy of the unit manager who expressed this policy to me on several occasions. It was an expressed goal of the unit manager to keep the number of staff on the unit as low as possible. This, I argue, was to enable the unit manager to keep control and maintain her policy of moulding staff.

This policy manifested in a number of ways, such as the staff rota, which the unit manager kept a tight grip on. This meant that the unit manager would rather the unit worked short-staffed than have a member of staff from another unit who did not comply with her rules. I argue that over time, the policy has become a belief among staff that the unit is a close-knit team because of its small size, which enabled staff to reach a consensus within the group. The below extract from CS1-CA6 goes to the heart of this perspective.

Researcher: *What are the elements of your unit which give it a positive culture?*

Participant: *"Well on my unit the culture is very open, I think we are quite a small unit, actually bigger now, but we are quite a small team. So we see the same people all the time, and if there is an issue with the people I work with you can tell them, and it does not become a big argument."* (CA6-CS1)

Participant: *"On a team level we work very well together, everyone communicates really well with each other. As a team we are very strong, that is like the cultural thing on my unit. We are a team and you stick together, and everyone works very well together. We have 10 or 12*

staff on our unit for both day and night whereas you look at the other units, they have 25. So out of the 25, you are more likely going to have people that can't work well as part of a team."

(CS1-N1)

CS1-N1 picks up the point in the above extract that comparing the number of staff on unit one to other units, unit one was the smallest unit in the care home. This small size is something that CS1-N1 believed contributed to the togetherness within the unit. From my observations, it was evident that the small number of staff working on the unit did make it easier for the unit manager to pass information on and set narratives. This links back to the characteristics of organisations which according to Schein (2004) make them more conducive to creating subcultures. Smaller group size is seen as increasing flexibility; in this instance, the size of the unit has helped in not only establishing this culture, but has also contributed to the intensity of the unit's culture (Schein, 2004). I argue that the unit manager's policy of restricting the number of staff working on the unit did have negative consequences, such as the unit having to work short staffed on several occasions when I was conducting my observations. Despite this, I got the impression that staff would rather work short than go against the unit manager, as they ultimately seemed happy to do so, which is detailed in the following extract.

***Researcher:** Today I think they are short staffed, but it seems to be a normal thing on this unit and they all seem ok with it. It's as if they would rather work short than have someone from another unit come and help out. Well, that is the impression I just got during handover anyway. (Case study one daily log on 8/2/17)*

I argue that the above extract reflects the character of the family put forward by Kendall & Kendall (1993) in which family members always stick together. Through my analysis of data related to CS1 and its predisposition towards having a small number of staff working on the unit, it is possible to argue that this preference did indeed contribute to the culture of the family on the unit. By keeping the numbers of staff small, it gave a feeling of a 'nuclear family', in which the unit manager occupied the sole position of power (Schein, 2004). At the artifacts level, my analysis of the staff rotas did indeed indicate that the number of staff working on the unit was very small as compared to other units. Therefore, I argue that it is possible to see how the small unit size in CS1 has helped to facilitate the family culture on the unit.

6.2.4.3 Beliefs around unit meetings

The final belief to emerge from my analysis of CS1, centred on the role of unit meetings in facilitating the family culture on the unit. From my observations, there were two types of meetings that took place on a regular basis, which helped to facilitate the belief among staff that the unit was indeed a family. The first was morning handovers, and the second was group meal times. This section aims to explore both, and in doing so, identify how such meetings contribute to the family culture present within CS1.

6.2.4.3.1 Morning Handovers

Morning handovers were a formal policy of the care home, which each unit had to engage in at the start of each shift. From my observations, these handovers would normally take place between 08:15 and 08:45. From my observations of these handovers, I realised that they had been adapted by the unit manager to include what I refer to as 'family elements' within them. That is, although the handovers would cover official work such as discussing each resident and establishing an action plan for the upcoming shift, there was also an element involving staff talking about their own issues. I observed on a number of occasions instances in which staff would have extensive conversations about their personal lives. Such conversations were mostly initiated by the unit manager who would act as a *mothering mediator figure*, offering advice and reassurance to staff. This is something which CS1-CA5 details in the below extract when asked about the culture on the unit.

Researcher: *What do you think from your view it is in your unit which gives it a different culture from the other units?*

Participant: *"We have handovers in the morning; we discuss more than just the service users. We might ask each other how we are doing, if there are any problems we have had at home, we say, are you doing ok? If someone is not very well, or not had someone in the family go well, we ask, do you need any kind of help? so we can sort that." (CS1-CA5)*

In the above extract, CS1-CA5 expresses that the way handovers were handled on the unit was one of the key factors which differentiated it from other units. CS1-CA5 mentioned the ability to talk about 'problems' during handovers, which, I argue, go beyond the formal processes required. This, I

suggest, demonstrates that such handovers facilitate the family culture on the unit because they reinforce the belief of belonging among members and allow them to open up about personal issues, which would not normally be the case within a care home handover setting. This is something which I explored in the below extract from my daily log.

Researcher: *Long handovers in the morning between the nurse and the care staff. Issues discussed go far beyond those relating to the delivery of care on the unit. These handovers are also used to 'gauge' what is going on with staff in their personal life and provide support and advice. (Case study one daily log on 8/2/17)*

I argue that the 'family elements' which the unit manager had incorporated into the handovers meant that they did instil and reinforce the belief among staff that they are part of a family and that the family has their best interests at heart (Schein, 2004). As such, it is possible to see how these handovers contributed to the family culture in the unit.

6.2.4.3.2 Family mealtimes

The second type of unit meeting that I identified during CS1 was family mealtimes, which took place between 13:30 and 14:30 each day. Such meals were an informal policy implemented by the unit manager in which all members of staff on duty would meet in the servery and have 'family lunch' together (Kenkmann et al., 2017). This was also an opportunity for staff to have a meeting and discuss more informal issues, which the handover did not allow for. From my observations of these family mealtimes, it was evident that conversations which took place during these meals, for the most part, had nothing to do with the unit or the care home. I argue that such meals were used as a socialisation tool by the unit manager to maintain cohesion among staff members (Bate, 1984). Such mealtimes were also used to celebrate the birthdays of staff members, which, I suggest, furthered the family culture within the unit. The following extract provides an insight into an occasion on which a staff member's birthday was celebrated on the unit.

Researcher: *One of the CAs had her birthday today, this was celebrated by ordering food, which the unit manager ordered and paid for. This also included ordering a large birthday cake and flowers. This is far beyond what you would expect from a unit manager and just goes to*

show that the unit manager will go to any length to maintain the family culture within the unit. Indeed, such birthday celebrations seem to be another way in which this is being achieved. (Case study one daily log on 21/2/17)

From the above extract, I put forward the argument that these family mealtimes and birthday celebrations were a strategy used by the unit manager to further instil family norms among staff members. By demonstrating the benefits of being part of the family, the unit manager was, I argue, able to keep staff on the unit on side and following her family rules, thus contributing to the family culture on the unit.

6.2.5 Basic underlying assumptions

The ramification of the above espoused beliefs is that over time specific assumptions have become entrenched among staff about what it means to work on this unit, assumptions which, I argue, have formed the foundations of the unit's family culture (Schein, 1983). Through my analysis, it has been possible to identify two key underlying assumptions which, as I will explain in this section, facilitated the family culture on the unit. Assumptions within a group are seen as non-debatable reality (Riley, 1982; Schein, 2004), thus I propose that understanding these within the context of CS1, will provide us with a deeper understanding of the family culture.

6.2.5.1 'It's them against us'

The first key assumption to emerge from my analysis of the data which gives us a better insight into the family culture observed during my analysis of CS1 is the assumption among a large number of participants that the unit was under threat from external forces. The assumption that 'it's them against us', was something which I picked up at different stages of my analysis of CS1. This assumption, I argue, underpins the notion I encountered multiple times during my study that members of the unit felt they had to stick together. Faced with a perceived external threat from other units and management, the unit felt a need to not only stick together but to also fight back as a unit family against all adversaries (Morgan, 1980). I concluded that this narrative brought the unit together and kept them united, thus further strengthening the family culture on the unit. The following extract from CS1-CA5 reflects the assumption of 'it's them against us'.

Researcher: *During your first few months on the unit, did you feel able to express yourself?*

Participant: *“In terms of the rest of the home there is a culture of sometimes, it is us against them rather than being the whole team working under (unit one) or (the organisation). That did not help, especially when I started off, there were some individuals telling me not to speak to this individual, and don’t go out with this individual.” (CS1-CA5)*

In the extract above, CS1-CA5 reflects on how parameters were given as to who to speak to. This can be seen as an attempt to keep CS1-CA5 within the family system, and as a new member of staff discouraging him from socialising outside the family (Bate, 1984). From my observations on the unit, it was evident that it was the unit manager who was behind a large majority of these narratives which I found being used as a way of keeping staff loyal to the unit. Under these circumstances, staff who did want to speak out against the unit or the unit manager were reminded of the alternative, thus, I argue, inadvertently stifling ‘critical voices’ on the unit. In the below extract, I attempt to grapple with this narrative and in doing so, offer my initial take on how it has come about, and why it was so effective within the unit.

Researcher: *In conversations I have been having with a number of staff members, I am starting to get a narrative from staff in relation to a them and us when it comes to their relationship with the rest of the home. Staff seem to believe that they have been mistreated as a unit and have not been given the credit they think they rightfully deserve. I sense a degree of bitterness within the unit, but I don’t know why. It also seems like this is a narrative which has come from the unit manager, and has fed been down to all other members of staff who would not in their right minds contradict this narrative so go with it or keep quiet. The threat of going against this narrative is not explicit but rather resides within the passion with which those at the top of this unit put their case forward, leaving no room for alternative views, thus the rest seem to follow very closely behind. (Case study one daily log on 9/2/17)*

From my reflections, it was evident that this messaging was being ‘fed down’ to staff from the unit manager as a way of maintaining control over the narrative of the unit and over the staff by tapping into their emotions. Furthermore, it was evident that due to the control that the unit manager had over the narrative on the unit, participants who disagreed were stifled due to the sheer passion and

emotion with which the unit manager put across views (Schein, 2004). That being the case, I argue that the unit over time adopted the assumption that, indeed, they were at war with other units and the management and they, therefore, had to stay together under the leadership of the unit manager (Havig & Hollister, 2018). According to Kendall & Kendall (1993), there is a degree of sacrifice associated with the deployment of a family metaphor within an organisational context due to the fact that all members feel a sense of belonging. I found that such assumptions did result in sacrifice, such as the unit choosing to work short. In the following extract, I reflect on how this assumption had become part of daily life on the unit.

***Researcher:** It can be said that the unit thrives on being 'different' and doing things differently. It serves as a mechanism for bonding the staff and enthusing them to further identify with other members of the unit, most important of all is the unit manager. This has fed into the family culture on the unit, which has been built from the top down and although it allows individuals to thrive within it, the boundaries and unwritten rules of engagement are very clear, and there is a demand that you follow without question. Within this context, not being part of the team means not being part of the family, which is not an option. (Daily reflexive diary on 13/2/17)*

From the above extract, I reflect on the fact that this assumption that it's them against us, has helped to underpin the important role of the family and solidify the unit manager's status as the head of the family. In the face of perceived external adversaries, the family has become closer and more reliant on their leader to navigate a path forward, which has put more power in the hands of the unit manager who has used it to further the family culture on the unit.

6.2.5.2 The unit manager brings the unit together

The second assumption to emerge from my analysis of CS1 was the assumption among participants that the unit manager brought the unit together. This assumption, I argue, had come about as a direct result of the moulding of staff I discussed at the beliefs level of my analysis. That is, through the moulding of staff members, which the unit manager openly acknowledges doing, one of the assumptions that have emerged from that process is that the unit manager in her capacity as the head of the family brings all the members of the family together. This assumption of unity and being

brought together is something which Kendall & Kendall (1993) view as a characteristic of a cultural family. The unit manager's role in facilitating this notion of bringing together the unit is very much apparent in the following extracts.

Researcher: *Is there anything the unit manager could do to improve things on the unit?*

Participant: *"She brings it together and makes it like a family, she always makes it together to be a family. We are together and talk together as a team and help each other."* (CS1-CA8)

Participant: *"Well, it is a little bit of a collective, but I would say it's the unit manager who pulls us all together. It's like coming to work and having my mum there, it really is."* (CS1-CA1)

Participant: *"Well she keeps the unit together, she is there for you personally and professionally, and she will help you out bathing people as well, she is happy to do that as well."* (CS1-TL1)

The assumption that the unit manager was a unifying force within the unit was something that was very common among all participants. As such, I argue that the assumption that the unit manager 'brings together' the unit is something that the unit manager had over time instilled in members of the unit. Furthermore, I suggest that such assumptions help to justify why the unit manager tightly controlled the unit.

There were a number of ways in which the unit manager maintained the assumptions that she was a unifier among her staff. One of the key ones I discussed in the previous levels was how the unit manager would go out of her way to celebrate the birthdays of staff members by buying them flowers and cake. I argue that such celebratory events were a way of celebrating the occasion, and also a wider celebration of the family. Although this is a celebratory event, the unit manager expected all members of the family to participate in this celebration, as is the case with all other events. The below extract from my reflective log close to the end of my observations of CS1 provides an insight into this position.

Researcher: *So, on the one hand, you have a unit manager willing to spend her own money on gifts for employees when it is their birthdays and go far beyond what is expected in any formalised working environment. On the other hand, you have a unit manager who is willing*

to punish her employees for talking off the unit, or not following the informal rules of the family, such as coming for family meals and eating on the unit. It is evident that the control and power the unit manager has over this unit is absolute, and as I come to the end of my observations, this is one of my key findings. (Daily reflexive diary on 22/2/17)

The above extract contrasts the loving mothering role played by the unit manager when buying birthday gifts for staff with the strict mothering role the unit manager adopts when staff do not comply with the family rules (Schein, 2004). What has become apparent is that this assumption that the unit manager brings the unit together has come about as a result of complex and sometimes contradictory positions held by the unit manager of both celebrating and punishing staff. However, taken together, I assert that the unit manager's ability to straddle these two opposite positions and make difficult decisions (Kendall & Kendall, 1993) has helped establish and maintain the family culture within CS1 (Schein, 2004).

And so, what has become apparent through my analysis of the three levels of culture within CS1 is that, indeed, at each level, it has been possible to identify characteristics which can be linked to the family culture of the unit (Scott et al., 2003a). I argue that the kissing and hugging of staff members as a visual representation of affection and family bonding contributed to this at the artifacts level. At the beliefs level, the process of the unit manager moulding staff and unit meetings also contributed to the assumptions within the unit, which ultimately has resulted in the family culture (Schein, 2004; Martin & Waring, 2013). The next section of this chapter aims to explore the influences within case study one that facilitated and mitigated against employee voice, in doing so enhancing our understanding of the influence the family culture had on employee voice.

6.3 Influences facilitating employee voice: the sense of belonging

Through my analysis of the data from all three methods deployed as part of my study, it has been possible to identify that the key cultural influence on facilitation of voice culture within unit one was a sense of belonging participants had about their role within the family culture. According to Morgan (1980), the use of the family as a metaphor invokes a sense of belonging which from my analysis was exactly how participants felt. That being the case, I concluded that in cases in which employee voice was permitted by the unit manager, the catalyst for participants to voice themselves was the feeling

of togetherness and belonging that members of the family had towards each other. The sense of belonging to the family meant that participants were more willing to express themselves within the parameters that had been set out by the unit manager. The following extract from CS1-CA5 gives an insight into this sense of belonging on the unit.

Researcher: *What role does your unit manager play, more specifically in relation to communication and voice?*

Participant: *“The unit manager I find to be extremely easy to talk to, I always know that I am protected, not in the case of doing something wrong, but I feel protected that my best interest is always held at heart. I know that personally, I have been going through things at home, and the unit manager has always had my back. Whether that be moving shifts for me or giving me the time off to attend appointments or something like that, she has always made that possible.” (CS1-CA5)*

In the above extract, CS1-CA5 reflected on ‘going through things at home’ and how the unit manager made CS1-CA5 feel protected through acts such as swapping shifts. Such acts led to CS1-CA5 feeling a sense of belonging on the unit and developing a perspective that the unit manager had CS1-CA5’s ‘best interest at heart’, which further emphasised this sense of belonging. This sense of belonging was expressed by several other participants as detailed in the below extracts.

Researcher: *Could you highlight some of the more positive aspects of the unit?*

Participant: *“We all just support one another, if someone is having a bad day or comes in unwell; we will support them a little more and may take on a little bit more to give them support so that they can rest.” (CS1-CA7)*

Participant: *“Well yeah, I think everyone on that unit works together, even before I even went on that unit everyone stuck together.” (CS1-TL1)*

It is clearer from the above that participants within this unit feel a close bond to each other, a bond that goes beyond the day-to-day working relationships of team members. This was something that Kendall & Kendall (1993) highlighted as being an important factor for family cultures within the organisational context. CS1-N1 depicts the unit as a very strong team that sticks together, CS1-CA4

compliments this by detailing a notion of we have each other's backs, which are both characteristics of the family which Kendall & Kendall (1993) state are related to a family culture.

From my analysis of the data, it became apparent that it was during handover where staff would voice themselves most. During my analysis of morning handovers at the espoused beliefs level, I detailed the family feel which accompanied such meetings. It is now apparent that this type of environment also facilitated employees on the unit to voice themselves. I argue that the family culture within CS1 meant that staff felt that during handovers they had an opportunity to voice themselves, as depicted by CS1-CA2 and CS1-CA4 below.

Researcher: *How is employee voice promoted on your unit?*

Participant: *"At handover, we will sort it out for that matter and things get sorted out then."*

Researcher: *And does it always get sorted out?*

Participant: *"Yeah it does." (CS1-CA2)*

Participant: *"Again, we have meetings and handover, and you are allowed to voice out some concerns if you have any. So there is that feeling that if you've got a concern, you voice it and you are easily listened to." (CS1-CA4)*

From the above extracts and my observations of these handovers, it was apparent that although participants had a voice during handovers they still knew they had to obey the family rules. This is evident in the above extract in which CS1-CA4 talked about being 'allowed to voice', suggesting that this is not always the case; indeed, through my observations of the working environment, this was not always the case. It would be wrong to think that this sense of belonging and the ability to voice out during handovers was an accidental phenomenon within the unit. The below extract from the unit manager indicates that this was something which had been carefully planned out and orchestrated by the unit manager.

Researcher: *How do you facilitate employee voice on your unit?*

Participant: *"Our handover, the way in which I am handling handover is not a handover, I will say if a specific person is ok or not on the general side, but I will go into depth, like how can we change things and what can we do to change things, even though I know the answer I will ask*

them. It is important to make them feel important in decision making, you do not make a decision on your own, that way it will be like some people will be against it and will talk about it to others, that's the problem on all the other units.” (CS1-UM1)

From the extract provided by the unit manager, it is evident that although the handover environment was one in which staff felt safe and able to voice themselves, as I argue, it was just another tool used by the unit manager to control the unit. The unit manager talks about already knowing the answers to questions which are posed to staff, but does so to give staff what I would describe as an ‘illusion of voice’. I refer to it as an illusion because, from my observations of such handovers, it would have been very unlikely that the consensus reached after any handover would contradict the narrative and control which the unit manager had over the unit. Rather this exercise served to even further entrench the culture of a family within the unit and did so effectively by making participants such as CS1-CA5 believe that the mother of the family (unit manager) had their best interest at heart and was willing to listen to their concerns (Waring, 2016).

6.4 Influences mitigating against employee voice: informal hierarchy and power imbalance

Although in the previous section I stated that employee voice within CS1 was facilitated especially within handovers, it was also the case that the unit manager was very hostile to staff voicing themselves outside the unit. From my observations, I concluded that the unit operated a system of being *internally open but externally closed* when it came to employee voice which influenced the voice culture on the unit. This was a peripheral value enforced by the unit manager through the informal hierarchy and power imbalance she had created between herself and other staff members (Schein, 1988; Silver et al., 2018; Weiss & Morrison, 2018). This power imbalance, according to my analysis, was underpinned by two factors which I regard as mitigating against employee voice on the unit. The first was the manner in which the unit manager used her power to *emotionally manipulate* staff through emotional outbursts against those who voiced themselves without her consent (Van Dyne et al., 2003). The second was the way in which the unit manager used *informal punishment* as a tool to punish those who voiced themselves against the norms of the family or of the unit.

6.4.1 Informal hierarchy power imbalance

I found that the power imbalance between the unit manager and the rest of the staff working on the unit went far beyond the formalised hierarchy of the organisation. This was because the unit operated primarily under peripheral values, which the unit manager had over the years created (Schein, 1988; Kendall & Kendall, 1993; Martin & Waring, 2013; Weiss & Morrison, 2018). On that basis, the unit manager not only established formal power within the unit but also created informal power and hierarchy (Silver et al., 2018; Weiss & Morrison, 2018), as the head of the family which within the context of CS1 I considered as far exceeding the formalised power in her role as unit manager within the care home (Donaldson-Feilder et al., 2014). The following extract gives an insight into the influence of the unit manager's power on employee voice.

Researcher: *You have also differentiated between the night staff and the day staff who you said have been indoctrinated or moulded differently, but yet it works?*

Participant: *"It works but if you took the day staff and put them on nights, it would not work"*

Researcher: *Why?*

Participant: *"This is because I think sometimes with the day staff their opinions can be a little bit suppressed, and I think if they were to come on nights, I don't know how they would manage the more laid back approach. I think if they did come onto nights, I think they would have an explosion of trying to express themselves and fight for that power if you know what I mean?" (CS1-N1)*

I thought this was a very important revelation made by CS1-N1, as this was the first time a participant had directly linked power to voice within this study. I decided to ask the following follow-up question to get more clarification on this relationship.

Researcher: *That kind of power, could you just elaborate on that a bit more, please?*

Participant: *"So like, on days, the power is the nurse that is on days kind of like oversees everything and is a very strong character and likes things to be done her way. But on nights myself and the old night nurse used to take on a more empowering approach, and we tried not to have that superiority over the carers. The power is not with us, it's like a respect for all, we*

are all one team. Because there is not that power difference, there is no one to fight me for that power.” (CS1-N1)

CS1-N1 had made an assumption that the way the unit manager runs the day shift is such that it deprives all staff of any meaningful power on the unit. According to CS1-N1, if such staff were to go and work a night shift they would not be able to handle the contrast in the power dynamics because they have over the years become totally accustomed to not having any power to voice themselves. From my interactions with participants who worked predominantly day shifts, I would say that some did recognise the informal power imbalance on the unit, as demonstrated by the following log entry made after a conversation with CS1-CA5.

Researcher: *Just spoke to CS1-CA5 about the unit manager, ‘she is very controlling, I think it will have a long term effect’ was the response I got. When asked how effective this controlling way of working is, CS1-CA5 said in the short term but not in the long term. ‘I think it is her personality’ said CS1-CA5, ‘the way she was brought up, but the impact it will have on staff moving forward can be a lot, not only on productivity but also mentally’.* **(Case study one daily log on 23/2/17)**

Within the confines of unit one, it is evident that the informal power dynamic created by the unit manager had a significant impact on how participants were able to voice themselves. In the above extract, CS1-CA5 suggested to me that the unit manager’s ‘personality or the way she was brought up’ contributed to her controlling nature. This suggests that from the perspective of CS1-CA5 the controlling nature of the unit manager went far beyond her role as a unit manager and she was, in fact, exhibiting a feature of her personality.

6.4.1.1 Emotional manipulation of staff

One of the key manifestations of this informal power imbalance between the unit manager and staff was the way in which the unit manager used this power to ‘emotionally manipulate’ staff into doing what she wanted and saying what she wanted them to say. The following extract gives an insight into a situation in which the unit manager interrupted a conversation I was having with staff to influence its direction.

Researcher: *In situations in which I would be talking to other members of staff, it was not uncommon for her (the unit manager) to come and interrupt and 'take over' the narrative of the conversation. From my perspective, this had two motives, the first one was just the fulfilment of the unit manager's need to be the centre of attention, and the second was to try to influence the narrative of my conversations with care workers. Comments like 'tell him how bad I am', said in a joking way, were an attempt, I felt, to influence how much they actually told me. The unit manager within this context was masterful at manipulating people and their voices. (Daily reflexive diary on 23/2/17)*

In my view the above extract as an example of a situation in which the unit manager, through comments such as 'tell him how bad I am', played on the emotions of staff to evoke a response which was favourable to her and the family narrative. I argue that this comment was an indirect warning to the staff in question to follow the family norms and not to talk out of place, and one which I recall the staff in question obeying. This was a clever and sophisticated tactic that I observed the unit manager deploying on several occasions to manipulate conversations I was having with participants. From the positive responses I received from participants when asking them about the unit manager, I would argue that it was a successful strategy. In the below dialogue between CS1-N1 and myself, the emotional manipulation of employees is evident.

Researcher: *Why do you think the moulded care workers conform and play along with the unit manager and what she wants?*

Participant: *"Ohh, you had to ask me that didn't you?..... because.... partly through fear, and also because they want to appease the day nurse."*

Researcher: *Fear of what?*

Participant: *"Errrm, fear of the kind of like, how a certain person or people may react if they voice their opinion and she did not agree with it maybe, which could result in shouting or kind of very stern conversations like, they're wrong and she is right kind of things."*

Researcher: *Have you ever witnessed any kind of occurrences.*

Participant: *"Yeah." (CS1-N1)*

From this account, the moulding process was non-negotiable, and that those who didn't agree were met with powerful signs of disapproval such as emotional reactions (Van Dyne et al., 2003). CS1-N1 reflected on witnessing the unit manager using 'shouting or stern conversations' to portray this emotional reaction. This is something which Schein (2004) elaborates on when discussing the use of emotional outbursts by leaders as a way of sending messages to subordinates and reinforcing power over subordinates. In this instance, the message would have been not to go against the indoctrination of the family system. Schein (2004) also explores the notion that subordinates find the emotional outbursts of leaders painful, and as such attempt to avoid them, over time resulting in the suppression of employee voice, which was apparent in this scenario and had a significant impact on the units voice culture.

6.4.1.2 Informal punishment of staff

The second manifestation of the power imbalance between the unit manager and staff was the way in which the unit manager would use her power to 'informally punish' those who went against the family norms (Morrison & Milliken, 2003; Weiss & Morrison, 2018). From my observation of the unit, the use of informal punishment by the unit manager to stifle voice was a very effective tool and one which was used with impunity against anyone who voiced themselves off the unit. In the below extract, I reflect on a situation in which the unit manager did use informal punishment against a staff member.

***Researcher:** The most significant thing to happen was for the first time experiencing the unit manager using her informal punishment technique to 'punish' a care assistant for speaking out about issues relating to the unit outside of the unit. The care assistant in question was heard by the unit manager, according to the unit manager, 'complaining' about being overworked and feeling tired.*

The unit manager took swift action by asking the care worker in question to get her bag and go home immediately, 'if you're tired then you should not be at work right now' said the unit manager. The unit manager went a step further by cancelling all the extra shifts the care assistant had voluntarily chosen to work, knowing that the care worker in question picked up the shifts because she was in financial difficulty. (Daily reflexive diary on 22/2/17)

Through the cancellation of the care worker's extra shifts and sending the care worker home, the unit manager had knowingly deprived the care worker in question of much-needed money. Officially, this action was legitimate because the care worker in question had already exceeded the allocated number of hours for the month. Informally though, this was a devastating act on the part of the unit manager and one which she went out of her way to publicise at handover to other members of staff as a deterrent (Morrison & Milliken, 2003; Weiss & Morrison, 2018). This got me questioning how and why the culture within CS1 was so effective if indeed the head of the unit can act in such a way to staff and fully justify it. I reflect on this in the following extract taken from my daily reflexive diary.

***Researcher:** The head of the family is able to dish out savage informal punishment to staff just for speaking out of the unit, boast about it, and expect the staff in question to come to work the next day as if nothing had happened. The degree of power and control the unit manager has over staff on this unit is phenomenal, and questions have to be asked as to how safe such power is in the hands of one individual. (Daily reflexive diary on 23/2/17)*

The above extract was entered on the last day of my observations on the unit and underscored my belief that the power imbalance between the unit manager and staff on the unit was such that the unit manager could do anything and get away with it by justifying it as part of the family norms. This I concluded was a problematic situation due to the way in which the unit manager was using this informal power to stifle and punish those who voiced out against family norms. What has become apparent is that within CS1, the strength of the family culture created and enforced by the unit manager meant that the unit manager was able to have total control over all aspects of the unit, especially employee voice. Although there were instances in which employees were 'allowed' to voice themselves, this was tightly controlled, and for the most part, employees were under strict guidelines in relation to where and to whom they could voice. I argue that the role of strong subcultures in influencing employee voice is an important one, which has far-reaching implications for our understanding of the influence of organisational cultures on employee voice within the care home context.

6.5 Cultural manifestations in unit two (case study two): the cliques' metaphor

As was the case in my analysis of CS1, I have also for CS2 deployed metaphors as a way of helping to understand better the complexities associated with the culture within CS2 (Morgan, 1980; Kendall & Kendall, 1993). After an analysis of all the data gathered, it was possible to use the *cliques'* metaphor to depict the culture within CS2. The cliques' metaphor emerged from participants and therefore provides participants' interpretation of the culture within the unit. Extracting a metaphor from the perspectives of participants is important as it aligns with my philosophical considerations for this study (Cook & Campbell, 1979; Guba & Lincoln, 1994; Mannion & Davis, 2018). From my analysis of the data, it became evident from the outset that participants perceived their unit as being culturally divided into two cliques of workers. The concept of cliques, or what Mannion & Davis, (2018) refer to as 'tribes', went beyond the functioning of the unit and rather represented what I claim to be a deep-seated complex relationship between different groups of staff on the unit, which has come to define the unit's culture (Schein, 2004). The aim of this section of the chapter is to apply my *Organisational Culture and Subculture Analytical Structure* to the clique culture in CS2 as a way of better understanding how this culture has come into being and its influence on employee voice.

6.5.1 The clique culture in case study two

From my analysis of the data, the clique culture within CS2 was underpinned by the assumption that those who had been working on the unit for a long time had increased legitimacy over other members of staff. This, I assert, inadvertently created two groups (cliques) of workers within the unit who had very different perspectives on how the unit should function, and its underpinning values. The two cliques I identified during my analysis of CS2 were '*the more experienced staff*' and '*the new ones*'; together, these two cliques formed the bases of the unit's culture. This was because through my observations it became apparent that the day-to-day realities of staff on the unit were determined by which clique they belonged to. Through my observations, it was apparent that members of staff would regularly congregate in small groups not only on the unit but also off it, in areas such as the staff room.

Furthermore, through informal conversations I had with participants, it was also apparent to me that members of the same clique would socialise outside work together, thus further entrenching the clique culture within the unit. From my observations, the only area of the care home in which such

cliques were not evident was the training room, the rationale for this having been explored in chapter five. The clique culture was the final theme generated from my analysis, and the data distribution for this is available in *appendix eighteen*. The following extract gives an insight into my initial perspectives of these different cliques.

Researcher: *The most important thing to happen today would have to be the realisation that 'cliques' are an entrenched part of the way this unit operates due to the fact that the working day is organised into teams of two care staff. Most significant is the realisation that these teams are always allocated along the lines of which clique a specific member of staff belongs to. From what I have seen thus far, this influences all aspects of the staff's working day. (Daily reflexive diary on 14/4/17)*

Due to the types of residents within CS2, two members of staff were required to deliver care to each resident at any one time. This requirement meant that staff had to be paired up, and this would always be along the lines of cliques. This working arrangement, I assert, entrenched the clique culture because specific groups of staff would always ensure they were working together.

Another feature of the unit which in my view perpetuated the clique culture within CS2 was the fact that the unit had a large number of staff who had been working on the unit for a considerable length of time (the more experienced staff). This group of care staff had over the years built up a strong bond and self-legitimacy in relation to the importance of their long service to the unit. Such strong bonds, I observed, excluded newer members of staff from socialising with 'the more experienced staff', and hence forced the former group to form their own clique, 'the new ones', as a way of also legitimising their position within the unit.

6.5.2 The clique's perspective of its unit's culture

In order to fully understand the culture within unit two, I deemed it important to first explore participants' understanding of the culture within their working environment. Hence, the same question put to participants during CS1 was repeated to participants in CS2.

Researcher: *How would you describe the culture in your unit?*

Participant: “I think it is good, I have no issue with this unit, obviously there are some people if you work with them they will try and make your day difficult cos they will try and bring their own issues from home to.” (CS2-CA6)

Participant: “Yeah there is but it depends who you work with, if you have a good shift, but also you find out that there are a few other staff that don’t get on. Earlier I heard that a few of my colleagues had fallen out, which looks bad on the unit.” (CS2-CA1)

Participant: “Yes, on the unit where I am working there is positive banter, and there are one or two people who rub against each other but in general they get on really well.” (CS2-N2)

Participant: “In the unit, I think it is peaks and troughs, we are either all really positive or we are all really miserable.” (CS2-N3)

Both CS2-CA6 and CS2-CA1 put forward the view that unit two had a positive culture but it was very much dependent on who was working on a specific day. This suggests that the cultural dynamics of the unit are not fixed as in the case of unit one, but rather there is a degree of fluidity influenced by individual differences. I argue that this was CS2-CA1 alluding to the different cliques on the unit and the different personalities who normally occupy each clique. This is substantiated by CS2-N2, who talked about ‘one or two people who rub against each’, which I interpret as a reference to the different perspectives between each of the cliques, and the conflict that sometimes results.

CS2-N3 moved this perspective forward by bringing up the notion of ‘peaks and troughs’ to describe the fluidity of the atmosphere on the unit. In contrast to some of the other perspectives, CS2-N3 focuses on the collective feeling on the unit, which I interpret as representing the different dynamics brought about when different combinations of staff from both cliques are working together. That is, when you had a shift with a large majority of staff from one clique, this would have brought more cohesion to the shift than if you had an equal split of staff from both cliques. From the below extract, it is apparent that both nursing and care staff had the ability to influence the mood on the unit on any given shift.

Researcher: *How would you describe the culture in your unit?*

Participant: “It’s a good place to work when you’ve got the right people, my mood totally changes when I come on, and I see who I am working with.”

Researcher: *Is that care workers or nursing staff?*

Participant: *“Both, and it ruins the whole day cos it is forever tension, there is no time to relax, to be able to get things done, no time to do your job the way you want to do it.” (CS2-CA2)*

I argue that the above extract can be linked back to the comments made by the home manager (HM1) when comparing unit one to unit two in which he commented that unit two had a ‘much more of a flat structure’ as compared to unit one. I claim that this can now be seen in the above extracts in which participants recognised this ‘flat structure’, and the ability of individuals at different levels of the care home hierarchy to influence the unit’s culture.

6.5.3 Artifacts

By applying my *Organisational Culture and Subculture Analytical Structure*, based on Schein’s theory of organisational culture, to my analysis of CS2, I argue that it will be possible to better understand how the notion of cliques has come to symbolise this unit’s culture. As was the case for CS1, and in following the examples given by Schein (2004) in his own case studies, I will use the same three considerations used at the care home level to analyse the artifacts in CS2 (Schein, 2004).

6.5.3.1 Entering onto the unit

Reflecting back on my research process, it is possible to say that accessing CS2 was more complex than the process I went through to access unit one. A number of factors contributed to this, but the most significant was the argument which the Clinical Nurse Manager (CNM1) had previously had with the unit manager of unit two (CS2-UM1), which I reflected on in the following extract.

Researcher: *Access to case study two was postponed by CNM due to an argument she said she had with the unit manager of unit two earlier that day. I thought this was interesting as it showed the power dynamics between different individuals within the management structures of the home. From my perspective, this shows that despite the official management structures within the home, individual characteristics play a significant role in shaping things. (Daily reflexive diary on 20/3/17)*

I did wonder if or how this argument would influence my ability to conduct my second study, but on reflection this had no impact on the study. On my first day, the unit manager called an informal meeting to introduce me as a researcher to all staff and explain the scope of the research and emphasised the anonymity element of the study. During this meeting, I observed that unlike the collective nature of CS1, CS2 comprised different groupings of staff who congregated together and seemed to form informal groups.

On subsequent reflection, it emerged that those who had been hostile to me during my first day on the unit were in fact part of the '*the more experienced staff*' clique who Dixon-Woods, et al. (2019) refers to as the 'untouchables'. On reflection would indicate why they must have felt nervous with an outsider coming onto the unit who could potentially in their eyes disrupt the ecosystem, which they had benefitted from up until that point. Although I did not know it at the time, the characteristics of the '*the more experienced staff*' clique were evident even on my very first day on the unit.

6.5.3.2 Observable characteristics of the environment

Reflecting back on the environmental characteristics of CS1, it is possible to say that the environment of CS2 was more open and seemingly more welcoming. This was characterised by open doors, especially the nurse's station, which when specific members of staff were on duty, such as CS2-N3, was kept open all day. The bright furniture within the unit also played a role in creating this feel to the unit. The most significant characteristic of the working environment was the fact that all members of staff always seemed to be very busy. I detailed this at the time in my reflexive diary below.

Researcher: *The working environment seemed to be always very busy, everyone just seemed to be rushed off their feet all the time. Getting time to talk to potential participants is proving to be very difficult. At first, I thought they were just avoiding me, but on reflection, I can see how busy they are when compared to the working environment of unit one. (Daily reflexive diary on 21/3/17)*

From my analysis of the environment in CS2, in relation to the notice boards and the presence of information relevant to employee voice the same elements were observed as in CS1. This was one of the few visible signs that unit one and two were indeed part of the same care home and not

individual entities in their own right. All artifact documentation present in the unit was developed at home level, thus was the same as that identified previously in CS1.

6.5.3.3 Interactions between staff members

From my observations, the way in which participants interacted with each other was an important element in understanding the clique culture in CS2. Through an analysis of my interview data, a narrative of 'needing to have a laugh' emerged as one of the key justifications underpinning why participants chose to interact with each other. The notion that staff need to have a laugh together was something I noticed very early on in my observations of the unit. Such interactions between staff involved staff taking on stereotypical roles and amplifying them through very informal jovial acts of joking around. After realising how important this process was to understand the cultural dynamics within the unit, I decided to incorporate the following question into my interviews as a way of exploring this issue.

Researcher: *Sometimes, I notice staff play around when you have quiet moments from the work, why is this?*

Participant: *"Yeah, definitely, when I come to work, and I see who is on, I know if I am going to have a good day. But you can't do that too much cos you will get told you are not working. It's like you get into trouble for being happy." (CS2-CA3)*

Participant: *"Yes, I am speaking for myself, but if I did not do that I don't think I could be in this job. I have to de-stressed and make my spirits be high so that I can do the work."*

Researcher: *So for you is it a way of coping with the hard work you do?*

Participant: *"Yes." (CS2-CA4)*

Participant: *"Yes, this is like a de-stressing thing, very often we get a little time to relax, as long as our work is done then we do have a chat. That's our little bit of relaxation." (CS2-CA7)*

Participant: *"Yes, I think so, you need to have a laugh, we work so hard, so we do." (CS2-N3)*

In all the above extracts, the idea of needing to have a laugh was put forward by CS2-CA4 and CS2-N3 who both said it was a coping mechanism for the hard work that staff do on the unit. This rationale would complement my observations made about how busy staff were in the previous section (Jones et al., 2019). On the surface, it could be said that the act of 'having a laugh' was just harmless fun

used to de-stress. In the below extract, I reflect on my initial thoughts on observing staff participating in these interactions.

***Researcher:** Staff interaction very good, despite the hard work they manage to offset it with 'joking about'. This joking about comes in the forms of play fighting, joking about each other, ironical joking about each other and taking on 'characters' in role-play is something which is used to offset the working environment. But how far-reaching this 'role-playing' is with staff and nursing staff as well, it will be interesting to see. (Daily reflexive diary on 22/3/17)*

Closer observation of who, how and when such occurrences were taking place revealed what I argue to be a more profound and more complex array of factors which have helped to entrench the clique culture within the unit. From my observations, it became more apparent that such interactions were influenced by the specific clique to which members of staff belonged. This would influence who interacted with who during these 'role-playing' sessions. I also observed that for the most part, members of different cliques did not normally interact during these times, and if they did it was minimal.

One of the key questions I kept asking myself while observing these role-plays was why staff would engage in such activities, which I perceived to be quite energy-consuming and requiring significant effort on the part of those who took part in them. In the following extract, I attempt to provide an answer to this question.

***Researcher:** From my observation, there was a significant amount of social capital to be gained by those who participated in such activities. That being so, it represents from my perspective an important cultural consideration within this context. (Daily reflexive diary on 13/4/17)*

It later became apparent that there was a lot of social capital and influence to be gained from this process. This social capital was very subtle but would include things such as other staff offering to make participants cups of tea, do their 15 minute and 30 minute checks, and being publicly promoted on the unit as a cool person. Furthermore, the majority of those who participated in such interactions were members of the 'the new ones' clique which, for the most part, comprised staff who were

younger and newer to the care home. Thus, I argue this was an attempt by ‘*the new ones*’ clique to assert themselves and gain some informal legitimacy within the unit.

6.5.4 Espoused beliefs

Following on from my artifact level analysis, I was able to build on the artifacts level of analysis and highlight three key beliefs, which I assert have helped shape the clique culture within CS2. According to Schein (2004), after an observation of the environment, the process of talking to people is the best way of attaining the next level of insight into a group’s culture. This is a strategy which I implemented, and in doing so, I have been able to arrive at the following beliefs which, I argue, have shaped the clique culture.

6.5.4.1 Beliefs around the policy of working in teams on the unit

From the perspective of Schein (2004), espoused beliefs are underpinned by goals and values, which a specific group shares within an organisation. Through my analysis, one such goal was what participants commonly referred to as ‘working in teams’. As detailed above, this was a formal policy within the unit geared towards meeting the complex needs of service users on the unit. From my analysis, I put forward the perspective that the working in teams’ arrangement had a significant impact on entrenching the clique culture in the unit. This is because the policy of working in teams of two care staff requires the same teams to work together throughout the 12-hour shift, which includes having lunch together. In such a situation, being able to work with someone who you get on with and relate to is very important, especially for performing as an effective team. This meant that staff would go out of their way to work with those to whom they related most, which I observed to normally be along the lines of the clique to which staff belonged. The notion of having to work in teams and its impact on the working environment are detailed in the below extract.

Researcher: *I would like to find out about teamwork, is teamwork good on your unit?*

Participant: *“Well if you have a good team, then yes cos we work in teams of two so if you are working with someone you get on with, then yes, it is. But then you get an issue that if you have good teamwork with your partner then other teams won’t want to help you.” (CS2-CA3)*

From the above extract, CS2-CA3 mentions that when staff are put into their working teams at the start of the day, the effectiveness of that team is normally down to whether the two members of that team get along or not. From my observations, it is possible to argue that participants who normally 'got along' were those from the same clique. In addition to this, CS2-CA3 then moves on to elaborate on the fact that when they do have a 'good team', other teams' unwillingness to help hampers them. I argue this would be because the other teams would be made up of members from the other clique, thus those teams would be unwilling to help teams made up of members of the opposite clique. This unwillingness to help can be seen as an example of the 'rubbing against each other' CS2-N2 put forward previously. Although CS2-CA3 was a member of 'the new ones' clique and put forward this perspective, from my observations, there was nothing to suggest that members of 'the new ones' were any more helpful than those of 'the more experienced staff' clique. I attempt to make sense of the teams' working arrangements and the impact such work practices had on the unit in the below extract.

Researcher: *The importance of the teams' working arrangements cannot from my observations be disputed; unlike CS1, this unit is totally reliant on two individuals working together for the entirety of the 12-hour shift. The informal processes which have come to accompany this formal demand on staff are very interesting and seem to play a bigger role in the dynamics of the unit than I had initially thought. (Daily reflexive diary on 13/4/17)*

On reflection, I concluded that this working arrangement was one of the most significant factors that contributed to the clique culture present in CS2. Furthermore, due to this working arrangement, those with the most power on the unit 'the more experienced staff' clique would go out of their way to control the allocation of work, thus ensuring they maintained control, and also got to do the jobs they liked. This is something that CS2-N3 discusses in the following extract.

Researcher: *What do you think can be done within this care home to make the quality of the job better for you?*

Participant: *"I think there are too many experienced care workers in this unit, so it is difficult to know who is in charge really. Sometimes they give themselves an easier team as well, to me that is not fair."*

Researcher: *Is that throughout the whole unit?*

Participant: *“Yeah but I think it is with the care staff who have been in this care home a long time.” (CS2-N3)*

When referring to *‘too many experienced care workers’*, CS2-N3 is referring to those who fall under *‘the more experienced staff’* clique. Due to their position within the unit, such members of staff are able to allocate work to themselves and, according to CS2-N3, use this advantage to give themselves easier workloads. Indeed, during my observations of handovers, it was apparent that daily work allocations were always undertaken by the team leader, nurse on duty or an ‘experienced’ member of staff, all of whom belonged to the same clique of *‘the more experienced staff’*. In contrast with the working environment of CS1, where staff prided themselves on working as one group and identified as a collective whole, CS2 was based first and foremost on which clique you belonged to. The notion of unit-wide collective effort or culture as evident in CS1 was absent in CS2.

6.5.4.2 A belief that there is an informal policy of favouritism towards those who are closer to the unit manager

Another belief to emerge from my analysis of the data related to the belief put forward mostly by participants from *‘the new ones’* clique that members of staff who were closer to the team leader received favourable treatment on the unit. My observations indicated that such treatment ranged in scope, but it would include such as better or easier allocation of work, as discussed above, and being given an informal platform from which to voice an opinion. According to Schein (2004), one of the key elements of the espoused beliefs and values levels of analysis is the notion that it is based on the process of social validation. From my observations, members of *‘the more experienced staff’* clique had a legacy of social validation which had built up over the years and thus were able to look upon each other with favouritism (Schein, 2010). The below extract from CS2-CA3 details the belief in favouritism towards staff who are closer to the unit manager.

Researcher: *Is it the organisational hierarchy?*

Participant: *“Yeah, those who are closer to the team leader or more playful with the unit manager, they get to do what they want, and those who have been here longer get to do what they want as well.”*

Researcher: *So, you notice the difference between those who have been in the organisation for a long time?*

Participant: *“Yes, definitely have noticed the difference, all I have wanted to do for the past 6 months is leave.” (CS2-CA3)*

CS2-CA3 puts forward the belief that those who are ‘playful’ with the unit manager ‘get to do what they want’. As a participant who self-identified as being part of ‘*the new ones*’ clique, there was a feeling of being disadvantaged because they were not able to associate appropriately with the unit manager in the same way as staff who were part of ‘*the more experienced staff*’ would. This, I conclude, is an important point as it links back to the comments made by the Home Manager (HM1) when detailing his perspective that the unit manager of unit two had too much of a ‘laissez-faire approach’ in how she led the team. From the comments of CS2-CA3, this approach was reserved for those who were part of the unit manager’s clique of ‘*the more experienced staff*’. The below extract demonstrates that those who benefitted from this informal policy of favouritism, or what the Home Manager referred to as a ‘laissez-faire approach’, were also very complimentary about the culture in the unit (Weiss & Morrison, 2018).

Researcher: *How would you describe the culture on your unit?*

Participant: *“I think it is brilliant.” (CS2-TL1)*

Participant: *“Yes, she is, I am very confident to talk to her, and she will take action and will pass it on.” (CS2-CA6)*

From the above, it is evident that both CS2-TL1 (team leader) and CS2-CA6 (one of the longest-serving members of staff), both had positive perspectives on the unit and its manager. As a self-identifying member of the group of ‘*the more experienced staff*’, it is possible to argue that they benefitted from a close relationship with the unit manager, thus were very positive about her

influence on the unit's culture. The positive perspective of the unit's culture put forward by members of *'the more experienced staff'* is not shared by CS2-CA2 when asked the same question.

Researcher: *How would you describe the culture in your unit?*

Participant: *"A few things have changed, there are things which really need addressing, or maybe interventions from management. I will wait to see what is going to happen, and if nothing changes, then I will look for another job."* (CS2-CA2)

The perspective put forward about the unit by CS2-CA2 is contradictory to those put forward by CS2-TL1 and CS2-CA6 in relation to the working environment on the unit. Indeed, the willingness of CS2-CA2 to change jobs if nothing changes on the unit would suggest that this member of *'the new ones'* is not experiencing the unit environment in the same way as those in *'the more experienced staff'* clique. The below extract from CS2-CA3 furthers this position and reveals even more clearly the differences which exist between the two cliques.

Researcher: *In relation to voice, are there things which can be done on the unit to improve it?*

Participant: *Basically give me the shifts I asked to work, and don't basically, what is going on is like some people get easy teams. There is too much favouritism, can we please mix it up. I know we are here to work, but I don't think they should treat us like crap."* (CS2-CA3)

The above extract from CS2-CA3 can be said to exemplify the cultural divide between the two cliques within CS2. As a member of the *'the new ones'* clique, CS2-CA3 paints a negative picture of the unit's culture and the informal favouritism CS2-CA3 believed was taking place, which was described as *'treating us like crap'*. I argue that such favouritism has created significant rifts between the two cliques in CS2, and further entrenched the clique culture on the unit. Although there could be a number of different reasons as to why there were significant differences between the two cliques, I suggest that such groups had different norms and values as to how the unit should be run (Schein, 2004). Such differences perpetuated the favouritism those in power gave to others like themselves, thus contributing to the clique culture within CS2.

6.5.4.3 The unit manager: We need to go around her

The third espoused belief uncovered during my analysis of the data is one which to a large extent crosses the boundaries of the cliques and is the belief among a large number of staff that the unit manager could not be trusted to effectively fulfil specific tasks. Such tasks included giving staff the shifts they had requested, and following through on suggestions and promises the unit manager made to staff. On that basis, there was a belief in the unit that you need to circumvent the unit manager's authority to achieve things on the unit. The below extract explores the perspective of CS2-CA3 as to how this belief in the need to circumvent the unit manager has come about.

Researcher: *What can be done to make things better for staff on the unit?*

Participant: *"Well if I want something done, I have to go behind my unit manager's back just to get things done."*

Researcher: *Why do you think you have to go behind your unit manager's back?*

Participant: *"Cos it won't get done!" (CS2-CA3)*

CS2-CA3 puts forward a strong case as to why she believes it is necessary to circumvent the unit manager. I argue that the lack of action on the part of the unit manager was a significant contributing factor. The below extract from CS2-N3 develops the point put forward by CS2-CA3 and explores the view that other staff members need to come to CS2-N3 rather than the unit manager to get things done.

Researcher: *Is there anything at the unit level which makes it difficult for you to voice out?*

Participant: *"Generally, I would say no, but then unit manager wise I feel she can hold people back. It's like she wants to take credit for people's ideas, I know people find it difficult, cos I have been in this care home for a long time it is easier for me to go around her".*

Researcher: *Do you feel you need to go around her?*

Participant: *"Not really me but other people, yes, she sometimes wants to take credit for things which go well. Some of the nursing staff are just yes men, they just do what she wants".*

Researcher: *What does that do for the dynamic?*

Participant: *"Well that's why care workers come to me, cos they know I will act. I feel like I am their voice." (CS2-N3)*

From the observations, it was apparent to me that CS2-N3 represented what I refer to as the de facto leader on unit two for those members of staff who had become disillusioned with the unit manager. For the most part, this would be a member of 'the new ones' clique, but the experienced staff also held her in high esteem. The above extract demonstrates the informal leadership position CS2-N3 knows she holds on the unit, which she acknowledges has come about because of inaction from the official unit manager (Havig & Hollister, 2018). CS2-N3 also differentiates herself from other nurses who she perceives as being 'yes-men' for the unit manager, and it is this differentiation which, I would suggest, CS2-N3 is proud of and sees as what has earned her the informal leadership role within the unit. CS2-N3 also makes the link between needing to go behind the back of the unit manager and employee voice when stating that 'I am their voice' in reference to speaking out on behalf of other care staff. This demonstrates that this last belief not only influenced the culture within the unit but also the ability of employees to voice themselves.

One example of how participants would continually circumvent the unit manager was their furtive accessing of the filing cabinet in which staff rotas were kept on days when the unit manager was not working. This is something which I noted in the below extract from my daily reflexive diary.

Researcher: *Today I observed some of the care staff going into a black filing cabinet, and the way they entered suggested that they should not have been looking into it. On further observation, it became clear that it was the unit manager's cabinet and they were looking for the upcoming rota. This got me thinking about the unit manager and her 'black box', the role it plays in the unit and the notion that those around the unit manager do not trust her. Hence, they are willing to go behind her back to get things done and find out information. (Daily reflexive diary on 19/4/17)*

In the above extract, I refer to the filing cabinet as a *black box* and question why participants were willing to go to such extents to get information. My conclusion is that participants felt that it was the only way of getting things done on the unit. For the first time, I had also found something which both cliques agreed on, although to differing extents. Indeed, I observed members of both cliques accessing the *black box* together and in later conversations both said that it was the only way to get

things done on the unit and get information. In this case, it is possible to argue that although the two cliques are very different, when it comes to some issues around employee voice, getting information and seeing action as a result of their voice, the two cliques were able to unite. This, in my view, demonstrates that participants within CS2 saw the need to voice and action taken as overriding any boundaries created by the different cliques, thus indicating how important employee voice was to the unit.

6.5.5 Basic underlying assumptions

The above espoused beliefs of participants within CS2 have provided an additional level of insight into the clique culture present on the unit. At the basic underlying assumptions level, Schein (2004) has already commented on the importance of fully understanding the assumptions of an organisation's environment as a prerequisite to understanding the organisation's full culture. Through my analysis, the underlying assumption within CS2, which facilitated the clique culture, was the assumption that the more experienced staff had more legitimacy within the unit (Morgan, 1980). At this stage of my analysis, it is possible to argue that the most significant factor contributing to the clique culture on the unit was the assumption among participants of both cliques that those who had been working on the unit for a long time had increased legitimacy over other staff (Schein, 2004). Therefore, this section aims to further explore this assumption, and in doing so not only link it to the overall culture within CS2 but also explore its influence on the voices of employees.

6.5.5.1 The more experienced staff have more legitimacy on the unit

The assumption that more experienced staff had increased legitimacy on the unit is one that I viewed as entrenched within the unit and influencing all aspects of its function, especially in relation to peripheral values and norms of the unit (Schein, 1988). For example, the metaphors of '*the new ones*' and '*the more experienced staff*' both originated from members of staff who had been working on the unit for many years (Morgan, 1980). These characterisations of groups of workers, I argue, were a strategy deployed by '*the more experienced staff*' as a way of differentiating themselves from newer members of staff. In doing so, they were indicating their seniority resulting from their longevity on the unit. In addition to this, newer members of staff would also self-identify themselves within this metaphor, suggesting that they had claimed the characterisation that had been ascribed

to them (Schein, 2010). In the below extract, I detail my realisation of how important this specific group of workers are within the unit.

Researcher: *From my observation, I have come to the realisation that within CS2, there exists a group of workers who have been working on this unit for a very long time. Hence, this group have built up bonds over the years which have withstood the test of time and a number of different management regimes. It is therefore important to recognise this factor and, in doing so, understand the power such care workers hold, especially informally, within the unit. (Daily reflexive diary on 27/3/17)*

In the above extract, I allude to the informal power this group of workers held through their ability to shape peripheral values on the unit, and their attempted indoctrination of new members of staff with these values from the first day they started working on the unit (Schein, 1988; Silver et al., 2018). For example, the conformity shown by *'the new ones'* in relation to accepting the characterisation ascribed to them by *'the more experienced staff'* can be traced back to the first attempts at indoctrination into the peripheral norms and values of the unit during their induction on the unit (Schein, 1988). This indoctrination, based on my observations, took on a number of forms, for example, from the first month, a new member of staff would be paired up with the team leader and inducted into the unit only by the team leader. At the end of that month, that new member of staff would be passed on to other experienced members of staff to work with them for a subsequent month. I argue that it is during these initial months on the unit that new members of staff develop such assumptions about the role played by *'the more experienced staff'* in shaping the power dynamics of the unit and ultimately its culture (Weiss & Morrison, 2018; Dixon-Woods et al., 2019).

Through my analysis, it is also possible to argue that the assumption that *'the more experienced staff'* had increased legitimacy and thus power over the unit did impact on the ability of participants to voice themselves. This can be seen in the following extract from CS2-CA1.

Researcher: *What is there in your unit that makes it difficult to speak out?*

Participant: *"I think it's mainly to do with some colleagues really, I find it quite intimidating to talk them."*

Researcher: *What do you mean by intimidating, what is it that is intimidating about those colleagues?*

Participant: *“From what I have heard, I know that a few of my colleagues are close to managers, like really close to the manager, so if I voice to that colleague, it would come back to me, if you know what I mean.” (CS2-CA1)*

In the above extract, CS2-CA1 puts forward the assumption that the closeness of members of ‘*the more experienced staff*’ clique to the unit manager meant that they were protected by the unit manager who was also a member of this clique. Therefore, if other staff voiced out about members of this clique, ‘it would come back to them’. I argue that such beliefs have further entrenched the assumption among staff on the unit that members of ‘*the more experienced staff*’ have increased legitimacy on the unit (Weiss & Morrison, 2018). The below extract from CS1-CA1, who was one of the few participants to have worked on both units, provides additional insight into the role of ‘*the more experienced staff*’ in controlling voice on the unit.

Researcher: *Comparing unit one and unit two, what are the key reasons why they are so different on communication?*

Participant: *“For me, the first unit staff have been on the unit for so long they are very tight-knit, and they are not very good at letting new people in. When I was a new starter, I felt like I was having to force my way into conversations rather than being included in it.” (CS1-CA1)*

In the above extract, CS1-CA1 portrays an image of how members of the ‘*the more experienced staff*’ clique attempted to control conversations on the unit and how CS1-CA1 needed to ‘*force my way into conversations*’. I deduced that clashing with members of ‘*the more experienced staff*’ was the only way in which CS1-CA1 could have been listened to on the unit, by pushing back and insisting on being heard.

According to Schein (2004), one way of determining a group’s core assumptions is to ask members their perspectives on what qualities new members should have, and to examine the career histories of present members. If this were to be applied within this unit context, it is evident that the ultimate currency would be longevity of service. Those who have been working on the unit the longest have

additional privileges which, from my observations, were formalised in the roles played by the team leader and unit manager, and had hence become part of the unit's culture (Scott et al., 2003). I argue that such clique cultures can be linked back to the 'ideological cultures' which form between specific groups of employees as detailed by the Kirkup Report in chapter two.

In the absence of more formal mechanisms within the care home, the people with more legitimacy (acquired through longevity in the unit) had created their informal mechanisms on the unit which shaped the unit's culture. From this position, it is possible to put forward the perspective that the clique culture present in CS2 did indeed have a significant influence on employee voice within the unit. To delve deeper into the nature of these influences, the next section of this chapter aims to explore the influences that facilitated and mitigated against employee voice within CS2. This exploration is intended to contribute to our understanding of the clique culture and employee voice within CS2.

6.6 Influences facilitating employee voice: social relationships

The key facilitator of voice culture to emerge from my analysis of the data was the role of personal relationships within the unit. At the artifact level of my analysis, I detailed how I observed participants congregating together and the formation of cliques which were based primarily on the longevity of service on the unit. Within such cliques, I also observed strong social relationships that went beyond the boundaries of a formalised working environment (Morrison, 2011; Weiss & Morrison, 2018).

At the espoused beliefs level, I detailed the policy of working in teams of two for the full day and the social relationships which inevitably build up as a result of such work practices. I also detailed the belief that there was an informal policy of favouritism towards more experienced staff on the unit. Through my analysis, it is now possible to put forward the perspective that such beliefs were manifested in practice, and that social relationships exerted the most significant impact on employee voice, as illustrated in the following extract from CS2-CA6.

***Researcher:** What promotes employee voice in your unit?*

***Participant:** "It depends on who you tell as to whether they will be able to raise your voice to other high people above them"*

Researcher: *So, it's more about the individual person?*

Participant: *"Yes, it is." (CS2-CA6)*

CS2-CA6 gives the opinion that who you tell governs whether your voice will be raised with other top management, suggesting that it is not what you voice about which matters within the unit, but to whom you voice. We have already established that the specific clique staff belonged to impacted their ability to voice on the unit, and that members of the same clique tended to be very close. This would imply that if you voiced to someone who was not in your clique, and, as such, not close to you, then that would result in your voice not being elevated. The below extract from CS2-N1 details this in relation to informal voice.

Researcher: *In relation to informal communication, is that something you use a lot, are you able to use that within the working environment?*

Participant: *"Yes, but not all of them, there are some who I am closer with, so I can talk to them." (CS2-N1)*

According to CS2-N1, the most crucial consideration when deciding whether to voice was how close CS2-N1 felt to that person. In this instance, the question relates to informal communication, so if CS2-N1 was not willing to talk to some members of the unit informally because of a lack of a personal relationship, it is possible to argue that formal conversations would also follow the same path. Indeed, other members of the unit, such as CS2-CA3 have previously indicated this to be this case.

Researcher: *How then do you think we can elevate and promote the voices of employees within this organisation?*

Participant: *"I think we need an independent manager who is independent of the care staff or management that you can talk to. You need someone who is independent of all of us so that you feel that you can talk to them, and you don't think there is any conflict, and also you will know your voice has been heard and you will not get punished." (CS2-CA4)*

Participant: *"Like I said, if you are in the cool group then maybe you can say you don't like something and they may listen, but if you are someone like me, then who are you to say I don't like this, I don't like that, you just have to get on with it." (CS2-CA3)*

From the extracts above, CS2-CA4 provides a damning picture of the current unit manager by implying that currently those who are not close to the unit manager, which is mostly members of *'the new ones'* clique, are at risk of being punished or not being listened to. CS2-CA3 also argues this perspective by claiming that only those members of the *'cool group'* *'the more experienced staff'* have their voices listened to. As a self-identified member of the *'the new ones'*, according to CS2-CA3, you get have to *'get on with it'*, which I argue indicates that CS2-CA3 is resigned to this fact within the unit. To counter the negative impact of personal relationships on some members of the unit, and their ability to voice out, CS2-CA4 called for a manager who was independent of both cliques.

I argue that the *'laissez-faire approach'* of the unit manager put forward by the home manager did influence the unit, especially the ability and willingness of some members to voice themselves (Weiss & Morrison, 2018). Furthermore, although social relationships within this unit have been detailed as a facilitator of employee voice, this was found not to be the case for all participants. What my analysis does appear to indicate is that social relationships within a care home context do play a role in influencing how staff voice themselves.

6.7 Influences mitigating against employee voice: misrepresentation of employee voice

A key issue mitigating against voice culture to emerge during my analysis of CS2 was the lack of trust staff had in the unit manager, due to her perceived predisposition to the misrepresentation of employee voice (Donaldson-Feilder et al., 2014). This issue bridged over the boundaries of the two cliques and can be linked back to the beliefs level of my analysis in which I detailed the belief that participants felt they needed to go around the unit manager to get things achieved. It also emerged that this misrepresentation of employee voice resulted in participants feeling that in the instances in which they did voice out, it was not appropriately addressed because the facts had been manipulated, as evident in the below extract by CS2-CA3.

Researcher: *Have you ever voiced out?*

Participant: *"Yeah, in supervision, well it's normally the unit manager who does it."*

Researcher: *Have you had anything positive come out of it?*

Participant: “Well not really, the unit manager will not even write anything down, she will just paraphrase, and it is more of like it is not your supervision, it’s more like it is for her. She will be like this is what you are doing wrong... blah blah blah.”

Researcher: *This paraphrase, does it reflect what you say?*

Participant: “Absolutely not, when it comes to that person no.” **(CS2-CA3)**

From the above extract, CS2-CA3 cast doubt on the unit manager and the way in which formal processes such as personal supervisions were documented, by manipulating the voices of staff. According to CS2-CA3, such misrepresentations resulted in no action being taken on issues by the unit manager, or in others documentation would indicate that there was no issue to address. In an attempt to understand the motive for this misrepresentation, the following follow-up question was put to CS2-CA3.

Researcher: *Why do you think this is being done, is it to alter your voice?*

Participant: “Yes, definitely, and it’s not just me, I know a few people who say when this person is doing supervision, it does not end up being what you said. Somehow it ends up being you did this and that, and you are in the wrong. It is never you have been complaining about things and we have figured out how we are going to solve it.” **(CS2-CA3)**

CS2-CA3 continued the interview by putting forward a perspective that this misrepresentation was intended to change the voices of participants. Furthermore, CS2-CA3 claimed that other staff had commented on this same point. Indeed, my analysis of the interview transcripts identified a number of participants who shared the same sentiments put forward by CS2-CA3. This was the view of CS2-CA5 who put a very diplomatic spin on this issue of manipulating the voices of employees in the below extract.

Researcher: *How would you describe the leadership in your unit?*

Participant: “Ha ha, need to be honest about it, but I think sometimes the unit manager can put a little cherry on it rather than saying what needs to be said, is that a good way of saying it?” **(CS2-CA5)**

Among members of the same clique as the unit manager, *'the more experienced staff'*, it was uncommon to openly criticise each other on record, but this was the case for CS2-CA5. In referring to the unit manager's misrepresentation of the voices of employees as *'put a little cherry on'* CS2-CA5 was admitting that such misrepresentation of employee voice did take place on the unit. The notion I put forward that the unit manager's misrepresentation of employee voice cut across both cliques is also evident in the following extract.

Researcher: *How would you describe the leadership in your unit?*

Participant: *"It is difficult for me to say this, but sometimes this person can be very manipulative, especially when it comes to changing things in meetings. When someone says something, it can be written in a clever way to change the meaning of it. So, like the minutes of meetings have been taken in the past they have been known to have been rewritten to reflect the unit better."*

Researcher: *Why is this?*

Participant: *"I think it is to make the manager look better and also to make the unit look better, and to make it look like they are doing their job." (CS2-N2)*

According to CS2-N2, the unit manager's misrepresentation of the voices of employees was a systematic and purposeful attempt on the part of the unit manager to control the narrative on the unit. The misrepresentation of formal unit minutes by the unit manager for the purpose of *'making the unit manager look better'* according to CS2-N2 was a recurring act on the unit. CS2-N2 talked about the clever way information was *'massaged'* so as to spin a different narrative from that which was actually reported at such meetings, which is something CS2-N3 also picked up on in the following extract.

Researcher: *As a collective group of nursing staff, what could you do to increase your voice?*

Participant: *"I think it's hard, cos if you look at the nursing staff on this unit, we are all so different, we all have different issues. Sometimes we have meetings, and the meetings go away and get tweaked as well which is very interesting."*

Researcher: *Can you elaborate on that?*

Participant: "Well yeah, we had aired ourselves, and the unit manager took the minutes home and changed them, changed some of the important things which we talked about."

Researcher: *What types of problems?*

Participant: "I don't remember, but I spoke to the Clinical Nurse Manager, and they could not do anything cos that was the minutes they'd got, which I think is fraud really." (CS2-N3)

CS2-N3 talks about the fraudulent behaviour of the unit manager in relation to the misrepresentation of meeting minutes and, thereby the voices of employees on the unit (Waring, 2016). I found this to be a damning assessment of the unit manager, which was not limited to my interview with the above participants. Indeed, through my interactions with other staff, there was a view that the unit manager systematically manipulated their voices for what some participants saw as promotional reasons. Such acts, I argue, had a detrimental impact on all participants and their trust in the formal voice mechanisms within the unit. This is evident in the following extract taken from my reflexive diary.

Researcher: *Talking to staff today and reflecting on the staff meeting it became evident that most people did not come for the meeting the other day, which may show a lack of enthusiasm in the current decision-making mechanisms on the unit.*

From talking to several care workers, it is evident that most of them do not expect much to come out of the meeting. That being so, they do not engage with it, and those who do, do not really contribute. (Daily reflexive diary on 28/3/17)

This lack of trust resulted in the majority of participants not attending unit meetings, as I outlined in my reflexive log above. From my observations and interactions with participants, the sense of disillusion with decision-making mechanisms on the unit went across both cliques and resulted in participants circumventing the unit manager as a way of getting their voices heard (Waring, 2016). Furthermore, I argue that the unit manager's lack of legitimacy furthered the clique culture within CS2, by forcing staff to seek alternative 'structures of legitimacy' on the unit. Such alternative came in the form of staff who had been working on the unit for a long time. Indeed, I claim that in the absence of a legitimate leader, longevity of service became the currency of choice.

6.8 Summary

Through the deployment of the *Organisational Culture and Subculture Analytical Structure*, this chapter has applied metaphors to analyse both the family culture in CS1 and the clique culture in CS2 (Morgan, 1983; Schein, 2004). In CS1, it was possible to highlight the role characteristics such as unity, group size and moulding of staff played in shaping the family culture on the unit. Furthermore, this analysis discovered that informal power dynamics play a significant role in influencing voice within the care home context. Finally, a sense of belonging and purpose within a group helps to enhance the willingness of staff within a care home to voice themselves.

In CS2, the clique culture was underpinned by factors such as staff having to work in teams of two at all times, and the existence of a core group of staff who had been working on the unit for a prolonged period. The staff's perception of the unit manager's lack of legitimacy was found not only to contribute to the clique culture but was also a reason why staff chose not to voice themselves on the unit. Finally, voice was promoted through social relationships participants had with each other, but this was only beneficial to those who had relationships with individuals in positions of both formal and informal power. Moving forward, the final chapter in this thesis will explore what implications my analysis has for our understanding of the influence organisational cultures have on employee voice within the care home context.

Chapter Seven

Discussions and Conclusions

7.0 Introduction

Through the previous two analysis chapters, it has been possible to establish a better understanding of the cultures that existed within the care home researched for this thesis. This final chapter first aims to recap on the context in which this study was first justified and argue that since its initiation, the justifications for this study are still relevant. In an effort to relocate the data back into the literature and the critical academic community (Guba & Lincoln, 1994), I detail what I propose are the contributions and practical organisational level recommendations of this study. I also put forward policy-level recommendations for future policies on employee voice and care home cultures. Through this process, I provide answers for each of the five research questions detailed in chapter three, and in doing so, compare my findings with critical traditions and pre-existing knowledge (Carpiano & Daley, 2006), thus following the postpositivist tradition underpinning my study (Guba & Lincoln, 1994). Together, these contributions and recommendations will also address the gaps I have previously identified in the literature.

7.1 Context of the study

Reflecting on the literature review chapters, it was possible through an analysis of the English Health and Social Care sectors to propose care homes as being disproportionately predisposed to the cultivation of closed organisational cultures (Skills for Care, 2017; Baird & McKenna, 2018). Care home cultures and employee voice also emerged as the key concepts underpinning the study (Van Dyne et al., 2003; Schein, 2004). Since this study was initiated, continued Health and Social Care failings linked to organisational cultures have been brought to the public's attention through such as the Gosport Independent Panel (2018) detailed in chapter two. Such failings demonstrate the important role organisational cultures continue to play in influencing Health and Social Care organisations in England.

Specific to the care home context, issues around staffing, low pay, and the lack of training opportunities detailed in chapter two continue to persist, resulting in ongoing failings (Argyle et al., 2017; Baird & McKenna, 2018; Karwowski, 2019; Surr et al., 2019). Additionally, Brexit is predicted to have a significant impact on the social care sector, particularly in relation to the proposed end to freedom of movement that accounts for around 95,000 employees (The King's Fund, 2019). As we get closer to a no-deal Brexit, Fahy et al. (2019) argue that such pressures are only going to increase. Furthermore, the low social status of care staff (Carr, 2014) and concerns around the increased financialisation of care homes (Horton, 2019; Karwowski, 2019) continue to have an impact on the sector, which, I argue, continues to perpetuate the types of closed organisational voice cultures detailed in chapter two (Baines, 2004; Baines & van den Broek, 2016; the King's Fund, 2019).

Within the researched care home, the formalised positions of the home on its culture and employee voice were detailed in chapter four, but the subsequent two analysis chapters have demonstrated that there was a disparity between this formalised position of the home and the realities on the ground. Other documents, also indicated that there was a disparity between what staff said, especially around raising concerns, and what this study has subsequently found. Indeed, this study has identified that the characteristics of care homes which disproportionately predispose them to the cultivation of the closed organisational cultures detailed in chapter two, were prevalent within this care home. Thus, on reflection, the decision to undertake this study within the care home context, exploring the influences of organisational cultures on employee voice, was a just one. Indeed, this is not to say that this study was not without its limitations or to say that it has made significant gains in bettering our understanding of voice cultures within care homes, but I argue that it is a step in the right direction.

7.2 Contributions

In an effort to understand the influence of care home cultures on employee voice, I have been able to offer three theoretical contributions resulting from my study, which I argue will help further our understanding (Carpiano & Daley, 2006). First, the undertaking of qualitative research exploring the influence of care home cultures on employee voice; second, the combination of Schein's theory of organisational culture with his views on pivotal and peripheral subcultures and its use for the first time as an analytical framework to study care homes (Schein, 1988); finally, exploring the relationship

between the perceived position of participants within the care home hierarchy and their understanding of employee voice (Morrison, 2011; Ruck & Welch, 2012; Martin & Waring, 2013). This section of the chapter will detail how all three contribute to our understanding, thus recontextualising my research (Morse, 1994) back into the academic literature (Cook & Campbell, 1979) as is expected by the postpositivist philosophical position adopted for this study. Again, it's important to note that these contributions are not as far-reaching as I would have liked given the scope and limitations associated with undertaking research for a PhD thesis, but it does represent a small but important contribution.

7.2.1 Qualitative analysis into the influence of care home cultures on employee voice

One of the key gaps identified in the literature review was the fact that thus far there have not been any qualitative research studies exploring the influence of care home cultures on employee voice (Frey et al., 2015). This study has been successful in filling this gap in the literature (Van Dyne et al., 2003) by, for the first time, undertaking a qualitative analysis of the influence of care home cultures on employee voice within the English context. As a result of this study, I argue that our understanding of care home cultures and employee voice has been enhanced. Furthermore, from the data, it is apparent that care home cultures which are comprised of multiple macro and micro-level factors do indeed influence employee voice in several complex ways (Martin & Waring, 2013; Sheard, 2013; Kingsmill, 2014; Mulligan, 2014; Schein, 2016). The literature on organisational culture and employee voice already indicate how complex these concepts are, so this is nothing new, neither was the discovery of subcultures within the care home (Schein, 2004; Morrison, 2011).

What the study did show was the impact of the subcultures in shaping the overall care home culture, especially in relation to employee voice. From my analysis, it was evident that unit-level subcultures were when it came to issues around employee voice more powerful than the care homes culture. Thus, within this context, voice subcultures were not periphery, but rather pivotal in determining if employees felt willing or able to speak out, and if indeed that voice was listened to and acted on (Van Dyne et al., 2003; Schein, 2004). This was also the case for day-to-day experiences relating to employee voice; thus I argue that in relation to care homes, it is essential to take into consideration that 'subcultures' may not always be inferior to the home's overall culture (Davies et al., 2000; Baylis & Perks-Baker, 2017).

This insight has strengthened our ability to better understand how care home cultures are cultivated and the factors which contribute to their cultivation. It is acknowledged that this was but one study, at one time point; thus more work is needed to fully establish the impact of subcultures on employee voice in relation to the overall culture of care homes, but this does provide another angle from which to explore cultures in care homes.

7.2.2 The combination of Schein's theory of organisational culture with his views on pivotal and peripheral subcultures as an analytical framework with which to study care homes.

Through integrating Schein's theory of organisational culture with his work on organisational subculture, I was able to develop the *Organisational Culture and Subculture Analytical Structure*, which I deployed for my analysis of both case studies (Schein, 1985; 2004). This structure was also used as the blueprint for reporting back on my findings in chapters five and six, thus offered an effective methodological approach to undertaking this study within care homes.

I argue that Schein's work on organisational culture and subculture offers an appropriate theoretical lens through which to explore the complexities of care home culture and its impact on employee voice (Skills for Care, 2017; Baird & McKenna, 2018). As such, it was possible to delve deeper into the culture of this care home and uncover that its culture was not a homogeneous whole as suggested in sections of the management literature (Deal & Kennedy, 1982), but instead was underpinned by strong peripheral values of the unit level subcultures (Schein, 1988).

Through my study, it has been possible to demonstrate that the boundaries between a care home's culture and care home subcultures are very fluid (Schein, 1985). Such boundaries are continuously negotiated within the 'culture-producing organism' of a care home (Tichy, 1982; Smircich, 1983). Thus, I argue that cultures and subcultures are a characteristic of a care home organisation (Smircich, 1983). That being so, I have been able to realise these cultures and subcultures through the exploration of the distinctive internal rituals, legends, and ceremonies underpinning this care home which have all come about as a response to the local context (Tichy, 1982; Smircich, 1983; Schein, 2010). This process of analysis which accommodated the potential existence of subcultures within a care home setting has, I argue, allowed for a better understanding of care home cultures within the English context (Schein, 2004).

As I explored in chapter two and three, there are a host of different approaches within the literature, and it is uncertain if indeed another approach would have resulted in the same outcome (Schneider, 1999; Martin, 2001). Furthermore, through our exploration of culture models within the international context, we were able to identify a rich body of work especially concerning several culture change models (Chapin, 2010; Banaszak-Holl et al., 2013). Although I justified in chapter three and four why I had chosen to follow Schein's approach to organisational culture, it is also the case that other approaches from this body of work would have provided additional insight. Such approaches perhaps provide areas for future study within the English care home context.

What my study has been able to establish though, is that there is a need to move away from the notion that organisational cultures are homogeneous and start appreciating the fact that local level considerations (discussed in the next section) play a significant role in shaping care home culture and voice (Gregory, 1983; Schein, 1993; Davies et al., 2000; Martin & Waring, 2013).

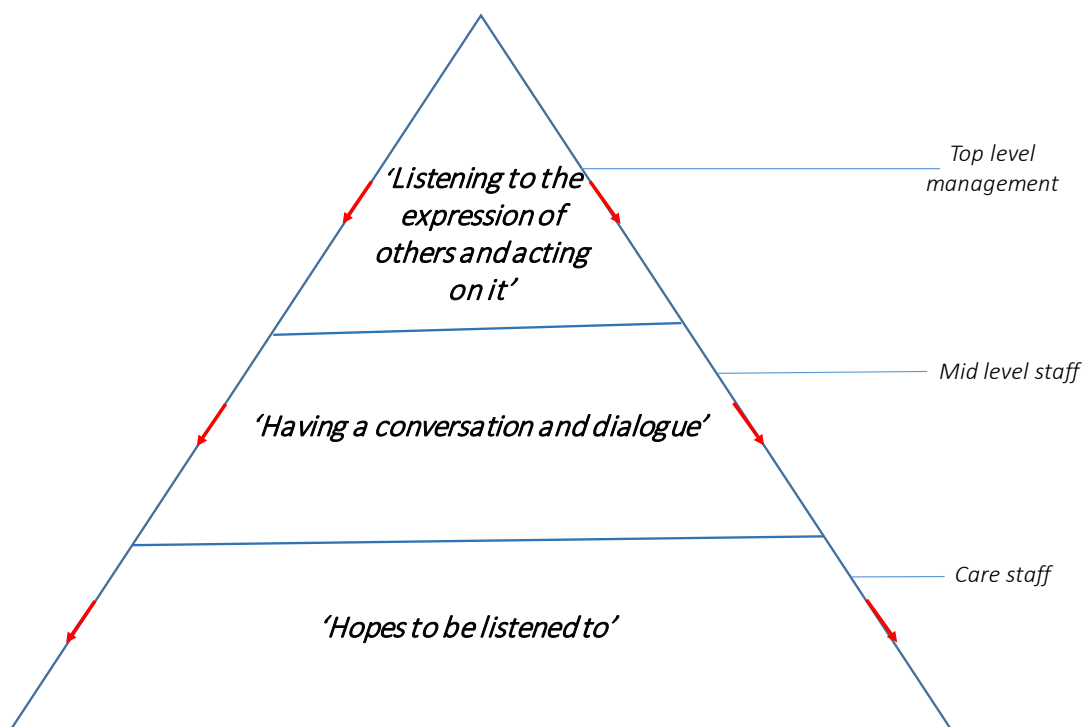
7.2.2 Perceived position within the care home hierarchy and participants' understanding of employee voice

The final contribution of this study also provides an answer to the first research question posed in chapter three, relating to participants' understanding of employee voice. From an analysis of the data relating to this question, it is apparent that the central theme underpinning participants' understanding of employee voice was their perceived position within the care home hierarchy (Morrison, 2011; Ruck & Welch, 2012; Martin & Waring, 2013; Miller et al., 2013). Perceived because some participants who had informal power within the home perceived themselves as being higher up the hierarchy than their official position would allow, which was especially the case in CS2 (Silver et al., 2018). Such an understanding of employee voice can be linked back to chapter four in which I detailed the hierarchical nature of the care home.

Through my analysis of data relating to participants' understanding of employee voice, three levels of understanding emerged based on where participants saw themselves in relation to the home's hierarchy (Koren, 2010; Ruck & Welch, 2012; Weiss & Morrison, 2018). It is important to note, as stated in chapter five, that hierarchy was not the only factor influencing employee voice, but during this study, it was the theme which emerged most prominently among participants. The following

diagram provides a visual representation of participants' perceived position within the care home hierarchy, and the influence this had on their perspectives on employee voice.

Diagram 7: Participants' Perceived Hierarchy Position and Employee Voice



As detailed in chapter five and visually depicted above, the first group of perspectives came from the bottom levels of the home's hierarchy, comprising only care staff; perspectives on employee voice within this level centred on 'hopes to be listened to'. I argue that this theme relates to the fact that such participants did not have the power or authority to bring about change due to their position within the home's hierarchy (Ruck & Welch, 2012; Miller et al., 2013; Waring, 2016). Thus, the best such participants could hope for when it came to employee voice was to be listened to (Van Dyne et al., 2003; Davies & Mannion, 2013).

The second group of perspectives came from participants who perceived themselves as being positioned at the middle level of the home's hierarchy. Participants' perspectives of employee voice at this level centred on 'having a conversation and dialogue' (Van Dyne et al., 2003). Such participants reflected through interview transcripts and my observations that they possessed enough legitimacy and power to engage in meaningful conversations as a means of voicing themselves to those who could bring about change within the organisational hierarchy (Martin & Waring, 2013; Weiss &

Morrison, 2018). Through my observations, it was apparent that such participants were made up of mostly nursing staff and care workers who were team leaders. Indeed, within the organisation's official hierarchy visually referenced in chapter four, such roles did occupy the middle level of the home's hierarchy (Davies & Mannion, 2013; Bashshur & Oc, 2014).

The final group of perspectives came from participants who perceived themselves as being at the top level of the home's hierarchy. Participants' perspectives of employee voice at this level were based on 'listening to the expression of others and acting on it' (Adelman, 2009; Willis, 2012; Keogh, 2013). Such participants within the organisation had both the power and legitimacy to act on the voices of others; thus, their views were not about voicing themselves but receiving voice from others and acting. Such participants did have external people and agencies who they were also accountable to and voiced to. As detailed in chapter four, this care home is part of a larger chain of care homes; thus the organisational hierarchy does not end with the care home, but rather is comprised of additional levels of decision-makers, all of whom were external to the care home. Within the confines of this study, the top-level participants were made up of the top management of the care home; as such, they also represent the top levels of the care home's hierarchy (Adelman, 2009; Koren, 2010; Davies & Mannion, 2013).

Reflecting on the views of Davies & Mannion (2013) who argued that hierarchies are essential considerations within the healthcare context due to the power those at the top have to influence change, I argue that this study furthers this viewpoint by demonstrating the influence of hierarchy on employee voice. From my analysis, those at the top of the care home recognised the power they had to bring about change to the way their employees voiced (Bashshur & Oc, 2014; Davies & Mannion, 2013). This contribution, I argue, moves away from generic definitions of employee voice within the management literature (Dundon et al., 2004; Wood & Wall 2007; Bashshur & Oc, 2014), and the emphasis on motive (Van Dyne et al., 2003). Instead, the analysis from this study suggests that within this care home context, where participants perceive themselves within the home's hierarchy plays a significant role in influencing how they see employee voice. (Dundon et al., 2004; Ruck & Welch, 2012). This was both in relation to voicing themselves and responding to voice from others.

Efforts to 'flatten' the hierarchy within care homes, I argue, would go some way to addressing the low perception of their position that the majority of care workers hold within care homes (Carr, 2014; Demos, 2014). This perspective is also in line with the views of the Home Manager, who called for a 'flat and open system' within care homes to promote voice. Such efforts would involve addressing both formal hierarchy structures such as pay (Kingsmill, 2014), and informal structures such as culture (Davis, 1981). From an analysis of the care home structure in chapter four, it was noticeable that the majority of the decision-making power resided outside of the care home; thus, within the current hierarchy model, creating a flattened system at the company level would be difficult (Weiss & Morrison, 2018). Furthermore, it is essential to state that this may not be the case in other care homes who may have different hierarchical relationships.

At the care home level, the characteristics of the training environment detailed in chapter five, such as having a working environment with a mix of staff from different levels, but not dominated by specific groups of workers and without visible signs of hierarchy, would be a starting point for such change. In addition, efforts to remove other barriers within the care home such as 'management only' signs and official titles on doors would, according to the Thomas Pocklington Trust (2015), further this 'flattening' of the hierarchy within care homes. Again, we must be aware that such characteristics are context-specific; thus, it is possible that in other care homes, training is undertaken in uniformed and on units, which would render this approach ineffective. But if we are to take a more optimistic view, one could take the lessons from this specific study and adapt them to suit the specificities of different care homes.

7.3 Organisational level recommendations of the study

As a result of this study, I have been able to arrive at three organisational level recommendations for our understanding of care home culture and employee voice (Allcock et al., 2015; Francis, 2015; Baylis & Perks-Baker, 2017). First, the need for a process of 'unlearning' those elements of an organisation's culture which contribute to silence (Davies & Nutley, 2000); second, the need for Organisational Environments of Learning (OEL) as a way of facilitating employee voice and greater employee decision making (Jones, 2016); finally, the need for a bottom-up approach to the cultivation of open cultures (Schein, 2004; Baird & McKenna, 2018; Thorlby et al., 2018). These recommendations have been informed by the recommendations provided by participants, and

available in *appendix nineteen*. Through an exploration of these recommendations, which as I argue should become part of care home practice, it will be possible to respond to what Martin & Waring (2013) saw as a lack of practicality in post-Francis policies. It will also be possible to provide answers to research questions three, four and five detailed in chapter three, address research gaps and report back on how things really are in relation to employee voice and care home organisational culture (Guba & Lincoln, 1994).

7.3.1 The need for a process of ‘unlearning’ elements of an organisation’s culture that contribute to silence

The fourth research question underpinning this study was aimed at exploring the factors within the care home, which mitigated against employee voice. As a result of this question, it was possible to establish at the care home level that the key factor which prevented employees from voicing themselves was the negative legacy left by previous management. From the perspectives of participants such as CS1-CA7, it was the managerial practices implemented by different management regimes to prevent staff from speaking out, which instilled a system of fear in staff. Such fears outlived individual managers and from my data, became part of the culture of fear of voicing out, especially at the home level of the care home (Weiss & Morrison, 2018; Robyn, 2019). The need for a process of unlearning reflects one of the characteristics of culture put forward by Schein (2010) in chapter three, demonstrating the need to undergo a purposeful process of unlearning, due to what Schein argues is the subconscious nature of culture.

I, therefore, put forward the proposal that in a care home’s efforts to establish a culture which is open to employee voice, a process of ‘*unlearning*’ must first take place (Davies & Nutley, 2000). That is, the process of indoctrinating staff within the care home away from processes which were not conducive to employee voice. An example of this was the continued negative influence previous management regimes had on the voice of employees within the care home. According to Smith & Simmons (1983), in an attempt to establish open organisational environments, efforts must be made not to ‘transport’ unresolved conflicts into the new working environment. From my data, this was something which the Home Manager (HM1) and the Clinical Nurse Manager (CNM1) were both attempting to do through the policy of proactively engaging with staff. The Home Manager identified the importance of unlearning during his interview in which he referred to instances in which

employees kept telling him 'they said we can't do this and do that', referring to rules developed by previous management.

Such rules, I argue, had outlived previous management and were still part of the care homes culture; thus, a purposeful process of unlearning rules which stifle voice is essential in any care home organisation's efforts to establish learning environments which are open to employee voice (Smith & Simmons, 1983; Robyn, 2019). According to Davies & Nutley (2000), in their efforts to unlearn negative cultural characteristics such as those of the previous management regimes, care homes must be willing to change whole routines which have normalised closed cultures as a first step in the cultivation of open cultures and facilitation of employee voice (Robyn, 2019). This view put forward by Davies & Nutley (2000) is very much in line with my findings, particularly at the care home level and the work being undertaken by (HM1) and (CNM1).

The process of unlearning organisational norms which are not conducive to employee voice can be a difficult one, according to Tingle (2014), especially if such norms have become part of the organisation's culture (Schein, 1983; 1993; Killest et al., 2013b). Indeed, from my observations, the efforts of both HM1 and CNM1 were still to have the desired effect, reflecting the position put forward by Robyn (2019) in his research on nurses. This ineffectiveness also reflects the complexities associated with care home cultures detailed in my study. Thus, unlearning cannot be a top-down initiative only, but instead requires input at all levels of the care home hierarchy to be effective. Furthermore, the concept of unlearning might not reverberate with care homes within different international contexts, and in an effort to unlearn, other valuable components of a care homes culture may inadvertently be lost as well. Thus, it is crucial in efforts to unlearn that the limitations of this process are also known.

7.3.2 The need for Organisational Environments of Learning (OEL) as a way of facilitating employee voice and greater employee decision making

The second organisational level recommendation to emerge from my study is the need for care homes to establish *Organisational Environments of Learning* (OEL). This organisational level recommendation is also a response to two of my research questions, namely what are the care home characteristics and factors, which facilitate employee voice and, question five, how employee voice

can be elevated to gain greater impact in care home organisational decision making. This terminology came about after my analysis of the training environment within the care home, which I deemed to have been a learning environment, in which employees felt safe to voice themselves (Jones, 2016). The establishment of such environments, I argue, is vital in creating a foundation from which employees at all levels of an organisation are made to feel able to voice themselves (Schein, 1993; Waring et al., 2013; Jones, 2016). This position is in line with the findings from the *Clwyd-Hart* Report which called for the establishment of working environments free from what Clwyd & Hart (2013) referred to in chapter two as a toxic cocktail of factors preventing employees voice. The need for OELs is also in line with the Department of Health and Social Care (2018), which has acknowledged the critical role learning environments play in fostering open working environments for staff.

The concept of learning environments within the management literature is nothing new, but has over the years been an elusive one with a host of differing definitions put forward (Davies & Nutley, 2000; Waring et al., 2013; Donaldson-Feilder et al., 2014). Calls for the cultivation of OELs have emerged from several sources such as DoH (2015a) and Francis (2015) in the aftermath of the Health and Social Care organisational failings detailed in chapter two. According to Waring et al. (2013), an OEL is one in which employees feel safe enough to disclose their mistakes and learn from them. The need for a safe environment free from fear was something picked up during this study, particularly at the care home level, and in line with the views of authors such as Clwyd & Hart (2013) and Willis (2012). I argue that once care home organisations have rid themselves of practices unfavourable to employee voice (unlearning), establishment of such environments is an essential step in sensitising the care home to change (Killett et al., 2013b; Willis, 2012). Thus, the definition of OELs put forward by Waring et al. (2013), I argue, best represents what my analysis has identified as an essential first step in cultivating open cultures and promoting employee voice within the care home context.

In an effort to create a learning environment, Donaldson-Feilder et al. (2014) argue that such learning does not just take place within formalised structures. Processes of informal learning within Health and Social Care organisations are equally as important and, according to Schein (1993), need to cut across the subcultures of organisations. This proved to be the case during my study, and in many instances, informal considerations emerged as being even more important than formal mechanisms when it came to employee voice. In CS1, this took the form of the unit manager 'moulding' staff into

the family way of working which established her own informal peripheral values of the family (Schein, 1988; Kendall & Kendall, 1993). Informal learning was also evident in the way staff had learnt to respect the informal power held by the unit manager and feared the informal punishment techniques the unit manager deployed to control voice on the unit (Morrison & Milliken, 2003; Silver et al., 2018; Weiss & Morrison, 2018).

In CS2, this took the form of members of *'the more experienced staff'* indoctrinating new members of staff into the informal norms and values of the unit which centred mainly around establishing themselves as having more legitimacy due to their longevity of service. In addition, the informal social relationships formed on the unit between staff were one of the key factors influencing the cultures within the units, which is in line with the views of Nevalainen et al. (2018) on informal relationships detailed in chapter three. That being the case, in the effort to cultivate OELs, I put forward the position that informal mechanisms and processes within an organisational context should be given equal consideration to their formal counterparts (Schein, 1984; Gagliardi, 1986).

7.3.2.1 Characteristics of a learning care home organisation that can facilitate and elevate voice to gain greater impact in care home organisational decision making

Through an analysis of my data and recommendations gained from participants on how best to 'create alternative possibilities' (Burns et al., 2014), in an effort to promote employee voice, I have been able to establish what I refer to as the 'characteristics of a learning care home organisation'. It is the effective implementation of these characteristics within care homes which, I argue, will help bring about OELs within care homes (DoH, 2015a; Francis, 2015; Jones, 2016). Thus I argue that such characteristics should over time, become Pivotal values within the care home (Schein, 1988; Boisnier & Chatman, 2002).

Through my analysis of the management literature, efforts within the care home context to identify anything similar to what I refer to as the characteristics of a learning care home environment have until now not been explored through an in-depth qualitative analysis. Thus, this study's ability to identify such characteristics does contribute to the literature (Carpiano & Daley, 2006) on care home cultures. The next section aims to detail these characteristics, and in doing so, indicate how they may help in establishing OELs. Indeed, it is essential to state that such characteristics do not represent the

exhaustive list of possible characteristics, but within the scope of this study, the following characteristics did emerge.

7.3.2.2 An environment guided by proactive leadership that facilitates employee voice and decision-making

The data highlights that one of the key characteristics needed within care homes to establish an OEL is the presence of proactive leaders. The role of proactive leadership and the efforts being made by both (HM1) and (CNM1) to proactively engage with staff and encourage them to express their opinions as part of the decision-making process became evident in chapter five. Such efforts are in line with research by Miller et al. (2010), in which the importance of proactive leadership in the cultivation of environments that later brought about culture change was established. Proactive leaders must be proactive in their efforts to promote the voices of employees (Weiss & Morrison, 2018), and engage staff in what Burns et al. (2014) refer to as the 'co-production of knowledge' so that staff are able to contribute to the home (McAlearney, 2006; Allcock et al., 2015; Rose, 2015). The lack of leadership within care homes was one of the characteristics identified in chapter two as disproportionately predisposing care homes to the cultivation of closed organisational cultures (Francis, 2015; Waring, 2016). This was also a reason why a significant number of the 25 inadequate care failed their inspections (CQC, 2016). The need for proactive leaders is also a view arrived at by a host of post-Francis Reports (Carr, 2014; Berwick, 2013), in which proactive leadership was deemed to be one of the most critical elements of establishing organisational environments of learning (Dixon-Woods et al., 2014; Havig & Hollister, 2018).

From my analysis, it was evident that both formal and informal leadership played a significant role in facilitating employee voice and shaping the care home's culture (Argyris, 1982; Morrison, 2011; Baines et al., 2014a). Within the context of CS1, this took the form of the 'matriarchal leadership style' deployed by the unit manager, which created a unit culture in which employee voice was permitted only within the unit and in compliance with her rules (Tichy, 1982; Smircich, 1983; Deal & Kennedy, 1982). The unit manager was proactive in her promotion of the family and the enforcement of its principles through emotional manipulation of staff and sanctions.

Within the context of CS2, I identified '*the more experienced staff*' clique as wielding informal power, and proactively using this power to influence the voices of other participants. Other members of

staff, such as (CS2-N3), took on proactive informal leadership responsibilities and went out of their way to elevate the voices of other staff members, especially those belonging to *'the new ones'* clique. From my analysis, it is evident that proactive leaders who facilitate employee voice and decision making can be a catalyst for learning environments within care homes (Allcock et al., 2015; NHS England, 2016b).

7.3.2.3 An environment which provides appropriate quality training to all staff on employee voice

Another characteristic to emerge from my analysis of the data relates to my argument of the need for care homes to offer high-quality training to all staff as a form of continuous education (Argyle et al., 2017). Low-quality training was identified in chapter two as something brought to our attention by a number of the post-Francis Reports, such as Demos (2014), Kingsmill (2014) and Rose (2015), which all highlighted a lack of training as a significant contributor to organisational failings. The Carer (2019) and Surr et al. (2019), both contribute to this perspective by stating that there is a real need across the whole sector to improve the quality of training provided to care workers. This is despite the introduction of the Care Certificate, which, as Argyle et al. (2017) argued, needed further development. I propose that it would not be possible to consider an organisation as possessing environments of learning if indeed the training given to staff was not of a level which would enable them to effectively carry out their caring responsibilities and know-how, and when, to voice themselves (Flynn et al., 2014). My position reflects the view of the Thomas Pocklington Trust (2015) and the Rose Review in 2015, who both argued that if indeed such organisations were to offer training at an appropriate level for the job, learning could begin to take place.

Through my research, it became apparent that the training environment offered what I referred to as a *'hub of voice and learning'* and was the only location within the home in which I observed participants from both units interacting. These training sessions incorporated members from all levels of the organisation's hierarchy, which demonstrates that the training environment was one that broke down boundaries between staff (Morrison, 2011; Ruck & Welch, 2012). I have in chapter five detailed the characteristics of that specific training environment, but I also argue that the provision of training to all staff is another way of establishing learning environments. This is a view shared by Hasson et al. (2014), who also called for staff at all levels to receive 'on-going' training as a way of maintaining quality. Furthermore, reflecting on the extract by CS1-N1, which detailed

sanctions for not following policies and procedures, I argue that appropriate quality training should also provide staff with the relevant information needed to effectively voice their concerns (Morrison, 2011; Flynn et al., 2014). If this is achieved, I argue that quality training will indeed contribute to the elevation of employee voice because employees will be more knowledgeable about the voice process. This, in turn, will contribute to the establishment of learning environments within care homes.

7.3.2.4 An environment that facilitates team meetings as a platform for collective staff voice and decision-making

Through the recommendations gained from participants, especially those lower down the organisational hierarchy (Weiss & Morrison, 2018), it was evident that they felt there was a need for more regular platforms from which they can voice themselves (Burns et al., 2014; Lewis & Vandekerckhove, 2018). This is something that participants saw as a way of facilitating their voice and is a position that authors such as Davies & Nutley (2000) say is important in any effort to establish effective OELs. This recommendation by participants was in line with one of the key recommendations to emerge from Kingsmill (2014), who argued that there was a need for care workers to have more collective platforms from which to voice themselves. To this end, Schein (1993) and Davies & Nutley (2000) both advocate for the establishment of effective approaches to working, which allow individual employees to come together as a collective, interact with each other and exchange ideas.

I did observe such processes, especially during morning handovers in CS1, which the unit manager would use to 'allow' her staff to voice themselves on any issue which did not contradict her narratives. In CS2, platforms for collective voice were available, but for the most part, were not taken up by staff due to the perception that the unit manager altered their voice. This, I argued, contributed to the fracturing of the unit's culture, as there were no trusted mechanisms to express a collective voice (Davies & Nutley, 2000). Schein (2004) would argue that it is through such a process that a collective work environment is created, and cultures are transmitted. I argue that this collective environment was lacking, resulting in the clique culture which I described in chapter six. Davies & Nutley (2000) suggest that it is through these frequent meetings that both formal and informal methods of learning are transmitted between members and passed on to new members.

Thus, I argue that within the care home context, if environments which facilitate team meetings were to be offered to staff, and collective voice encouraged, this would go some way to creating OELs within care homes (Donaldson-Feilder et al., 2014).

7.3.2.5 An environment consisting of trusted channels of communication which encourage staff to engage in reflective practice and decision-making

One of the key characteristics, which facilitated employee voice within CS1, was the use of handovers as a trusted and regular reflective space (Burns et al., 2014; Waring, 2016). Although the unit manager of CS1 used them as a way of controlling the narrative on the unit, I argue, based on participant responses, that such mechanisms are also an effective tool when establishing OELs (Waring, 2016). Such opportunities, according to Allcock et al. (2015), are essential as means of sharing information and learning, and, as such, help in an organisation's effort to develop learning environments. Furthermore, I argue that through reflective practice, organisations would become less predisposed to the blame culture which the DoH (2015d) detailed during the Freedom to Speak Up Consultations, because staff would have a better understanding of each other and recognise this as a critical barrier to open cultures. From my analysis of the literature in chapter three, it was evident that the most significant factor influencing employee silence was the fear of punishment (Morrison & Milliken, 2003; Weiss & Morrison, 2018), thus trusted communication channels I argue would counter this fear.

From my data, what is also apparent is the fact that such channels of communication need to be trusted by staff; otherwise, they become a barrier to voice rather than facilitating it (Ronnerhag & Severensson, 2019). The need for trust when voicing is a perspective that reflects the view of Van Dyne et al. (2003), and the notion of employees utilising defensive voice within the organisational context. This was evident during my analysis of CS2, in which several participants suggested that the unit manager would regularly hijack reflective practice sessions, which resulted in participants distrusting the formal communications channels within the unit (Van Dyne et al., 2003). I argue that this became a barrier for employees who no longer trusted the system, refused to engage with it, and stopped attending meetings. Therefore, opportunities for staff to engage in reflective practice and decision-making were being missed, which contributed to the clique culture on the unit, because such cliques offered informal trusted channels of communication (Francis, 2015).

The most significant difference between CS1 and CS2 in relation to participants' willingness to engage in reflective practice was the degree to which participants trusted the channels of communication to be responsive to their voice. This analysis reflects research conducted by Ronnerhag & Severensson (2019), who found that the provision of trusted communications channels by leaders was an important consideration within the healthcare context. In CS1, although heavily controlled, my observations indicated that participants did trust these channels, but in CS2, this was not the case (Donaldson-Feilder et al., 2014). Thus, having communications channels in care homes that are trusted by employees would help facilitate reflective practice, and consequently, employee voice (Morrison, 2011).

7.3.2.6 A working environment which values staff and their insight

The last characteristic of a learning environment to emerge from my study relates to the first recommendation in *appendix nineteen* put forward by a significant number of frontline staff regarding the need to be listened to (Davies & Nutley, 2000; Morrison, 2011; Burns et al., 2014; Kingsmill, 2014). From my analysis, it was evident that particular care staff felt that they were not being listened to and that their insight did not matter; thus they did not voice their concerns (Morrison, 2011; Whelan, 2016; Moeini et al., 2019). Davies & Nutley (2000) would argue that the effective establishment of learning environments depends almost exclusively on frontline staff; hence, there is a need to value such staff and their insight. This was the same rationale that participants put forward; that is, they are at the forefront of delivering care within the home and thus best placed to know what is right for patients (Wood & Wall, 2007). This is a position recognised by Morrison (2011) who called for staff to voluntarily contribute ideas and information to their organisation, acknowledging the fact that since those at the top of the organisation are not best placed to have all the information needed to act effectively, there is a need to actively listen to staff (Keogh, 2013).

The issue participants put forward in chapter five was that they were attempting to provide the type of ideas and information called for by Morrison (2011), but those with the power to act were not listening to their voices. Francis (2010) touched on this point during his investigation and concluded that a '*weak professional voice within the Trust*' was a contributing factor to the failings that

occurred. This relationship suggests that an organisational environment which do not listen to staff and value their insight and dialogue (Schein, 1993) are at risk of the same types of failings uncovered by Francis (2010). Indeed, Killett et al. (2013b) also touched on the point and emphasised the need to create a care home environment which valued staff and empowered them to take on responsibilities. The view of Killett et al. (2013b) is also substantiated by Cavendish (2013), who recommended that care organisations needed a culture change which would 'recognise the positive contribution of care assistants' within the health service. To achieve this, Cavendish (2013) called for 'supportive cultures', and Kirkup (2015), for 'cultures of openness' in which staff feel able to express themselves, which from my data was an important consideration when employees were voicing themselves (Baines et al., 2014a). Thus, I argue that care homes which value the insights of their staff would ultimately encourage staff to voice themselves more, and in doing so, help establish OELs.

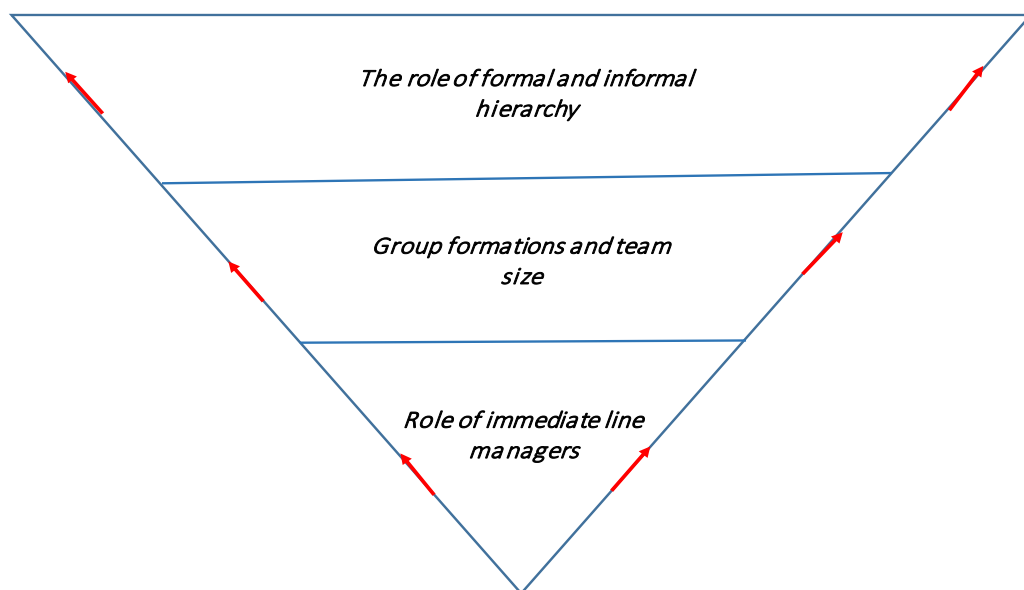
In setting out the above characteristics, there is a need to acknowledge that individual characteristics of an organisation play a significant role in shaping an organisation's culture (Donaldson-Feilder et al., 2014). Davies & Nutley (2000) put forward the perspective that as organisational environments differ, so too will the environmental characteristics underpinning their ability to learn. This was evident in some of the differences in characteristics identified between the two units case studied for my research and the care home environment. That being so, it is recognised that within different care homes, there will exist characteristics that differ from those present within this care home. Indeed, there may exist other characteristics which this study has not been exposed to due to its scope of context. Nevertheless, I argue that within any care home context, it would be possible to implement a combination of characteristics in an effort to establish an OEL (Waring et al., 2013; Jones, 2016).

7.3.3 The need for a bottom-up approach to the cultivation of open care home cultures and the facilitation of employee voice

Another organisational level recommendation to emerge from my data was the need for a bottom-up, micro-level approach to the cultivation of open cultures. Such an approach must account for the role of immediate line managers, group-level formations and the influence of informal hierarchies in shaping open cultures (Schein, 2004; NHS England, 2016b; Baird & McKenna, 2018; Thorlby et al., 2018). This organisational recommendation is also a response to the third research question on the facilitation of employee voice. From my data, it was apparent that although cultures

are within the literature understood at the macro-level, there was a need to take into consideration the micro-level influences on care home culture, such as leadership and group formation and informal hierarchy, as a way of better understanding 'how culture really works' within the care home (Smircich, 1983; Guba & Lincoln, 1994; Davies & Nutley, 2000; Sheard, 2013; Kingsmill, 2014). In chapter three, Adelman (2012) detailed that the most significant factors influencing employee voice were organisational context, behaviours of leaders and individual employees; this study has identified similarities to these factors. The following diagram provides a visual representation of the bottom-up approach that I argue is required in a care homes effort to cultivate open cultures.

Diagram 8: Bottom-Up Framework



7.3.3.1 The role of immediate line managers in shaping culture and voice

The first micro-level factor to emerge from the data which influenced the culture and voice within the care home was the role played by the immediate line managers and the way in which they related with frontline staff (Martin & Waring, 2013; Sheard, 2013; Kingsmill, 2014; Schein, 2016). From this study, it was apparent that this was one of the most significant contributing factors to the culture within each case study, and also had a considerable influence on employee voice. In their analysis of effective culture change, Allcock et al. (2015) recognised the need for effective interactions between staff, and the role managers played in such interactions in relation to getting staff involved in issues which influence daily life within the organisation. As such, Allcock et al. (2015) advocated for the 'co-creation' approach in which managers effectively and positively interact with

staff. This approach can be seen as a way of cultivating open cultures because it would allow staff to feel that their voices had an impact within the organisation, which was also a view put forward by participants in *appendix nineteen*.

This co-creation approach supports the Tyler & Parker (2011) argument for a bottom-up approach to culture change and calls for such an approach to take account of individual employee voices (Thorlby et al., 2018). From my study, I argue that there was a historical lack of a co-creation of knowledge (Burns et al., 2014) when it came to employee voice and open cultures. In CS1, the immediate line manager deployed a form of co-creation during handovers, but this was in hindsight, just an illusion geared towards maintaining her position of power and control over voices of staff (Morrison, 2011; Martin & Waring, 2013; Schein, 2016; Silver et al., 2018). In CS2, there was no evidence of co-creation by the immediate line manager, which furthered the distrust staff had towards that individual, furthered by a lack of trusted communication channels within the unit (Ronnerhag & Severensson, 2019), which influenced the proceedings and the culture. Although efforts were being initiated by the top management of the home to engage staff, I argue that they were too far removed from the day-to-day working environment; thus, their impact was limited (McAlearney, 2006; Martin & Waring, 2013; Whelan, 2016).

From my analysis, the individual personality of the immediate line managers was the most significant factor in shaping how they responded to employee voice, and as such shaped the cultures of their units, reflecting the perspective of Adelman (2012) from chapter two. Immediate line managers would deploy a combination of formal and informal mechanisms to shape the culture of their working environment for employees (Morrison, 2011). I argue that this system of operation meant that immediate line managers were able to cultivate 'cultural narratives' (Tichy, 1982; Smircich, 1983) and work practices which were out of line with the pivotal values of the care home (Schein, 1984). Furthermore, due to the lack of organisational level oversight within the care home, mainly due to the prolific turnover of management staff (Davies & Mannion, 2013; The Carer, 2019), line managers cultivated what I refer to as 'multiple silo subcultures' within a care home (Boisnier & Chatman, 2002). These subcultures have been able to shape the cultures of those who work within them, and hence their voices, as evident in the data provided in chapter six.

The impact of these cultures on employee voice within the care home was noticeable. In CS1, the unit manager was able to establish cultural narratives around her vision of the family as a way of shaping and controlling the voices of staff on the unit. This control took on several forms, ranging from such as the creation of narratives around the unit being under attack to the members having to stick together as a family (Morgan, 1980). In CS2, the role of the unit manager in building up social relationships with specific sections of staff and misrepresenting the voices of staff contributed to the culture on the unit and how staff voiced themselves (Morrison, 2011).

Although such managers were influential in cultivating the cultures within their units, it is important to acknowledge that immediate line managers were also accountable to those higher up the hierarchy. This lack of managerial control was something that I detailed in chapter four after exploring the business model of the organisation and identifying that a significant amount of the decision-making power of the organisation resided in the head office and not individual homes (Silver et al., 2018; Goodwin, 2019). Therefore, the power each care home and subsequently, each manager had to implement real change was limited (Willis, 2012). Consequently, such managers were responding to pressures and working parameters which were out of their control. Furthermore, I argue that such macro-level pressures may have contributed to the significant levels of managerial turnover within the care home (Mulligan, 2014; CQC, 2016). That said, care homes which aim to cultivate open cultures and facilitate employee voice must take into consideration the influence of immediate line managers in the process (Martin & Waring, 2013; Sheard, 2013; Kingsmill, 2014; Schein, 2016).

7.3.3.2 The role of group dynamics and team size in shaping culture and voice

The second micro-level factor from my data centres on the need to take into consideration the role of group dynamics in shaping organisational cultures and team size (Smircich, 1983; Schein, 2004). Most of the literature on culture views it as being a unified whole within the organisational context, but one of the key findings of this study is that care home cultures are a combination of smaller subcultures (Schein, 2004). In chapter two, I argued that one of the features that prevented post-Francis policies from bringing about change was their inability to grapple with the size and complex dynamics within such organisations (Donaldson-Feilder et al., 2014; Baylis & Perks-Baker, 2017). This was something which I observed in CS2 in which the two cliques formed parallel groups

within the unit, shaping its culture. Indeed, Smircich (1983) and Tyler & Parker (2011) both acknowledge the vital role group dynamics play in shaping cultures and thereby influencing employee voice (Schein, 2004).

Apart from the group formations, another consideration to emerge from the data was the impact of staff numbers in the group on culture formation. Key to understanding the subcultures of both units was a recognition that size of the unit (number of permanent workers) influenced how cultures were formed and their strength (Schein, 2004). The data in chapter six indicates that it was evident that in smaller groups, subcultures can develop very fast and have a significant influence on employee voice. From my analysis of the literature, there is a case to be made that it was the lack of appreciation for group-level formations and the size of such groups within care homes which contributed to the ineffectiveness of the policies detailed in previous chapters (Donaldson-Feilder et al., 2014; The Carer, 2019). This perspective is backed up by research by Scott et al. (2003a) who found that care cultures that emphasised group affiliations had been associated with more significant improvements in care delivery.

In CS1, there was an assumption among staff that the success of the unit and its unity were as a direct result of its small size. This assumption manifested itself in several ways such as in the unit's rota at the artifacts level of analysis and staff choosing to work short to maintain the family unit at the beliefs level of analysis. In CS2, the unit was forced to split into smaller cliques due to the large number of staff, and one of the few ways of differentiating between staff on the unit was through their length of service on the unit. Other factors influencing the fragmentation of the unit's subculture did exist, but I argue the size of the staff pool was a significant one (Adelman, 2012).

In influencing the cultures within the care home, group formations and team size also had a significant impact on employee voice. In CS1 the formation of the group as a small family culture meant that staff felt safe and able to voice concerns within their unit. Although regulated by the unit manager, due to the group dynamics and the size of the unit, it was evident that employee voice was possible within the working environment. In CS2, the formation of groups along the lines of how long participants had been working within the care home meant that one clique (the more experienced staff) had significantly more voice than the newer members' clique. From my analysis, the large staff

size in CS2 did influence the fracturing of the unit into cliques, which then had an influence on who had the ability to voice themselves (Schein, 1984).

One must note that group dynamics and team sizes are very complex and subjective, especially within working environments such as care homes (Schein, 1984). It is essential to recognise that within a specific care home, the influence of group dynamics and team sizes will be very different. Indeed, it may be the case that the cultures of some care homes may respond in a contradictory way to that which was observed during this study. This realisation further focuses our attention on the need for more research in this area. That being said, from the data gained during this study, what emerged was that in attempting to shape cultures and facilitate voice within care home organisations, it is essential to take into consideration the roles group formations and size play (Tyler & Parker, 2011).

7.3.3.3 The role of informal hierarchy in shaping cultures and influencing voice

The final micro-level consideration to emerge from my study was the role played by informal hierarchy within the care home and the influence it had on culture and the voices of employees. According to Weiss & Morrison (2018), informal hierarchies and status within organisations normally come about as a result of others within that organisation recognising individuals within a specific role. At the care home level, I observed a significant amount of informal hierarchical systems in place, which suggested that despite the formalised environment of the home, informal hierarchy played a significant role in shaping the home's culture (Schein, 1984; Kendall & Kendall, 1993; Koren, 2010; Goodwin, 2019).

In chapter five, it was possible to identify that it was informal rules and hierarchy within each unit which underpinned the cultural assumptions of the unit. In CS1 it was the informal hierarchy system promoted by the unit manager which underpinned the family culture within the unit. In CS2, it was the informal hierarchy systems controlled by the more experienced staff clique, which had a significant influence on the unit's culture. These informal hierarchy structures formed the basis of what I referred to as *informal rules-based hubs* on each unit, which, from my observations of both units, shaped their cultures (Trice & Beyer, 1984; Schein, 1988; Rice & Beyer, 1993).

One of the main reasons why informal hierarchy was so prominent within the care home was the fact that staff felt disadvantaged by the formal hierarchy system and the policies and procedures which underpinned them (Weiss & Morrison, 2018). At the beliefs level of my analysis of the care home, it was evident that formal hierarchy did play a significant role in shaping the culture of the home, but formal processes within the care home were perceived negatively by frontline staff such as CS1-N1 and CS2-CA6. Such staff believed that there was a disparity between what the formalised processes within the care home stated and the realities on the ground which they perceived as negatively disadvantaging frontline staff, resulting in frontline staff distrusting formal hierarchy structures. I argue that this distrust contributed to the rise of informal hierarchies within the care home (Ronnerhag & Severensson, 2019).

Informal hierarchy also had a significant impact on employee voice within this study. This is something which I explored with HM1 and CNM1 in chapter five, where the managers of both units identified the informal nature of their units as playing a significant role in shaping employee voice. For CS1, HM1 commented that it was the power dynamics at play within the informal hierarchical structures of the unit which prevented employees from opening up outside the unit. For CS2, HM1 commented that the informal hierarchy was having the opposite effect, and that it had resulted in what HM1 referred to as a 'laissez-faire approach' adopted by the unit manager when it came to employee voice.

CNM1 also alluded to the role of informal hierarchy when commenting that it was the confidence staff had in their individual unit managers which influenced their willingness to voice (Davies & Mannion, 2013). In CS1, staff were more confident in the informal hierarchy systems in place on the unit and thus were more willing to voice themselves. In CS2, staff were less confident in the informal hierarchy systems on the unit, thus would seek to voice themselves more outside the unit. Such actions by staff in CS2 can be seen as reflecting the need for trusted channels of communication detailed above (Ronnerhag & Severensson, 2019). In both case studies, what emerged was the realisation that at the organisational level, consideration needs to be given to the role of informal hierarchies within the care home, and the impact such hierarchies have on employee voice.

According to Goodwin (2019), informal hierarchies involve very complex relationships, especially within the healthcare context. As such, generalising the role of informal hierarchies to other care homes would be problematic. Indeed, what constitutes an informal component of an organisations hierarchy would differ from organisation to organisation, and the same can be said for care homes (Kendall & Kendall, 1993; Koren, 2010). So, although informal hierarchies emerged as prominent within this study, another study undertaken by another researcher may come to a different conclusion (Guba & Lincoln, 1994; Symon & Cassell, 2012). The same can be said about the different levels of the bottom-up approach I have put forward. It is essential to acknowledge that within a different care home context; various factors might have emerged as being more critical in the levels of the bottom-up approach. To that end, I view the idea of a bottom-up approach which counters the top-down policy level endeavours which continue to fail as being most important regardless of the specific elements constituting that approach.

7.4 Policy level recommendations

The policy recommendations emerging from this study represent the final level of considerations related to this study. At this level, I identify considerations for policymakers in their efforts to cultivate an open organisational culture and effectively promote employee voice within care homes (Schein, 2004; Davies & Mannion 2013; Skills for Care, 2017). In chapter two, I detailed the need for future policies to take account of the complexities associated with care home environments (Baylis & Perks-Baker, 2017; Skills for Care, 2017), both in relation to organisational cultures (Schein, 2010) and employee voice (Bashshur & Oc, 2014). Indeed, the data that has emerged from my subsequent study has indicated this to be the case, further justifying my study. These recommendations have been guided by which can be found from *appendix eleven through to nineteen*. The below policy recommendations on cultivating open cultures and promoting employee voice are also a response to the third and fifth research questions posed in chapter three. The postpositivist position taken by this study, according to Durning (1999), is an effective angle from which not only to undertake policy analysis but also to contribute to the development of new policy on care home cultures and employee voice (Guba & Lincoln, 1994).

7.4.1 An acknowledgement of organisational differences and the accommodation of a multi-level understanding of care home cultures

From my analysis of the policy landscape post-Francis in chapter two, I argue that efforts to cultivate open cultures and promote employee voice disregarded the diversity between organisations (Donaldson-Feilder et al., 2014; Baylis & Perks-Baker, 2017). Donaldson-Feilder et al. (2014) and Jones (2016) both share this view by arguing that policies which lacked flexibility contributed significantly to the majority of such policies failing to bring about open culture change. In relation to continued failings, such as the report by Gosport Independent Panel (2018) indicated that the circumstances surrounding those failings reflected those detailed by Francis (2013) five years earlier, which, I argue, demonstrates the need for future policies to better accommodate organisational differences. Although there have been calls to move away from the one size fits all approach (Baylis & Perks-Baker, 2017), and have more consideration of factors such as geographic areas, I argue that this would still not go far enough to accommodate organisational differences. Thus, I put forward the recommendation that future policies should acknowledge the organisational differences which exist within care homes.

Additionally, I argue that such policies have failed to appropriately account for the micro-level aspects of an organisation's culture such as those detailed by Schein (1983) and Donaldson-Feilder et al. (2014). Consequently, I put forward the argument that it was also the inability of the policies detailed in chapter two to gain a multi-level understanding of the culture which contributed to continued failings even after such policies had been implemented (Gosport Independent Panel, 2018; Baird & McKenna, 2018). Such micro-level considerations may be unique to care homes; thus, I put forward the perspective that future policy initiatives not only need to have a multi-level understanding of organisational culture, but they should also be specific to care home cultures (Thorlby et al., 2018; The Carer, 2019). This is a key policy level contribution to emerge from my study, which attempts to move the care policy agenda away from perceiving culture at just the organisational level so as to recognise the micro-level factors influencing culture and voice detailed above (Horton, 2019; Karwowski, 2019).

On employee voice, I argue that one of the key reasons why policy initiatives have failed to effectively tackle the issue is the fact that government policies relating specifically to the promotion of employee voice were (DoH, 2013) and are still (King's Fund, 2019) disjointed and complex. Post-

Francis policies on employee voice have been, for the most part, top-down and have failed to grapple with the complex care home environment (Pyper, 2014). Donaldson-Feilder et al. (2014) also detailed the complex nature of care organisations, which all have 'distinct cultural habits' which need to be taken into consideration when considering culture change aimed at promoting employee voice. Indeed, this study has shown that what voice means may differ in different contexts; thus, this additional layer of complexity also needs to be accounted for by allowing adequate flexibility when future policies are developed.

From my research, distinct cultural habits such as the micro-level considerations detailed in the previous sections of this chapter were also present at the unit level; thus it is not farfetched to propose that it would be the same between different care homes (Donaldson-Feilder et al., 2014). Although it is acknowledged that such distinct cultural habits will differ from care home to care home, I propose then that future care home policies should acknowledge organisational differences (Skills for Care, 2017; NHS England, 2018), and accommodate a multi-level understanding of cultures (Sinclair et al., 1993; Killett et al., 2012; Thomas Pocklington Trust, 2015). Indeed, this approach would not bring a complete stop to care home organisational failings, but it would start to appreciate the more localised nature of failings, thus encouraging solutions to also be localised.

7.4.2 National-level leadership training for frontline managers within care homes on how to cultivate open learning environments which facilitate employee voice

From my research, unit managers emerged as the gatekeepers of employee voice on their units and also as being influential in shaping their units' culture. In CS1 I detailed the role played by the unit manager in creating the family culture, and in CS2, the role the unit manager played in galvanising frontline staff to form cliques. From my research, it was evident that front line managers played a significant role in shaping all aspects of the working environment, but yet such managers had not been provided with any formal leadership training on how best to facilitate employee voice within the working environment (Moeini et al., 2019). I, therefore, put forward the recommendation that there should be policy-level initiatives aimed at training such managers in effective leadership skills, to deal with the internal and external pressure associated with managing care homes and facilitating employee voice (Havig & Hollister, 2018; Surr et al., 2019).

According to Mannion & Davis (2018), effective leadership training is an important component in any healthcare organisations efforts to improving its culture. In their research, Mannion & Davis (2018), found that positive culture shifts were more likely in healthcare environments in which employees felt that there was a learning environment and leaders were participating in this learning. This is a view shared by Tyler et al. (2014), who also suggested that the provision of training would, amongst other things, improve communication skills and result in more effective managerial practices. All of which Tyler et al. (2014) argue would go some way to enhancing cultures of communication within such organisations which follows the data gathered during this study. The cultivation of open voice cultures cannot happen accidentally. I argue, what is required is the implementation of tested approaches to leadership training, especially for frontline managers within care homes.

According to Goodwin (2019), organisational culture change within the health and social care context has a predisposition towards focusing on attitudes and behaviours of individuals at the lowest level of an organisation's hierarchy. This is the view shared by Miller et al. (2013), who also points out that it is those same people within the organisation who have the least decision-making power. Moreover, while frontline staff hold a great deal of clinical know-how especially within the health context, they are usually unable to persuade those higher up the hierarchy to act (Miller et al., 2013; Goodwin, 2019). This analysis resonates with comments from participants within this study who consistently mentioned the lack of decision-making power they had even on issues which they were most suited to comment on, such as the delivery of care. Although this is not a favourable position, it is important to acknowledge its existence and to implement training for those frontline managers so as to expose them to the importance of cultivating open learning environments which facilitate employee voice.

From the data in chapter five, it was evident that there was a disconnect between frontline staff and management on several key issues relating to culture and voice. For example, in relation to the home's open-door policy, it emerged that managers were out of touch with the views of frontline staff as to their effectiveness, which created a disconnect between staff and managers. In addition, comments from participants such as CS1-N1 indicated that there was a perspective among frontline staff that management did not know how to lead or communicate with staff effectively, resulting in a further disconnect between frontline staff and management which reflects the perspective taken by

Moeini et al. (2019) during their study. Surr et al. (2019) also contributed to this perspective by concluding that training was an important consideration in the improvement of leadership skills within the care home. From this date, it can be argued that more training especially in relation to communication would have helped bridge the gap between frontline staff and the management and would have helped in alleviating the disconnected culture within the care home.

From the data, good leadership within the care home context comprises characteristics such as showing staff respect (CS1-CA1), listening to staff and acting on their concerns (CS2-N2), and leaders who are willing and able to effectively interact with staff (CS2-CA7). These participant perspectives are backed up by authors such as Havig & Hollister (2018) whose research also identified such characteristics within the health context. It is acknowledged that some managers may already possess such skills; indeed, I observed several occasions on which managers did exhibit such skillsets as those described by participants above. Despite this, such characteristics were not universal within the researched care home, and from the literature on care homes, it is possible to state that the same is the case across English care homes.

As such, the implementation of a national-level leadership training programme for frontline managers within care homes underpinned by some of the characteristics detailed in the study such as respecting staff, listening and acting, would I argue represent important efforts towards the cultivate open learning environments which facilitate employee voice (Waring et al., 2013; Jones, 2016). These characteristics may differ from care home to care home, due to the complex individualised nature of care home organisations, which is acknowledged (Baines et al., 2014a; Baylis & Perks-Baker, 2017). Through this study though, what has also become evident, is the need for such training and for it to be delivered not at the individual care home level which is normally the case, but rather, at a national level ensuring consistency and credibility (Cavendish, 2013; Dayan, 2017).

7.4.3 A minimum level of training for all staff on national policies and procedures relating to employee voice provided independently of the care home

The final policy-level recommendation to emerge from my data, and one which builds on the previous recommendation, is the need to implement a national-level training programme for all staff on how to effectively report concerns within the care home context (Hasson et al., 2014; Dayan,

2017; Moeini et al., 2019). This recommendation was born out of the data, which indicated that, for the most part, staff were not knowledgeable about national policies relating to employee voice. Furthermore, there were instances within my study in which care staff were punished for not following correct policies when reporting an incident, such as the case of CS1-N1, who had her probation extended by six months for not following correct procedures. In this instance, CS1-N1 was unaware of the correct processes and had not received an appropriate level of training to be fully informed as to what to do in such circumstances. CS1-N1 concluded that this experience would reduce her confidence to speak out in future (Van Dyne et al., 2003); thus I put forward the argument that policy initiatives aimed at improving the knowledge of care workers on the processes involved in voicing themselves would empower such workers to voice themselves in future (Department of Health, 2015).

Although in recent years steps have been taken to address the training inadequacies within the Social Care sector post-Francis (Powell, 2015; Argyle et al., 2017), my data shows such initiatives have not had the desired impact. From my analysis of policy documents relating to staff voicing their concerns, it was evident that such documents did little for employees' understanding of formalised processes involving voicing out within the home, which is something both CS1-CA6 and CS1-N2 have alluded to above. This lack of understanding of policies and procedures relating to employee voice among care staff also contributed to the disconnect between frontline staff and management within the care home. This disconnect was, according to the data, partly responsible for the unit-based culture within the care home and the subsequent influence that had on employee voice. According to Goodwin (2019), there continues to be a lack of learning at all levels within the healthcare context resulting in continued failings. To this end, I argue that new initiatives geared towards educating staff about policies and procedures relating to employee voice would increase learning, but in a way which can have practical benefits for staff who want to voice themselves.

I propose that one way this issue can be addressed is to have staff training specifically on national policies and procedures relating to employee voice independently of the care home thus subverting any impact of negative cultures within the care home. Although study participants such as CS1-CA4 and CS1-CA8 said that the training environment had provided them with a better understanding of employee voice, from my observations of these training sessions, they did not detail the processes

through which staff could raise concerns (Moeini et al., 2019), especially outside the home. Thus, although staff understood the concepts, the practical knowledge needed to implement this knowledge whilst following correct policies and procedures were lacking. This lack of application was something Tingle (2014) also detailed in chapter two; I argue this demonstrates the complex nature of internal policies around employee voice, which require simplification to become more accessible for all staff within care homes. Thus, efforts to have such training independent of individual care homes means all staff receive the same level of information, which is untainted by the cultural practices of individual care homes, which I argue to an extent, was evident within my study.

From my observations, the training environment was most effective when delivered by someone independent of the care home, because staff then felt more able to voice concerns and communicate ideas (Mannion & Davis, 2018; Moeini et al., 2019). This could mean staff going to an external provider or the external provider coming to the care home, but from the data, this was one of the characteristics which I identified in chapter five as contributing to the 'hub of voice and learning' within the training environment (Flynn et al., 2014; Surr et al., 2019). The need for independent facilitators of voice was a point which also emerged in CS2 in which participants such as CS2-CA4 called for managers who were independent of unit cultures to be brought in to provide voice to all staff. I, therefore, put forward the proposal that future training on employee voice should be delivered externally of the care home as a limiter to any possible negative voice cultures within specific care homes (Mannion & Davis, 2018). If this policy initiative were effectively implemented, I claim that it would contribute to the cultivation of open cultures within care homes.

I argue that this lack of external validation and internal appreciation has impacted on the subsequent cultures within the care home, which is in line with the views of Sinclair et al. (1993) detailed in chapter two. The views of CS2-CA4 who talked about being exposed to the low status of care workers on tv and radio and CS2-CA2 who talked about managers perceiving care staff as stupid are at the heart of this recommendation. Weiss & Morrison (2018) argue that the perception among participants of having a low status within society influences how staff interact and voice themselves, which from my observations was the case during this study. One way in which I propose this can be changed is if future care home policies work towards the professionalisation of the care industry through externally regulated training which is also delivered externally (Costa-Font et al., 2015;

Dixon-Woods et al., 2019). This would provide credibility to training an employee voice policy, reducing the stigma of working within the sector, and speaking out.

7.5 Limitations of the study

In undertaking qualitative research within the scope of fulfilling a PhD, it is acknowledged that this process would bring with it several limitations, one of the key limitations is associated to my *organisational culture and subculture analytical structure*. Although I put forward the argument that the above analytical structure positions similar care homes favourably to cultivate open care home cultures, it is acknowledged that this study was conducted in just one organisation. Thus, this study cannot be said to represent all types of care home, but my findings do align with the wider literature on culture, voice and care homes. The analytical framework developed for this study, although proven to be appropriate and very effective in furthering our understanding of the complexities associated with care home cultures, is just one of many such frameworks which could have been deployed (Schein, 1985; Schneider, 1999; Martin, 2001). It is possible that if this study had deployed a different analytical framework such as those detailed in chapter three from the international context, the ensuing results would have differed from those described above (Chapin, 2010; Banaszak-Holl et al., 2013).

Moreover, this study was only conducted at one-time point, although extensive in its ability to gather relevant data relating to employee voice and organisational culture, this study does not have another timepoint for reference. We have during the course of this study, further clarified the complex nature of organisational cultures, especially within the care home context (Schein, 2004; Morrison, 2011). With this in mind, an analysis of an organisations culture at only one timepoint may be seen as being problematic, given the fact that cultures are continuously evolving. This was something which I considered at the outset of this study and decided to implement the most comprehensive data collection procedure possible, given the limitations of this study. As such, it was possible to gain current and historical perspectives about employee voice and culture within the care home. This was achieved by asking participants to reflect on past and present experiences and undertaking a document analysis process which took account of historical documentation relevant of employee voice within the care home. Although this was not an absolute remedy, it did go some way towards limiting the impact of this constraint on the study.

The role of my intersubjectivity within the study was another potential limitation (Johnson & Duberley, 2007). According to Yin (2013), this meant I was bringing a degree of 'cultural baggage' to the study, which might have been a limitation. This is since my ability to analyse this data gained would be unique, and if compared to another researcher analysing the same data, it is highly likely that the results would be different (Bryman & Bell, 2007). Although this can be seen as a limitation, I did deploy what Johnson & Duberley (2007) refer to as the process of thinking about our own thinking through the employment of methodological reflexivity (Bryman & Bell, 2007) into my study. Despite this, it is important at this stage to acknowledge that this would not have guaranteed absolute objectivity; indeed, I have previously referred to this as a regulatory ideal (Guba & Lincoln, 1994).

The sample size of (30) for this study means that it does not claim to represent the perspectives of the diverse care home workforce. The aim of this study was to undertake a careful examination of the culture of one care home, which resulted in a noticeable amount of context specificity in relation to the examples given by participants. Although it was possible to relocate the recommendations which emerged from this study back into pre-existing knowledge (Carpiano & Daley, 2006), the study cannot claim full generalisability of the results. Indeed, throughout this chapter, I have made the point that the findings from this study may not represent all English care homes, but this study does represent a starting point from which to undertake further research.

7.6 Future research

As a result of this study, it has been possible to put forward direction for future studies which aim to build on this work. First, this study was only conducted within one English care home; thus I put forward the case that more research exploring the influence of care home cultures on employee voice should be conducted in care homes of different sizes (Skills for Care, 2017; Thorlby et al., 2018; The King's Fund, 2019). This, I argue, would enable us to understand better the impact of the care home business model on organisational cultures and employee voice, which is an area yet to be researched (Karwowski, 2019).

One of the limitations I discussed previously was the fact that my *Organisational Culture and Subculture Analytical Structure* was untested in other English care homes; thus I propose that future

studies should test this approach to analysing cultures within different care homes. Such tests would enable us to understand better the real impact of this analysis structure in exploring cultures within care homes. Although it proved useful within the care home researched, this may not always be the case within different types of care homes.

Additionally, I propose that given the number of different characteristics of organisational environments of learning to emerge from my study, it is right that future studies test these characteristics to determine the extent to which they facilitate and elevate voice to gain greater impact in care home organisational decision making (Francis, 2015; Jones, 2016). I propose that studies should also test a combination of different characteristics to determine which combination is most effective at facilitating employee voice and within which care home context are specific combinations effective.

The testing of my bottom-up approach to the cultivation of open care home cultures and the facilitation of employee voice is my final proposal for future research. This is an untested approach which has for the first time emerged from my study, thus testing its impact within different care home would enable us to better understand of the levels of this bottom-up approach are only relevant within this specific care home, or if they have resonance within broader English care homes. Together, I argue that the above future research directions provide a focused trajectory from which to proceed from this study.

7.7 Conclusions

Through this study, it has been possible to contribute to the literature by exploring for the first time, the influence of care home cultures on employee voice. This study has also been successful in answering the five key research questions to emerge from the literature, thus contributing to our understanding of culture and voice. The finding that within the English care home context, organisational cultures do indeed influence the willingness and ability of employees to voice themselves helps to bridge the key gap identified in the literature in chapters two and three. Furthermore, it has emerged that this relationship is a very complex one, comprising multiple macro and micro-level factors, all of which influence employee voice differently. Although for the most part participants had a uniform understanding of organisational culture as being the norms of an

organisation, their perspectives of the care home's culture differed significantly but could be mostly linked back to how participants had experienced the care home (*research question two*).

Participants' understanding of employee voice was linked to their perceived position within the home's hierarchy, which emerged as an important consideration within this care home. The facilitation of employee voice at the care home level centred on the training environment, whose characteristics largely removed the unit-based cultural barriers to facilitation of voice. At the unit level, the facilitation of employee voice was based around the inter-personal relationship participants had with each other and, more importantly, with their unit manager. On the other hand, factors mitigating against employee voice at the care home level related to the negative experience participants had with previous management regimes. Such experiences had outlived the managers and still impacted on participants, thus limiting their voice. At the unit level, factors mitigating against employee voice related to the way in which the managers of both units informally managed voice. In CS1, this was through her informal power, and in CS2, it was through the misrepresentation of participants' voice (*research questions one, three and four*).

This study concludes by putting forward three contributions, namely the undertaking of qualitative research exploring the influence of care home cultures on employee voice; the combination of Schein's theory of organisational culture with his views on pivotal and peripheral subcultures to create the *Organisational Culture and Subculture Analytical Structure* used to undertake this study; finally, identifying the relationship between the participants' perceptions of their position within the care home hierarchy and their subsequent understanding of employee voice. Together, I argue that these contributions do add to our knowledge and understanding of culture and voice within the care home context (*research question two*).

The practical recommendations of my study for care home organisations seeking to cultivate open organisational cultures and facilitate employee voice were three-fold. First, such organisations need to undergo what I referred to as a process of 'unlearning' those elements of an organisation's culture which contribute to silence. This was followed by what I argued was the need for Organisational Environments of Learning (OEL) as a way of facilitating employee voice and greater employee decision making. I finished this section by proposing that all care home organisations need to

establish a bottom-up approach to the cultivation of open cultures which takes account of the role of immediate line managers, group-level formations and the influence of informal hierarchies in shaping open cultures. From my data, it is possible to put forward the proposal that by proactively seeking to implement these practical steps care home organisations could go some way towards the cultivation of open cultures (*research question five*).

Finally, this study has put forward three policy-level recommendations, which I argued would contribute to the cultivation of open cultures and the promotion of employee voice within care homes in England. I have, in so doing, detailed the need for policymakers to acknowledge organisational differences and accommodate a multi-level understanding of care home cultures in their development of future employee voice policies. Furthermore, future policy initiatives should be geared towards the implementation of national-level leadership training for frontline managers, and finally, training for all care staff on national policies and procedures relating to employee voice. Together, these contributions and recommendations address all the research questions and literature gaps put forward by the study.

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Appendix

Appendix One: Analysis of 25 'inadequate' CQC care homes

Care Home Name	<i>Euxton Park Care Home</i>
CQC Inspection Area Failed	<i>Is the service was effective</i>
Analysis	<p>During the inspection of Euxton Park care home, Inspectors were informed that agency workers did not know how to 'put a feed up'. Staff members also reported that senior staff on occasions had to work over their shift hours because the home was regularly short-staffed. This is something that Kennedy (2014) explored during his report as a significant contributing factor to poor quality care.</p> <p>This inspection also found evidence that some complex health care tasks were delegated to staff members who were not qualified nurses (CQC, 2015b). In these circumstances, there must be robust systems in place to ensure the safety and quality of the care being provided. This was not evident, and practically demonstrates the effect of the unspecific job description of care workers which inevitably puts care quality at risk, and it can be said to have done so in this instance (Burns et al., 2013; CQC, 2015b).</p>
Care Home Name	<i>Marlborough Court</i>
CQC Inspection Area Failed	<i>Is the service effective</i>
Analysis	<p>During the inspection of Marlborough Court, employees were found not to have completed mandatory training that enabled them to meet peoples care and support needs. Employees were not receiving on-going supervision in their roles to make sure their competence was maintained. Willis (2012) commented on the inadequate training opportunities given to employees; the knock-on effects on patient care are evident within this report.</p>
Care Home Name	<i>Cold Springs Park Care Home</i>
CQC Inspection Area Failed	<i>Is the service effective</i>
Analysis	<p>The inspection of this service found that residents were not having their individual needs assessed or correctly identified before their admission to the home. As such, the home from the outset was not providing the right service for each of its residents.</p> <p>This inspection also found that consent and best interest decisions were not always done in line with the Mental Capacity Act 2005. Thus the individuals' rights were not being respected by this service.</p> <p>All this refers back to the notion of person-centred care. Research by Chenoweth et al. (2009) identified that person-centred care has a positive</p>

	<p>impact on residents and how agitated they are, especially within the care home context in which a large number of residents may potentially have dementia. Person-centred care was also identified by Burns et al. (2016) as an integral aspect of good quality care; this was not realised within this service, thus it cannot be surprising Cold Springs Park failed this inspection.</p>
Care Home Name	<i>The Oaks Private Residential Home</i>
CQC Inspection Area Failed	<i>Is the service effective</i>
Analysis	<p>The inspection of this care home, which had several residents with dementia found that there was a lack of colour to distinguish certain areas such as bathrooms and bedrooms. This is a very important element in the care of residents with dementia, according to Chenoweth et al. (2009). It was also observed that residents were not provided with adequate nutrition and hydration. There was a lack of finger food/ snacks for people, which is important for people living with dementia and people's dietary needs were not adhered to.</p> <p>The service was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People were not supported to make choices and decisions, and some people were unlawfully deprived of their liberty.</p> <p>The inspection team also identified that staff training and staff supervisions and staff appraisals were significantly overdue. This is seemingly a common trend among such failing care homes and could go some way to explaining why this service was not meeting its requirements to its service users.</p>
Care Home Name	<i>Mappleton House</i>
CQC Inspection Area Failed	<i>Is the service effective</i>
Analysis	<p>In their most recent inspection in July 2016, Mappleton care home was deemed to have been providing inadequate service. Although it did not fail all the inspection categories, about if the service was effective, Mappleton was found not to have been providing an effective service for its residents.</p> <p>This was due to a range of factors, including the fact that staff assisted residents without the appropriate training or supervision to do so.</p> <p>It was also noted that residents who could not make certain decisions were not always protected under the Mental Capacity Act 2005 and this led to people having restrictions placed upon them which may not have been needed.</p> <p>This service was also not sensitive to individual residents' nutrition needs, and it was observed that people were not supported to maintain their nutrition and hydration needs.</p>
Care Home Name	<i>The Swallows</i>
CQC Inspection Area Failed	<i>Is the service safe</i>

Analysis	<p>During the inspection of The Swallows, the service was identified to have not had adequate measures in place to protect people in the event of a fire. It was also noted that the service did not have sufficient numbers of staff to meet their needs during the night. There were insufficient numbers of staff to support people to safely exit the building in times of an emergency. Kingsmill (2014) touched on this during his report, and in this instance, the potential for serious consequences for residents cannot be underestimated. Indeed it is clear to see a relationship between low staffing and care safety, and although there is not a specific number of staff for each shift, it was evident that this service did not have enough staff to maintain a safe service.</p>
Care Home Name	<i>Cambridge Court Care Home</i>
CQC Inspection Area Failed	<i>Is the service safe</i>
Analysis	<p>This inspection team deemed this home as being inadequate based on the category that it was deemed to have not been a safe environment. Staff were observed to have been undertrained and did not know how or when to record incidents. Risk assessments were also observed not to have contained sufficient detail, with medications observed not to have been managed appropriately. This suggests a lack of adequately trained staff and management systems in place to make sure things were done in the correct manner. Staff numbers were also observed to have been inadequate to undertake the tasks at hand during that home, therefore having a direct impact on the care being provided (Kennedy, 2014).</p>
Care Home Name	<i>Clyde House</i>
CQC Inspection Area Failed	<i>Is the service safe</i>
Analysis	<p>This home was found not to protect the health, safety and welfare of their residents. According to the inspection team, the home provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008. This reflects back on the lack of effective leadership within this specific care home organisation, and the impact this has on care quality, which is something that Ham and Murray (2015) have also established. Thus it is clear that among other things, good leadership and organisation is needed to maintain a safe care environment, and when this is not present, Clyde House provides an example of what can happen to services.</p>
Care Home Name	<i>Holywell Home</i>
CQC Inspection Area Failed	<i>Is the service safe</i>
Analysis	<p>This home failed its inspection because it was not providing a safe environment for its residents.</p>

	<p>This was evident in the staff shortages identified by the inspection team. It was also observed that staff were not appropriately trained thus were not equipped to provide the care needed (CQC, 2015b). This view is shared by both Willis (2012) and Kingsmill (2014) and was reflected in both their reports into strategies for improving care home services.</p> <p>In this instance, the recommendations of such reports had not been taken into consideration; thus it was not able to provide a safe service for its residents.</p>
Care Home Name	<i>Eaton Lodge Nursing Home</i>
CQC Inspection Area Failed	<i>Is the service safe</i>
Analysis	<p>During their most recent inspection, this service was deemed to have been inadequate in the area of providing a safe service.</p> <p>This was because risks to service users had not always been identified, and action had not been taken to reduce risks. The inspection team also found that staff were not appropriately trained, and as such guidance was not provided about how to keep residents safe in an emergency.</p> <p>It was also uncovered that the provider's recruitment policy had not been followed consistently, gaps in employment had not been checked, and not all staff had completed a health declaration. Thus it was unclear if all the staff members were adequate for the job at hand, further calling into question the quality of care being provided.</p> <p>It was also uncovered that residents were not always protected from the risks of unsafe medicines management. This can be seen as referring back to the issue of training and a lack of leadership and management within that service.</p>
Care Home Name	<i>Beaufort Grange</i>
CQC Inspection Area Failed	<i>Is the service responsive</i>
Analysis	<p>This home was found to have not been consistently responsive, with residents not always receive care in line with their assessed needs. Care records were also observed not to have demonstrated a person-centred approach to care, which CQC (2011) had called for within all home a few years prior.</p> <p>This was evident in other care plans observed by inspectors, which did not always provide enough detail for staff on how best to support individual residents. As such, it is difficult to say that all residents were receiving the appropriate services.</p> <p>Again, in this instance, the issue of services not providing person-centred care can be seen as one of the biggest contributing factors as to why this service failed its inspection.</p>
Care Home Name	<i>Wordsworth House</i>
CQC Inspection Area Failed	<i>Is the service responsive</i>

Analysis	<p>This inspection picked up on the lack of consistency in the complaints processes within the home. The inspection also identified that a system to establish an effective investigation and evaluation of complaints was inadequate. <i>‘There was little evidence of the complaints or how they were dealt with despite evidence of complaints located in several different files in the home’.</i></p> <p>An example given to this effect referred to one record which had no evidence of the details surrounding the complaint other than the comments on actions taken to resolve.</p> <p>Another record identified concerns which had been raised with the home manager; however, again, these were incomplete. The inspection team also saw records of notes from the home manager to staff which indicted complaints relating to an activity undertaken by staff. However, again, there was no reference to the specific complaints.</p> <p>It is evident that the complaints process within this home was insufficient and lacking and credibility and ability to undertake its function (Francis, 2013).</p>
Care Home Name	<i>The Friendly Inn</i>
CQC Inspection Area Failed	<i>Is the service responsive</i>
Analysis	<p>This inspection found that care and support were not responsive to the resident’s individual needs and was provided in a task-orientated way. It was not evident people had been involved in planning their care. Opportunities for people to follow their interests or be involved in social activities were limited. This shows again the importance of person-centred care approaches in the delivery of good quality care, something which Burns et al. (2016) clearly identified in their research.</p> <p>The role of employee voice also come up in this inspection; it was observed that staff knew how to make a complaint if they wished to do so. However, some employees were not satisfied with how their complaint had been handled. It can be said that this potentially creates a situation in which employee complain externally.</p>
Care Home Name	<i>Drayton Village Care Centre</i>
CQC Inspection Area Failed	<i>Is the service responsive</i>
Analysis	<p>During this inspection, it was discovered that care plans were not written in a way that identified each person’s wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support. This draws on the notion of person-centred care which seems to be running through the majority of these reports regardless of which CQC category is being analysed</p> <p>This inspection also identified that the care home in question did have a complaints procedure, but some complaints had not been responded to in line with their own procedure. This demonstrates the disparity between policy and</p>

	practice within such organizational contexts, and also highlights the facts that policies alone are not sufficient in cultivating an environment in which employees have their voices listened to, and acted upon (Berwick, 2013; Cavendish, 2013).
Care Home Name	<i>Avon Lodge</i>
CQC Inspection Area Failed	<i>Is the service responsive</i>
Discussions	<p>The inspection of Avon Lodge found that residents care plans were not written in a way that was person-centred or tailored to meet the needs of individuals within that home. It also noted that relatives were not involved in creating residents care plans.</p> <p>This again draws on the issues associated with person-centred care, and the fact that it is an approach to care which requires all members of the care team to proactively engage in putting employees at the heart of the care they deliver. This was not the case within the care home.</p>
Care Home Name	<i>Ismeer</i>
CQC Inspection Area Failed	<i>Is the service well-led</i>
Analysis	<p>This service was deemed to have been inadequate on the grounds that it was not well-led. This was because the inspection team identified that although arrangements for the day to day running of the service had been put in place, there was no clear oversight or guidance from the provider's representatives. This created a lack of leadership within this care home, thus putting care quality at risk.</p>
Care Home Name	<i>Southfield Court Care Home</i>
CQC Inspection Area Failed	<i>Is the service well-led</i>
Analysis	<p>Good and effective leadership at all levels within healthcare organisations has been described by NHS England (2014) as essential in creating good quality care. As such, comments from relatives like "<i>There have been about three or four managers. I don't know who the manager is. I come here most days. It is terrible</i>" indicates that the service is not working as it should, and those who should know who is in charge did not. As such, in an emergency, it would be difficult to identify who was responsible for manage the situation.</p> <p>This home was also found to keep the low quality and inaccurate care records in relation to the care that was being delivered.</p> <p>The home was also found to have a large number of inexperienced staff working at the home which according to Kennedy (2014) has become commonplace but inevitably puts pressure on more experienced employees, and impacts on care quality.</p>
Care Home Name	<i>The Birches</i>

CQC Inspection Area Failed	<i>Is the service well-led</i>
Analysis	<p>This care home was found to have not been effectively led, with systems not being in place to assess, monitor and improve the quality of care. The home environment was also noted to have been poorly maintained, and a hazard to residents.</p> <p>Policies and procedures that were in place had not been reviewed regularly and did not reflect the current best practice or the changes in the law that governs health and social care services. This can be seen as other laps in the management of this home, which ultimately impacted the care being delivered because it was not up-to-date with best practice.</p>
Care Home Name	<i>Avenues South East - 4 Westhall Park</i>
CQC Inspection Area Failed	<i>Is the service well-led</i>
Analysis	<p>The inspection of this home identified some important factors relating to the running of this home. The systems in place to monitor the safety and quality of the home were deemed by inspectors to have been inadequate. In situations in which actions were identified, they were not subsequently followed up and acted on. As such, the lack of leadership within this home resulted in the degradation of services over time.</p> <p>Staff engagement and voice also come up during this inspection; it was noted that staff did not feel supported by the registered manager and attendance at staff meetings was poor. This can be seen in the context of employee voice, that is because employees did not feel supported; they chose to disengage with the formal processes within that home. Such instances tend to create situations in which employees feel that have no option but to express their views externally of their organization</p>
Care Home Name	<i>The Birches</i>
CQC Inspection Area Failed	<i>Is the service well-led</i>
Analysis	<p>This care home was found to have not been effectively led, with systems not being in place to assess, monitor and improve the quality of care.</p> <p>The home environment was also noted to have been poorly maintained, and a hazard to residents.</p> <p>Policies and procedures that were in place had not been reviewed regularly and did not reflect the current best practice or the changes in the law that governs health and social care services.</p> <p>This can be seen as other laps in the management of this home, which ultimately impacted the care being delivered because it was not up-to-date with best practice.</p>
Care Home Name	<i>Kathryn's House</i>
CQC Inspection Area Failed	<i>Is the service caring</i>

Analysis	<p>The inspection team identified within this home that residents were woken up at an unreasonable time and personal care needs were not met in a dignified way. This also points to a degree of institutional practice within this home. People were not always spoken to respectfully. Residents were also not involved in planning and reviewing the care they received. This observation again points to the issue of person-centred care or the lack of it within this home, and the effects it has had on care quality and the ability and or willingness of employees to care for their residents appropriately.</p> <p>This is even though the main aim of this service is to care for its resident, most of whom have paid for that service.</p>
Care Home Name	<i>Harker Grange Nursing Home</i>
CQC Inspection Area Failed	<i>Is the service caring</i>
Analysis	<p>This nursing home was one if very few to be deemed inadequate on all five of the CQC inspection criteria. In relation to if the service was caring, that service was deemed to not have been caring, especially in relation to taken resident's privacy into consideration.</p> <p>It was observed that there was no mention of privacy or dignity in any of the 'room risk plan of care' documents.</p> <p>The inspection team noted that '<i>these documents did not reflect the individual needs and preferences of the people sharing rooms</i>'.</p> <p>Again, in relation to privacy, the inspection team on two occasions witnessed one person using a commode in their bedroom and another person using their commode as a seat, in full view of anyone passing their rooms. Staff continued with their normal daily duties and gave no thought or consideration to the privacy and dignity of the residents in question as if this was a normal occurrence.</p> <p>This was deemed to have been in breach of the Health and Social Care Act 2008 Regulations 2014 Regulation 10 Privacy and Dignity. As such, this service failed, but it is also evident that a failure on behalf of the home to appropriately take individual needs into consideration led to this inspection outcome.</p>
Care Home Name	<i>Chilton Meadows Residential and Nursing Home</i>
CQC Inspection Area Failed	<i>Is the service caring</i>
Analysis	<p>This service was another to be deemed inadequate on all five of its inspection areas. In relation to if the service was caring, this service was deemed not to have been caring.</p> <p>It was observed that staff did not always treat residents in a caring and compassionate manner and were observed on several occasions to have ignored the requests of residents for help.</p> <p>As such, the inspection team concluded that positive relationships were not established between employees and residents within this service.</p>

	The inspection team also identified that a culture of kindness and compassion was not promoted by the service, and that poor practice was not addressed by unit managers. As such, a negative culture was allowed to flourish in which poor quality care becomes normalized, thus it is unsurprising that this service failed in all areas.
Care Home Name	<i>Evergreen Residential Home</i>
CQC Inspection Area Failed	<i>Is the service caring</i>
Analysis	<p>The Evergreen Residential home was another to fail its most recent inspection on all five of the CQC's inspection area. The service failed about being caring because it was deemed that the staff used institutionalized practices which did not show respect for people's privacy and dignity. Such as residents being left for long durations, and failing to engage with residents at any point during the shift, most of whom had dementia.</p> <p>This service had been in breach of Regulation 10 about privacy and dignity at the inspection in January 2015. This inspection found that not much had changed since then, care workers were noted as saying that that they started 'getting everyone up' at 5 or 6 am. Which can also be seen as institutional abuse</p> <p>The serves were noted to have had volunteer activities organiser but the person only came from time to time, as such, there were no organised activities which were meaningful to people who used the service. Thus it can be said that the service did not cater to the specific needs of its service users.</p>
Care Home Name	<i>Wentworth Croft Residential and Nursing Home</i>
CQC Inspection Area Failed	<i>Is the service caring</i>
Discussions	<p>It was observed during this inspection that the leadership within this home did not support staff to be caring (NHS England, 2014). The inspection team observed that staff had little or no time to interact positively with the residents they were supporting.</p> <p>It was also observed that some staff had adopted a task-orientated approach to care and support to deliver the assistance required. The team also spoke to a staff member who admitted that low staffing numbers were having a detrimental impact on the daily functions of the home.</p> <p>Relating this to the positive effects that person-centred care has been shown to have on care quality and promoting employee voice and autonomy, it is little wonder that this home failed its inspection in the area of not being caring (Burns et al., 2016).</p>

Appendix Two: Care Home Information Sheet



Research Information Sheet for Care Homes

Title of Research Project: ***A comparative case study analysis into the micro-level negotiation and enactment of 'speaking out' in adult social care***

Name of Researcher: Albert Attom

Invitation to participate in the above research study

I would like to invite (name of care home) to take part in my research study, which forms part of my PhD. I have produced the following information sheet to outline the nature and scope of this study. It is hoped this will help your organisation understand how and why I am undertaking this research study.

Why has this care home been invited to take part?

This care home has been invited to participate in this study because it meets the criteria set out in my research methodology, which is based on different types of business model operated by the care home.

What is the study about?

This study aims to explore the role of workers voice in care homes. Worker's voice refers to worker's expressing their opinions and views about care, their jobs and other issues and the influence this has within care homes. To do this, I would like to find out how worker's voice is understood in a range of care homes and the role it can have in the care provided and how this understanding influences how workers express themselves.

This study will also look at how the organisational characteristics of care homes can support or prevent the worker's voice, as well as how the voices of workers can be enhanced.

The study will also explore how worker's voice can be elevated, to give employees more impact within care homes.

What will happen if this home chooses to take part?

After agreeing to participate, I will provide the home and all potential participants (management and care staff) with detailed information about the research project. This will be undertaken in three ways; (1) I would like to discuss and plan the scope of the study with management and resolve any concerns the home may have about participating in the study. (2) I would then aim to inform potential participants about the study through several methods such as holding information sessions, talking at training sessions, produce a

detailed observation and interview information sheet and utilising any other information dissemination mechanisms within the home. This is to provide potential participants with as much information as possible and also give them a chance to think about participating and ask any questions they may have. (3) Those who wish to participate in the study would then be asked to sign a consent form indicating that they understand and agree with all the terms of the study.

What types of questions will staff members be asked during the interviews?

The interview will cover topics about how the care home works and the role and input of worker's voice in the day to day work of the home. At the end of the interview, employees will be allowed to discuss any aspect of voice they think are important but were not covered. The interview will be recorded with two audio recording devices just in case one fails to work and would be approximately 30-60 minutes. Anonymity and confidentiality will be maintained for all participants. However, if a member of staff raises issues regarding the safeguarding of residents, the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report it to the appropriate person.

What will be observed?

Observations will centre on staff voice and communication and will cover specific areas of the home such as staffrooms, staff smoking areas, care home reception area, managers and administrator's offices, staff training rooms. These areas and situations in which observations would take place will be negotiated with the care home manager and would be recorded with field notes.

What are the possible risks of taking part in this study?

We do not think there will be any risks to the home or any participant who takes part in this study. However, it is possible that some participants may find recollecting past events about voicing themselves at work during the interviews emotionally challenging. The questions asked during the interview have been designed so that they can say as little or as much as they wish. Participants will not be asked to answer questions they feel uncomfortable with, and they are able to decline to answer any question they don't want to answer without giving a reason why.

What are the possible benefits of taking part?

The aim of this study is to develop an understanding of the role of worker's opinions and views in the provision of care in different care home settings.

As such, although the benefits of taking part may not be immediate, there is potential for this study to have a beneficial impact on promoting and strengthening employee voice in care homes in the future.

Will the information gained from this care home be confidential?

Yes, all information provided as part of this study will be kept safe and confidential at all times, apart from when the information raises safeguarding concerns of residents. The UK Data Protection Act 1998 will be applied to this study, thus all the personal information gained during interviews will be kept locked on my computer within the University of Sheffield premises. Computer-based information will be stored using password protected files.

What will happen to the information gained from the study?

The information gained from this study will be used as part of my PhD thesis. Information will also be used for future publications and to develop recommendations relating to the promotion of employee voice within care home settings.

What if I have any issues during or after I participate in the study?

If you have any problems relating to you taking part in this study, please do feel free to contact me, or my research supervisors on the following details:

Albert Attom
Doctoral Centre
169-171 Northumberland Road
Sheffield, S10 1DF
aatom1@sheffield.ac.uk

Research Supervisors:
Dr Diane Burns
Sheffield University Management School
1 Conduit Road, Sheffield
S10 1FL
[44 \(0\) 114 222 3216](tel:44%20114%20222%203216)
d.burns@sheffield.ac.uk

Thank you for reading this information sheet, if you have any further questions relating to participating, please let me know

Appendix Three: Care Home Consent Sheet



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Care Home Case Study Consent Form

Title of Research Project: *A comparative case study analysis into the micro level negotiation and enactment of 'speaking out' in adult social care*

Name of Researcher: Albert Attom

Please initial the following boxes if you agree with the statement

1. I confirm that I have **read** and **understand** the information sheet dated (___ / ___ / ___) explaining the above research project and I have had the opportunity to **ask questions** about the project.

2. I understand that the participation of our care home in this research is **voluntary**.

3. I understand that anonymity and confidentiality will be maintained during this study. However, if the researcher was to observe any instances in the home that raises safeguarding concerns of residents the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report the details to the appropriate person.

4. I give permission for members of the research team to have access to all information collected as part of this project. I understand that this care homes name will not be linked with the research materials, and I will not be identified or identifiable in the PhD thesis report or reports that result from the research.

5. I **consent** to the participation of this care home in the above research project.

6. I **consent** to all the methodological processes (non-participatory observations, interviews, Documentary analysis) being employed by the researcher during this project.

Name of Manager

Date

Signature

Name of researcher

Date

Signature

Appendix Four: Observation Information Sheet for Participants



Care Home Observation Information Sheet

Title of Research Project: A comparative case study analysis into the micro-level negotiation and enactment of 'speaking out' in adult social care

Name of Researcher: Albert Attom

Invitation to participate in the above research study

I would like to invite you to take part in my research study, which forms part of my PhD. It is important to note that you should only take part in this study if you wish to do so and that you will not be disadvantaged in any way by choosing not to take part. Before deciding if you would like to take part in this study, please read all the information provided on this information sheet, and ask any question you may have relating to participating in the observations.

If you chose to take part, you would be required to sign a consent form indicating that you have read and understood all the information relating to this study and that you are willing to participate.

What is the study about?

This study aims to explore the role of workers voice in care homes. Worker's voice refers to worker's expressing their opinions and views about care, their jobs and other issues and the influence this has within the care home. To do this, I would like to find out how worker's voice is understood in a range of care homes and the role it can have in the care provided and how this understanding influences how workers express themselves.

This study will also look at how the organisational characteristics of care homes can support or prevent the worker's voice, as well as how the voices of workers can be enhanced.

The study will also explore how worker's voice can be elevated, to give employees more impact within care homes.

Why have I been invited to take part?

You have been invited to take part in this study because you are an employee of a care home that has agreed to be involved in this study, and your job role involves providing care for residents.

Do I have to take part in this study?

You have no obligation to take part in this study, and you will not be disadvantaged in any way by choosing not to take part. Also, if you choose to take part in the observations, you are free to change your mind at any point. If you decide to withdraw from the study, all the information you have provided will be destroyed and will not be used.

What will happen if I choose to take part?

All participants will be provided with a consent form that you will be asked to sign. You will be allowed to consider taking part and to ask any questions you might have about the research and taking part in the care home observation.

What will I be observing?

During the study, I will be observing specific areas of the care home in which staff may be present. These will be areas where employees engage in day-to-day activities within the home, such as situations where employees voice themselves or speak out, such as handovers, staff meetings and training sessions. I will use field notes to record only information which is relevant to this study. All content recorded as part of this observation process will be anonymous. I will seek to strike a balance between engaging with and observing participants who have agreed to participate while respecting the rights of those who have declined to be observed.

I will not be observing any caregiving or interactions you may have with service users at any time.

What are the possible risks of taking part in this study?

There are no foreseeable risks associated with you participating in the observations. This is because all information gathered will be anonymised. Any information collected, which makes it possible to identify participants, will also be removed; pseudonyms will also be used to anonymise participants. If some members of staff still do not want me to be present during specific meetings, I will withdraw myself from that meeting.

What are the possible benefits of taking part?

This study aims to develop an understanding of the role of worker's opinions and views in the provision of care in different care home settings.

As such, although the benefits to you of taking part may not be immediate, there is potential for this study to have a beneficial impact on promoting and strengthening employee voice in care homes in the future.

Will the information I give be confidential?

Yes, anonymity and confidentiality will be maintained. However, if a member of staff raises issues regarding the safeguarding of residents, the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report it to the appropriate person.

Personal information about you (your name and other identifying details) you provide during the interview will be anonymised.

The UK Data Protection Act 1998 will be applied to this study, thus all the personal information gained during interviews will be kept locked on my computer within the University of Sheffield premises. Computer-based information will be stored using password protected files.

What will happen to the information gained from the study?

The information gained from this study will be used as part of my PhD thesis. Information will also be used for future publications and to develop recommendations relating to the promotion of employee voice within care home settings.

What if I have any issues during or after I participate in the study?

If you have any problems relating to you taking part in this study, please do feel free to contact me, or my research supervisors on the following details:

Albert Attom
Doctoral Centre
169-171 Northumberland Road
Sheffield
S10 1DF
aatom1@sheffield.ac.uk

Research Supervisors:
Dr Diane Burns
Sheffield University Management School
1 Conduit Road,
Sheffield
S10 1FL

Thank you for reading this information sheet, if you have any further questions relating to participating, please let me know

Appendix Five: Observation Consent Sheet



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Care Home Observation Consent Form

Title of Research Project: A comparative case study analysis into the micro level negotiation and enactment of 'speaking out' in adult social care

Name of Researcher: Albert Attom

Please initial the following boxes if you agree with the statement

1. I confirm that I have **read** and **understand** the information sheet dated (___ / ___ / ___) Explaining the above research project and I have had the opportunity to **ask questions** about the project.
2. I understand that my participation in the observations is **voluntary** and that I am free to **withdraw at any time** without giving any reason and without there being any negative consequences
3. I understand that anonymity and confidentiality will be maintained during the observation. However, if a member of staff raises issues regarding the safeguarding of residents the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report it to the appropriate person.
4. I give permission for members of the research team to have access to the observation notes.
5. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the PhD thesis and any publications that arise from it.
6. I agree to take part in the above research project, and understand that field notes will be Taken.

Name of Participant

Date

Signature

Name of researcher

Date

Signature

Appendix Six: Interview Information Sheet



Interview Information Sheet for Care Homes

Title of Research Project: **A comparative case study analysis into the micro-level negotiation and enactment of 'speaking out' in adult social care**

Name of Researcher: Albert Attom

Invitation to participate in the above research study

I would like to invite you to take part in my research study, which forms part of my PhD. It is important to note that you should only take part in this study if you wish to do so and that you will not be disadvantaged in any way by choosing not to take part. Before deciding if you would like to take part in this study, please read all the information provided on this information sheet, and ask any question you may have relating to participating in an interview.

If you chose to take part, you would be required to sign a consent form indicating that you have read and understood all the information relating to this study and that you are willing to participate.

What is the study about?

This study aims to explore the role of workers voice in care homes. Worker's voice refers to worker's expressing their opinions and views about care, their jobs and other issues and the influence this has within the care home. To do this, I would like to find out how worker's voice is understood in a range of care homes and the role it can have in the care provided and how this understanding influences how workers express themselves.

This study will also look at how the organisational characteristics of care homes can support or prevent the worker's voice, as well as how the voices of workers can be enhanced.

The study will also explore how worker's voice can be elevated, to give employees more impact within care homes.

Why have I been invited to take part?

You have been invited to take part in this study because you are an employee of a care home that has agreed to be involved in this study, and your job role involves providing care for residents.

Do I have to take part in this study?

You have no obligation to take part in this study, and you will not be disadvantaged in any way by choosing not to take part. Also, if you choose to take part, you are free to change your mind at any point. If you decide to withdraw from the study, all the information you have provided will be destroyed and will not be used.

What will happen if I choose to take part?

All participants will be provided with a consent form that you will be asked to sign. You will be allowed to consider taking part and to ask any questions you might have about the research and taking part in the research interview.

What types of questions will I be asked in the interview?

The interview will cover topics about how the care home works and the role and input of worker's voice in the day to day work of the home. The interview will be recorded with two audio recording devices just in case one fails to work. At the end of the interview, you will be allowed to discuss any aspect of voice you think are important but were not covered. The interview would last approximately 30-60 minutes, depending on staff time.

What are the possible risks of taking part in this study?

We do not think there will be any risks to you if you take part in this study. However, it is possible that you may find recollecting past events about voicing yourself at work to be emotionally challenging. The questions asked during the interview have been designed so you can say as little or as much as you wish. You will not be asked to answer questions you feel uncomfortable with, and you are free to decline to answer any questions you don't want to answer and without giving a reason why.

What are the possible benefits of taking part?

This study aims to develop an understanding of the role of worker's opinions and views in the provision of care in different care home settings. As such, although the benefits to you taking part may not be immediate, there is potential for this study to have a beneficial impact on promoting and strengthening employee voice in care homes in the future.

Will the information I give be confidential?

Yes, anonymity and confidentiality will be maintained. However, if a member of staff raises issues regarding the safeguarding of resident, the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report it to the appropriate person.

Personal information about you (your name and other identifying details) you provide during the interview will be anonymised.

The UK Data Protection Act 1998 will be applied to this study, thus all the personal information gained during interviews will be kept locked on my computer within the

University of Sheffield premises. Computer-based information will be stored using password protected files.

What will happen to the information gained from the study?

The information gained from this study will be used as part of my PhD thesis. Information will also be used for future publications and to develop recommendations relating to the promotion of employee voice within care home settings.

What if I have any issues during or after I participate in the study?

If you have any problems relating to you taking part in this study please do feel free to contact me, or my research supervisors on the following details:

Albert Attom
Doctoral Centre
169-171 Northumberland Road
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Research Supervisors:
Dr Diane Burns
Sheffield University Management School
1 Conduit Road, Sheffield
S10 1FL
[44 \(0\) 114 222 3216](tel:44%20114%20222%203216) d.burns@sheffield.ac.uk

Thank you for reading this information sheet, if you have any further questions relating to participating, please let me know.

Appendix Seven: Interview Consent Sheet



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Care Home Interview Consent Form

Title of Research Project: *A comparative case study analysis into the micro level negotiation and enactment of 'speaking out' in adult social care*

Name of Researcher: Albert Attom

Please initial the following boxes if you agree with the statement

1. I confirm that I have **read** and **understand** the information sheet dated (___ / ___ / ___) explaining the above research project and I have had the opportunity to **ask questions** about the project.

2. I understand that my participation is **voluntary** and that I am free to **withdraw at any time** without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.

3. I understand that anonymity and confidentiality will be maintained during the interview. However, if a member of staff raises issues regarding the safeguarding of residents the researcher will be obliged to follow the safeguarding procedures in operation in the care home and report it to the appropriate person.

4. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the PhD thesis report or reports that result from the research.

5. I agree to take part in the above research project.

6. I agree to have the information I provide during my interview recorded by audio recording equipment.

Name of Participant

Date

Signature

Name of researcher

Date

Signature

Appendix Eight: Unstructured, overt, non-participatory observations
strategy for case study one and two

<i>Case Study One Events</i>	<i>Times of Observation</i>	<i>Case study Two Events</i>	<i>Times of Observation</i>
The transition between day staff and night staff	07:45-08:15	Smoking area and staff room before the start of the shift	07:30-08:00
official handover would take place between the night nurse and the day staff	08:14-08:45	The day staff have very formal handovers.	08:15-08:40
staff would congregate in the kitchen and have an informal conversation about how the shift was going	11:00-11:20	Lunchtime for residents was another time in which employees would engage in informal conversations	12:30-13:30
Staff would have lunch together, this would normally take place on the unit	13:30-14:30	Staff would take it in turns to go off the unit and have lunch in their teams of two	13:00-14:30
This was a quiet time when staff would congregate in the nurse's station and have informal conversations	16:30-17:00	Staff on the unit more informal and willing to engage in conversations with others	13:00-14:00
Informal handovers between staff and nurses, and also interactions between day and night staff	19:45-20:15	Staff have break time in teams of the unit	18:00-18:30
Night staff have informal handover and chat in the nurses' station	20:15-20:45	Night staff arrive and have handover from day nursing team	19:45-20:15
Night staff have informal chat after work has been finished	22:00-22:45	Informal conversations and handover between night staff before work starts	20:15-21:30
Quiet point in the shift, staff engage in a number of different informal acts	02:00-06:00	Quite time of the shift, fewer interactions between staff that in CS1	03:00-06:30

such as watching TV and listening to music together			
Total	142	Total	127

Appendix Nine: Interview Times in Case Study One and Two

<i>Case Study One Participants</i>	<i>Interview Times</i>	<i>Case Study Two Participants</i>	<i>Interview Times</i>	<i>Management</i>	<i>Interview Times</i>
CS1-CA1	1:42:02	CS2-CA1	41:52	NUM	53:59
CS1-CA2	31:14	CS2-CA2	48:15	CNM1	52:18
CS1-CA3	41:22	CS2-CA3	45:09	HM1	1:18:21
CS1-CA4	54:30	CS2-CA4	1:00:06		
CS1-CA5	48:01	CS2-CA5	48:55		
CS1-CA6	1:27:08	CS2-CA6	44:45		
CS1-CA7	1:40:17	CS2-CA7	31:56		
CS1-CA8	53:23	CS2-CA8	30:06		
CS1-CA9	39:12	CS2-TL1	47:39		
CS1-TL1	48:47	CS2-N1	29:27		
CS1-N1	1:10:57	CS2-N2	1:13:09		
CS1-N2	46:59	CS2-N3	48:01		
CS1-N3	1:10:12	CS2-UM1	1:02:33		
CS1-UM1	1:30:06				
<i>Total</i>	<i>883.22 min</i>	<i>Total</i>	<i>611.88 min</i>	<i>Total</i>	<i>184.63 min</i>

Appendix Ten: Initial codes from the data analysis process

<i>CS1 Codes</i>	<i>Number of Documents</i>	<i>Number of References</i>	<i>CS2 Codes</i>	<i>Number of Documents</i>	<i>Number of References</i>	<i>Care home codes</i>	<i>Number of Documents</i>	<i>Number of References</i>
Action	3	14	Abuse of voice	11	16	Access to management	11	20
We are one	3	26	Teamworking	21	29	Talking to managers	5	34
Care quality	7	20	Communication	17	33	Action	4	27
Confidence	4	16	Clash	7	23	Beaing heard	6	34
Collective voice	15	47	Black box	3	28	Business	6	26
Communication	23	83	Charts and checks	5	16	Care worker experince	4	20
Nursing station	8	27	The favourates	9	19	Managers on units	7	36
Kitchen cupboard	4	17	The cool ones	15	34	Visability	4	44
Moulding staff	12	22	No real voice	15	31	Formal environemnt	19	56

Cultuer	36	76	Cultuer change	18	45	Care worker-management relationship	4	13
Hierarccy	22	32	Meetings	8	20	Command	8	6
Cultueral backgroud	11	31	Equality	6	21	Chain of command	3	21
Emotional consensus	19	36	Group dynamics	13	54	Change	12	54
Emotional controle	10	26	Handovers	12	48	Cultuer change	7	19
Empowerment	7	21	Informal communication	8	37	Dissemnation of information	9	23
Expert care	5	11	Narrative contrsution	18	35	Downward communication	18	32
Externally closed	8	16	Nurse-care worker communication	4	21	Financialisation	21	40
Financialisation	18	41	Informal power	10	27	Formal voice	27	43
Handovers	24	54	Professionals	4	32	Home cultuer	10	50

Informal voice	15	34	Speakign out	8	36	Informal voice	4	23
Informal punishment	13	36	Stigma on voice	4	19	Listening	21	43
Internally open	21	56	Teamwork	19	33	Opnennes	14	66
Opnnes	25	76	Time out to chill	7	53	Policies and proceduers	32	76
Power	9	31	Teams	21	76	Legacy	6	31
Social interractions	12	43	Trust	4	44	Speakign out	17	38
Staff autonomy	14	26	Undestanding voice	23	65	Team	9	14
Stigma on voice	8	29	Unit manager	11	54	Traning	19	17
Society	17	34	Ununited	7	38	Traning room	6	9
Teamwork	27	56	Unit leader	9	13	Undercurrent of controle	6	7
Close team	31	67	Experinced staff	8	17	No unity	10	24
The other units	13	27	Relationships	12	43	Negative voice	9	14

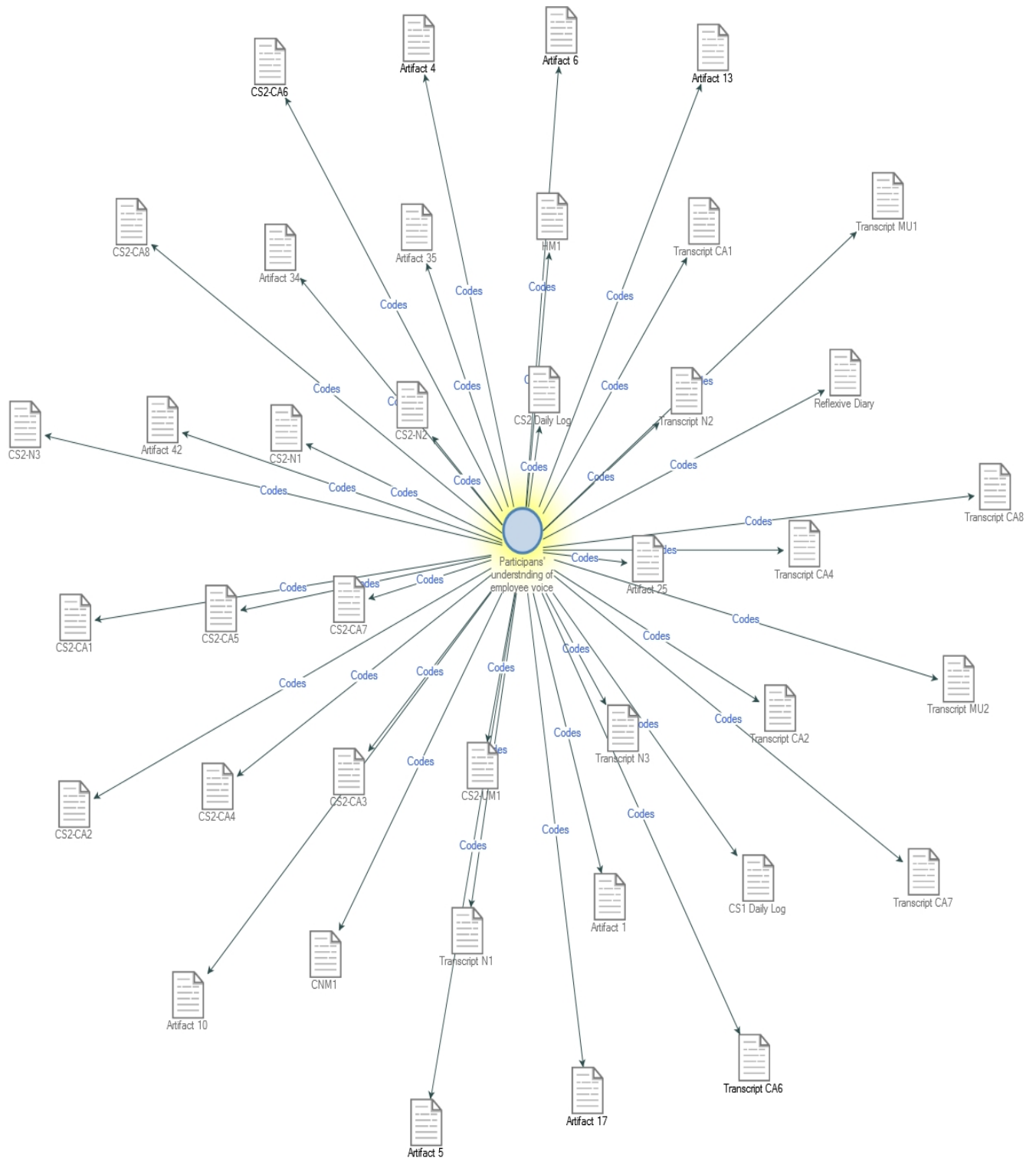
Transparency	12	23	Rota	6	23	The home manager	11	32
Togetherness	23	44	Outside the unit	4	21	External power	16	65
Unit manager	12	54	New staff	3	17	Voicing	33	56
Unit consensus	6	34	Smoking time	4	9	Working together	21	40
Unit leadership	11	25	Team leader	6	11			
Voice communication	9	22	Playing around	4	31			
Voicing out	7	17	Destress	5	29			
Working together	4	8	Voice to others	6	15			
Working environment	7	12						

Appendix Eleven: Initial themes from case study one, two and care home

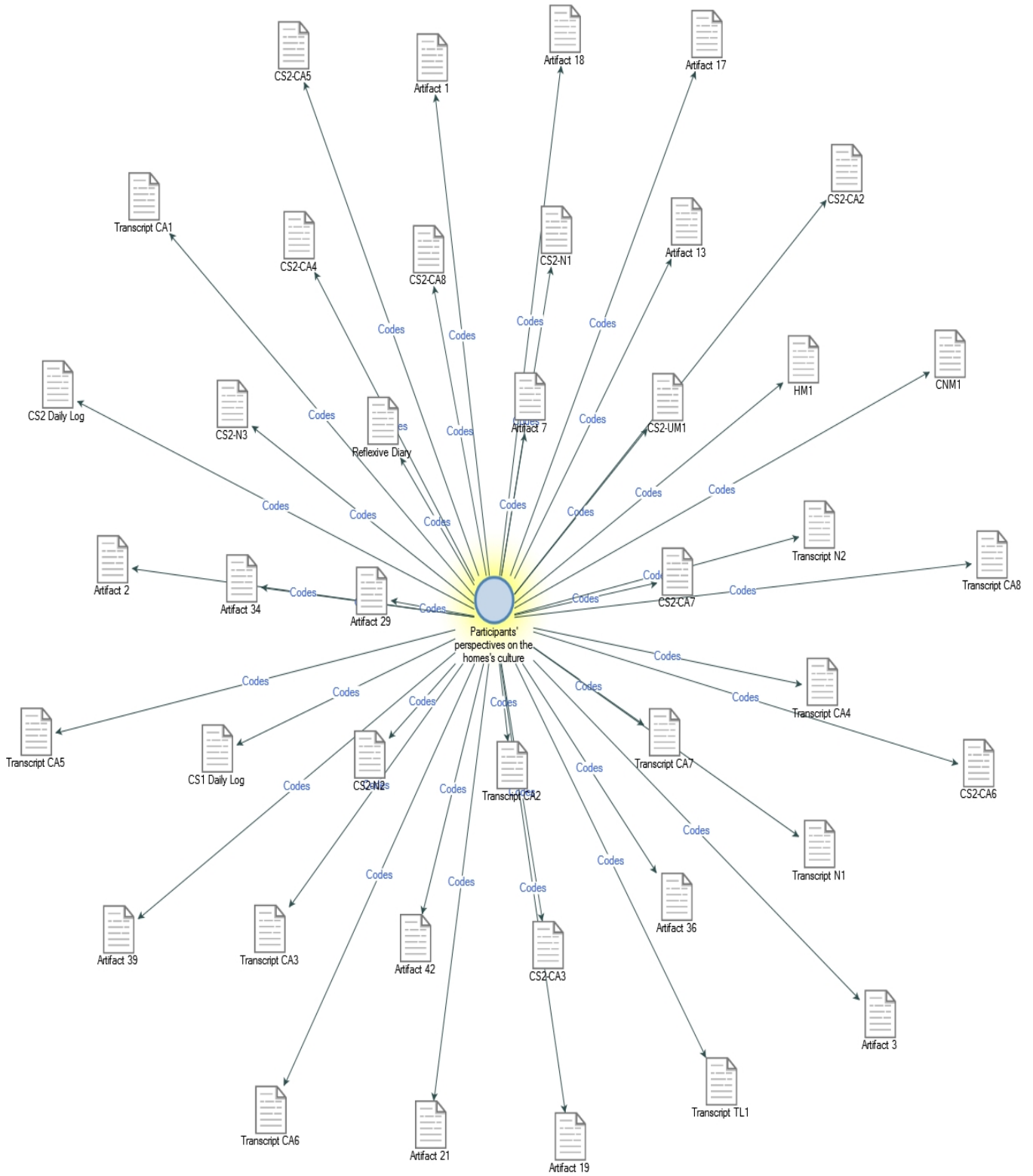
<i>Case Study One Themes</i>	<i>Number of Occurrences</i>	<i>Case Study Two Themes</i>	<i>Number of Occurrences</i>	<i>Care Home Themes</i>	<i>Number of Occurrences</i>
Family first	56	Inaction	27	Training and voice	43
Team unity	45	Negative formal communications	33	Legacy of old management	46
Togetherness	41	The groups	47	Policies and procedures on voice	67
Internally open to voice	31	Informal leadership and voice	57	Disconnected home	36
Externally closed to voice	24	Group formation	44	Profit motive	16
Information and voice	37	Unit manager and voice	50	Leadership not management	22
Handovers and voice	22	Trusted communication	35	Job quality and care quality and voice	37
Freedom to talk	19	Lack of formal voice	52	Voice is listening	49

External threat	18	The old staff	70	Voice is talking	27
Sense of belonging and voice	26	Longevity and informal power	57	Voice is acting	10
Emotional control	30	Informal voice	45	Culture is changing	18
Informal power	26	Informal power	23	Culture is norms	21
Leadership and voice	37	Cliques	29	Disconnected voice	63
One voice as a family	47			Formal hierarchy	48
Team sizes and voice	45			Informal hierarchy	35
The unit manager and voice control	58				

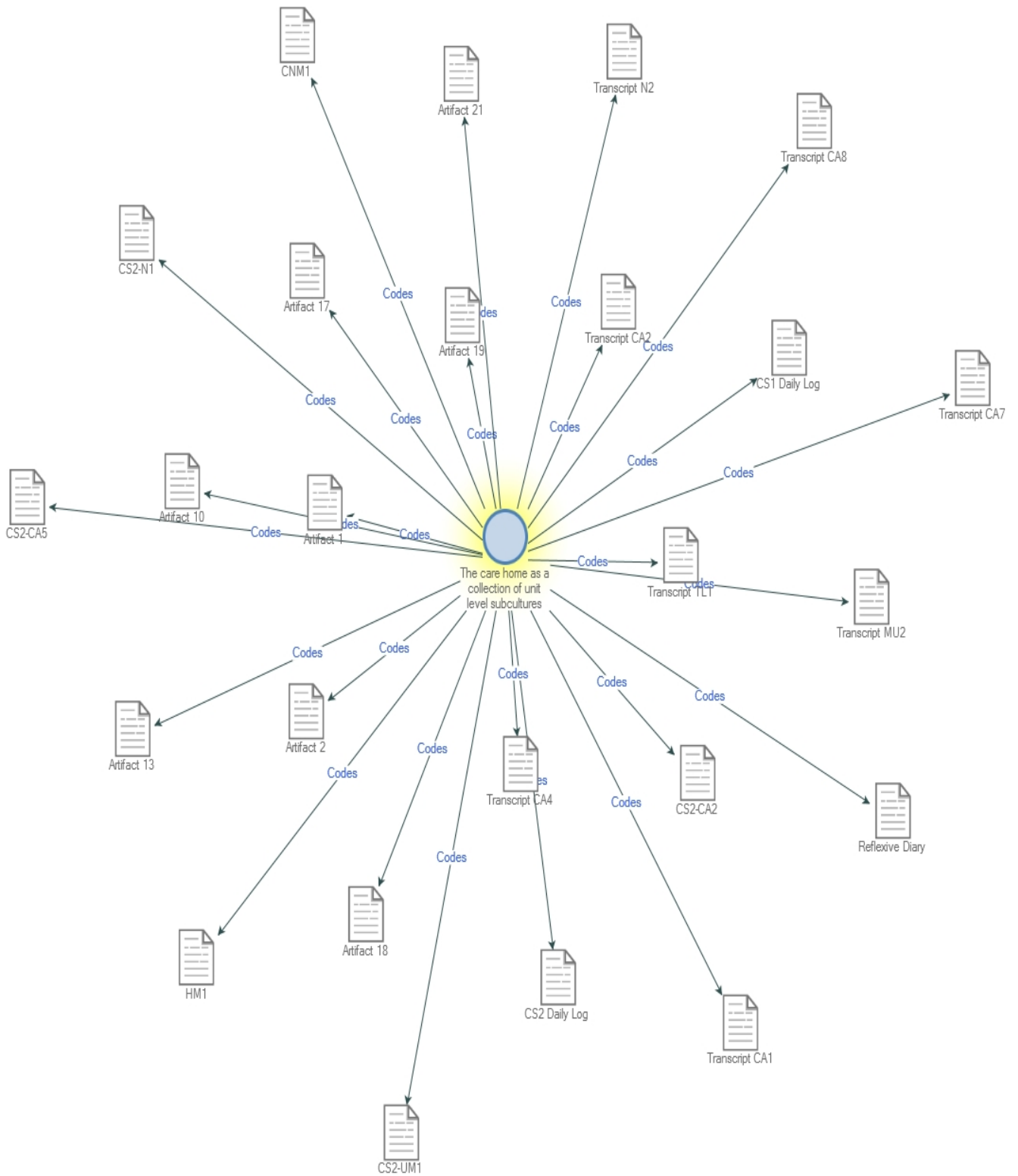
Appendix Twelve: Theme One; participants understanding of employee voice data distribution



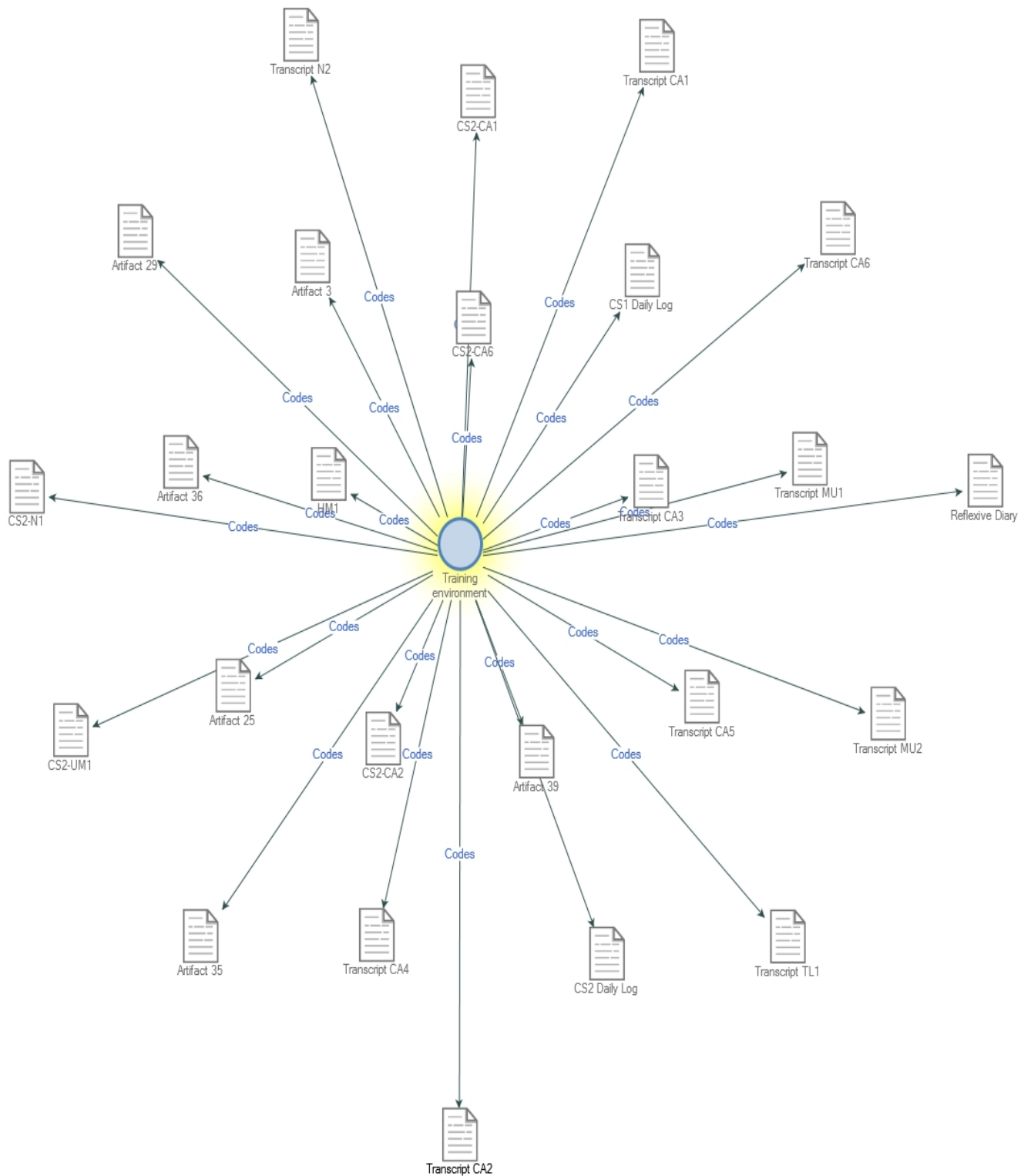
Appendix Thirteen: Theme Two; participants' perspectives on the home's culture data distribution



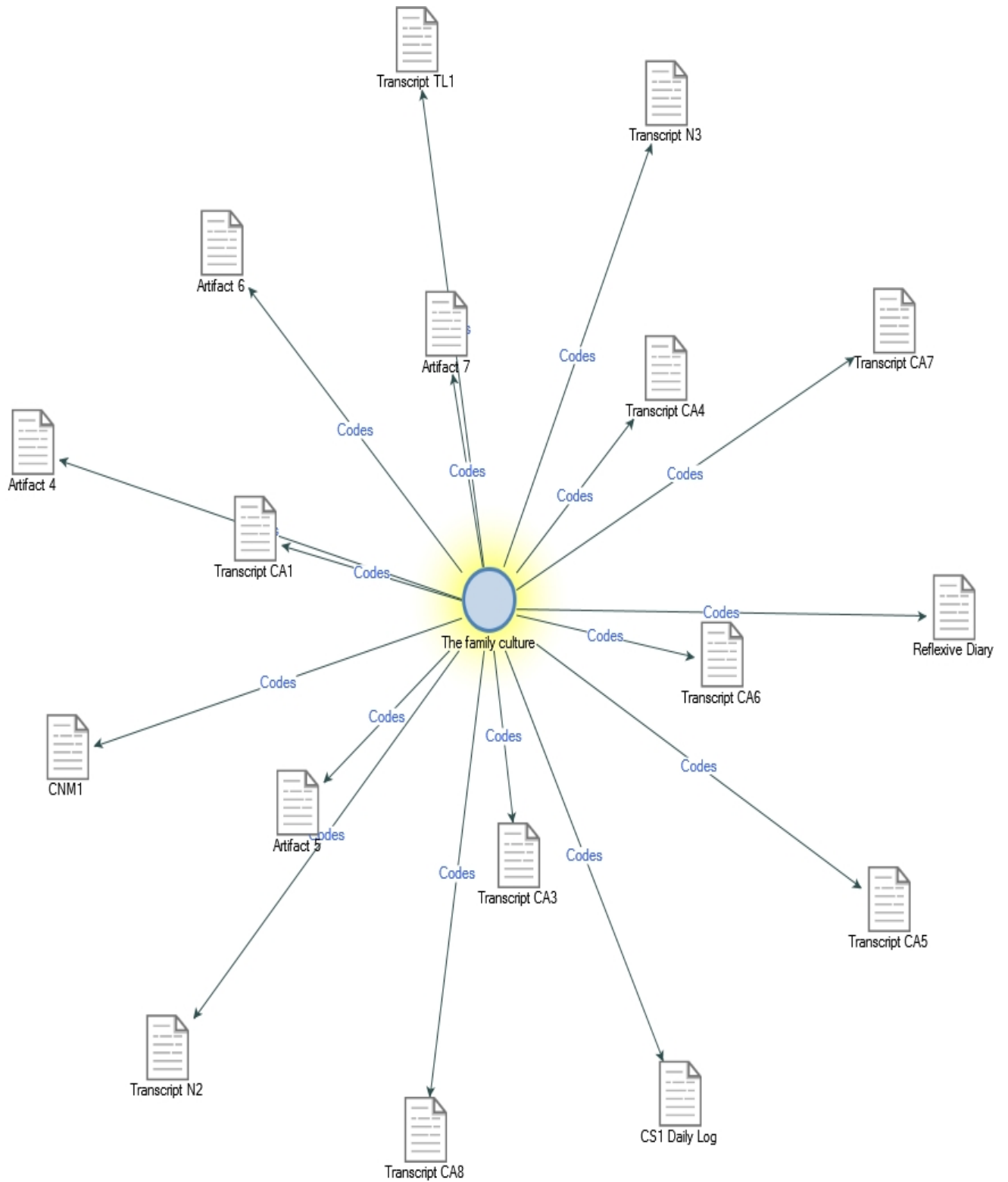
Appendix Fourteen: Theme Three; the care home as a collection of unit level subcultures data distribution



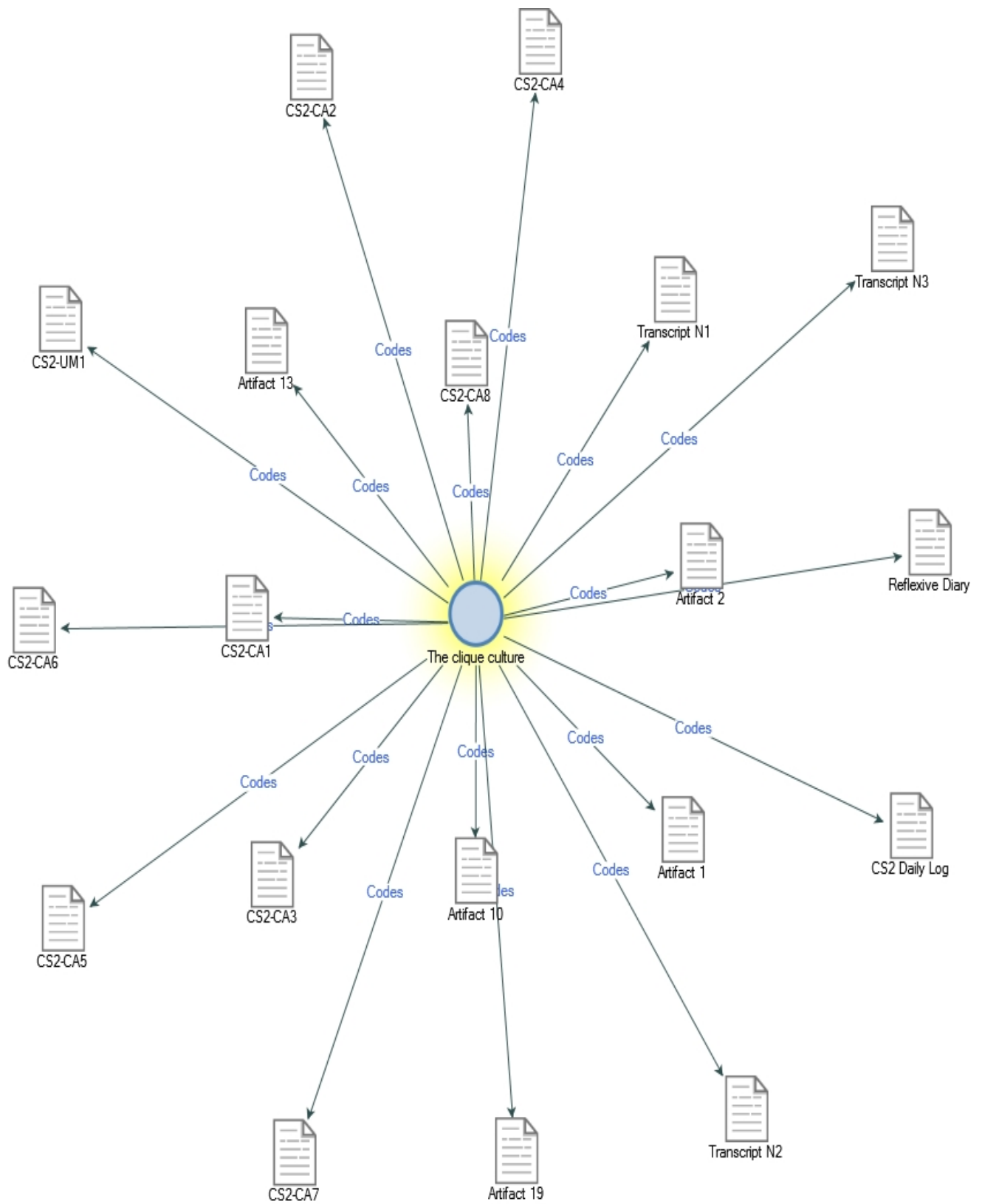
Appendix Fifteen: Theme four; training Environment data distribution



Appendix Sixteen: Theme Five; the family culture data distribution



Appendix Seventeen: Theme Six; the clique culture data distribution



**Appendix Eighteen: Participant recommendations on promoting
employee voice within care homes**

<i>Recommendation one; Showing care workers respect as a path to a greater sense of self-worth and voice</i>	<i>Analysis of Recommendation One</i>
<p><i>Researcher: I would like to find out how you think employee voice could be elevated within this organisation?</i></p> <p><i>Participant: "Well you need someone who does not think care workers as the lowest of the low, although it's normal management, there are some nurses who see carers in that way like they are second class citizens. We spend more time than anyone with those clients, so if anyone is going to know it's going to be us." (CS1-CA1)</i></p> <p><i>Participant: "Stop treating adults like children maybe.... like with the memos, and stuff like how to answer the phone. It makes you feel like we are not children, but why are they treating us like children." (CS1-CA6)</i></p> <p><i>Participant: "I would like to see them have more respect, I have been to many care homes within this organisation, and</i></p>	<p>The first theme centred on the notion that there was a need to accord staff with more respect. This theme centres on extracts from predominantly care workers within the home and arguably demonstrates the lack of worth participants who were care workers felt within this home. Extracts from participants indicate that staff did not feel respected; thus, such staff did not feel they had the power to voice out.</p> <p>Efforts to show staff more respect, I argue, would not only help in promoting the status of care staff but also provide staff with the platform they need to voice themselves. In addition, this would enthuse care workers to feel that their voice has the potential to have an impact thus encouraging them to voice themselves at the top levels of the care home, in doing so generating greater impact. This theme can be seen as being</p>

<p><i>my impression is that it is very hierarchical.” (CS2-N2)</i></p> <p><i>Participant: “They could show appreciation and stuff like that, like just recognition.” (CS1-TL1)</i></p> <p>Researcher: <i>I would like to find out what you think the status of care workers within this home?</i></p> <p><i>Participant: “ha ha ha ha... no!!! Let’s put it this way, it’s been on tv and the radio, I even heard it just yesterday. Health management people have been on tv saying how health workers are undervalued, short staff, money, depression. This problem of being appreciated in a place does not only mean money, a little smile, show of appreciation, but people also don’t know how that would raise your spirits; I think that would be good.” (CS2-CA4)</i></p> <p><i>Participant: “I don’t think care workers get enough respect or praise from management. I don’t know what the reasons are, but from my understanding, I think that cares don’t get enough respect for what they do.” (CS2-CA4)</i></p>	<p>linked to the characteristics facilitating employee voice in CS1. The sense of belonging and worth provided by the family culture was a catalyst for voice within CS1, and I argue from this data within this theme, was also something which was recognised across both case studies. As such, efforts to recognise and facilitate the self-worth of care staff, would I argue go a long way to promoting employee voice.</p>
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<p><i>Participant: "Some think we are intelligent, but others look at us and think off course they are stupid that is why they are doing care work if they were worth anything they would be a doctor or something." (CS2-CA2)</i></p>	
<p><i>Recommendation two; I think they could listen to staff a bit more</i></p>	<p><i>Analysis of recommendation two</i></p>
<p><i>Researcher: How do you think employee voice can be elevated or promote your voice?</i></p> <p><i>Participant: "I think they could listen to staff a bit more, certain management, cos I feel that there are some management that they see carers and the think they are not really worth listening to, so I feel that there is some that do need to listen to carers." (CS1-CA3)</i></p> <p><i>Participant: "I think management could listen to staff more, they just got their agenda, and that's all they care about. They don't really listen, and also acting on what people are saying." (CS2-N2)</i></p> <p><i>Participant: "If they listened to us actual, what we are saying and what we are feeling, it would encourage and like promote voice, we would feel more</i></p>	<p>Following on from the need to give staff more respect was the second recommendation which put forward the view that management needed to listen to staff more. This second recommendation can be seen as linking to the first in that participants who felt they did not get respect from management also left that those same managers were not listening to their voices as part of this lack of respect.</p> <p>Predominantly care staff felt that because they were not being listened to, their voice was not significant. As such, there was no desire on the part of employees to voice themselves. CS1-CA7 talked about if management listened, it would motivate employees to voice themselves, and it would 'lift morale'. What this demonstrates I argue is that the perspectives of</p>

<p><i>motivated, we are being listened to, they are doing the things that we are saying, which would then lift morale and know that we are being supported by our management.” (CS1-CA7)</i></p> <p><i><u>Participant</u>: “I feel like it’s up to management to listen to the care staff and realise that there are issues on the units. So I feel like it’s up to management to listen to the staff, and hopefully do something.” (CS2-CA1)</i></p> <p><i>Researcher: So, what you are saying is, someone left, who would have stayed if management had just listened to them and tried to communicate with them.</i></p> <p><i><u>Participant</u>: “Yeah, so we are losing staff cos they are not listening, that is why a lot of staff are going, cos they are not listening to them.”</i></p> <p><i>Researcher: And do you think they are aware of this,</i></p> <p><i><u>Participant</u>: “Yeah.”</i></p> <p><i>Researcher: Has anything in your view been done to address this issue of listening?</i></p> <p><i><u>Participant</u>: “No, like I said, this person left under this new management, I don’t</i></p>	<p>participants on if they are being listened to or not has a significant impact on general feelings of wellbeing within the home, which subsequently influences their voice.</p> <p>In addition to a lack of listening impacting on employee voice, there was another perspective put forward by CS1-CA7 that it also resulted in employees leaving the home, which is something I explored in the following extract. According to CS1-CA7, frustrations resulting from management not listening to employees resulted in some of them choosing to leave. This I argue, can be seen as an extreme form of acquiescent silence in which employees feel so disengaged that they leave the organisation Van Dyne et al. (2003).</p> <p>Although this theme has been pushed by care staff, the home manager agrees with their perspective that being listened to is an essential element in the facilitation of employee voice.</p> <p>This recommendation links back to the first theme identified when reviewing</p>
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<p><i>even think she had an exit interview. She just left; she put her notice in and left.”</i> (CS1-CA7)</p> <p><i>Researcher: Ok, what things work well within this care home to facilitate care home voice?</i></p> <p><i>Participant: “Being able to have everyone’s voice listened to, I think that is really important to listen to people’s opinions. I think everyone brings something to the table. I would also hope that we have a flat and open system cos there is nothing more demoralising than having a good idea and it takes four months for anything to happen or it gets lost in the system. I think you should be able to implement things quickly, and people will see that they have a voice.” (HM1)</i></p>	<p>participants understanding of employee voice as a situation in which employee is listened to. Significantly, it is those at the bottom of the organisational hierarchy who were more likely to put forward these points’ indication that one’s position within this care home had a significant impact on how they perceived their ability or willingness to voice. And so, efforts to promote the voices of employees from my data would be enhanced through listening and acting on what employees say.</p>
<p><i>Recommendation three; The need for proactive management willing to interact with staff</i></p>	<p><i>Analysis of recommendation three</i></p>
<p><i>Researcher: How do you think employee voice can be elevated or promote your voice?</i></p> <p><i>Participant: “Be approachable, and honest, forthcoming, if you are coming</i></p>	<p>The third recommendation to emerge from my thematic analysis of the data from both case study one and two was the idea that the voice of employees could be promoted by management proactively seeing out the</p>

<p><i>to the unit and talk to employees, this makes you more approachable to express your views.” (CS1-UM1)</i></p> <p><i><u>Participant</u>: “I think it would be better if someone comes into the unit and talk to us, I think then we would know that they are listening to us as well.” (CS2-CA2)</i></p> <p><i>Researcher: How can managerial communication be improved?</i></p> <p><i><u>Participant</u>: “I think they should come on the unit and see how it is done, then if they want you to do it in a specific way, they can say why they want you to do it that way.” (CS2-CA5)</i></p> <p><i><u>Participant</u>: “I think they should come to us face-to-face; they should put it up. Not just put it up and say that is the new rule, it’s like we would like to know if they are getting new clients. When you think about it, we are all one team.” (CS2-CA7)</i></p> <p><i><u>Participant</u>: “Well I would like to see the manager. I have just seen his picture but not met him.” (CS2-N1)</i></p> <p><i><u>Participant</u>: “Come and speak to us on the unit, organise meetings, even if you have to stay Monday to Friday and do</i></p>	<p>voices of their employees. That is, rather than waiting for employees to approach management, they should instead make a purposeful attempt to go and seek the voices of staff. This is something which is put forward in the following extracts from participants</p> <p>CS1-UM1 called for managers to not only be approachable but also come to the unit and proactively seek out the views of employees. This, according to CS1-UM1 would make other managers more approachable for employees to voice to. What all the extracts associated with this theme demonstrate is that within this care home, there is a broad perspective that the promotion of employee voice can be furthered through proactive initiatives on the part of management such as coming to the units and interacting with staff.</p> <p>Moving forward I argue efforts by management within care homes to be proactive in the engagement of staff would help in the process of starting conversations, and over time, make employees feel more willing to voice</p>
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<p><i>different times on the unit, would it hurt? No! speak to us all, not just the day carers, the night carers too.” (CS1-CA7)</i></p> <p><i><u>Participant:</u> “I think they could come in at night or at weekend, I think that excludes night staff a little bit, cos if they want to talk to management they have to wait till 9 or come back, and that does not fare cos they work long shifts.” (CS1-CA1)</i></p> <p><i><u>Participant:</u> “Well I mostly speak to the management if they come onto the unit. Well, obviously I mostly do nights so if I see them in reception in the morning before I go I talk to them then.” (CS1-CA3)</i></p>	<p>themselves, knowing that it will be listened to.</p>
<p><i>Recommendation four; Establish regular forums as a platform for employees to voice themselves</i></p>	<p><i>Analysis of recommendation four</i></p>
<p><i>Researcher:</i> <i>I would like to ask you how can we promote the voices of care workers at the top of this home?</i></p> <p><i><u>Participant:</u> “I think we need more meetings as a whole, I think we need a home meeting, even if we got people from the head office coming to talk to us that would be good as well.” (CS1-TL1)</i></p>	<p>Another recommendation to emerge from my thematic analysis process was the need to establish regular forums within the care home in which employees would have an opportunity to voice themselves.</p> <p>Participants called for more meetings in which staff could voice themselves. This would suggest that such participants did not feel that there were enough meetings in</p>

<p><i>Participant: “I think during meetings we can sit down and talk about things, the only time we come in is during work time, and it is so busy that there is no chance that people can sit down and talk.” (CS2-CA2)</i></p> <p><i>Participant: “I suppose we could have meetings, talk more, share our experiences more. The thing is the unit is so busy there is no time for anything to happen.” (CS2-N2)</i></p> <p><i>Participant: “Having meetings for just carers without management, so that they can come up with ideas amongst themselves of things they would like to change within the home, then collectively take it to management.” (CS1-N1)</i></p> <p><i>Participant: “I think having meetings without the management, I think that would be good cos we normally having a meeting without a manager I think you would say more.” (CS2-N1)</i></p>	<p>place at the time of this study. This could also suggest that those meetings at the time were not effective enough at getting the voices of staff across.</p> <p>From the viewpoint of CS1-N1 meetings without the involvement of would make staff feel more ‘confident’ to bring up issues which they may have otherwise not. This is a view shared by CS2-N1 who though meetings without management would enable staff to ‘say more’. In light of the fact that both of the above participants are nursing staff, indicates that this is an issue which is very much at the forefront of perspectives of middle-level staff within the care home.</p> <p>Indeed, in the above instance, nursing staff are advocating for meetings without management because it can be argued that they already have a significant amount of legitimacy attached to their voice. As such, the seek lees for management to listen, and more for them to act on their voice.</p>
<p><i>Recommendation five; The need for more collective approaches to voice</i></p>	<p><i>Analysis of recommendation five</i></p>

<p><i>Researcher: At the group level, what can you do to promote your voices?</i></p> <p><i>Participant: “I just feel like, not really stick together, but carers that work together, then, if you not being listened to then just keep raising your voice. Sometimes the carers are more involved, and do make more decisions than the nurses. That’s how I feel.” (CS1-CA3)</i></p> <p><i>Participant: “You all need to be on the same page for that to work, I think there are certain things that people should agree with it, I think the majority.” (CS1-CA1)</i></p> <p><i>Participant: “All stick together, obviously if you are all saying different things, managers are going to get different things said, and they won’t know what to do.” (CS1-CA7)</i></p> <p><i>Participant: “Nothing is happening on this unit, I think we need to get a union, or something like that will make people talk better.” (CS2-CA8)</i></p> <p><i>Participant: “Yes, maybe having per group meetings, I think staff might like that and feel more comfortable with that. Maybe one that crosses units, and</i></p>	<p>Following on from the last recommendation, the next calls for staff within this care home to engage in more collective approaches to promoting their voices. This recommendation I argue goes further than the last as it not only calls for forums for voice but also for staff to establish consensus and collectively voice themselves to management rather than as individuals.</p> <p>In the extracts provided, participants put forward the perspective that a unified front is another good way in which to promote their voice within this care home. CS2-CA8 goes further by calling for staff to join unions as a way of promoting the voices of staff. This would suggest that CS2-CA8 believes that other efforts have up until that point proven to be ineffective. Indeed, CS2-CA8 did say that ‘nothing is happening on this unit’ suggesting this to be the case.</p> <p>Other participants such as CS1-CA7 and CS1-CA3 make calls for staff to ‘stick together’ as a way of promoting their voices suggesting that particularly among care workers, a collective approach to employee</p>
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<p><i>everyone has a meeting and feeds back into the management team.” (HM1)</i></p>	<p>voice was perceived by some participants as being more effective. Thus, I argue efforts to give care staff more collective voice would facilitate any effort to improve voice for care staff.</p>
<p><i>Recommendation six; The need for informal channels of communication</i></p>	<p><i>Analysis of recommendation six</i></p>
<p><i>Researcher: Do you use informal communication voice mechanisms within the working environment?</i></p> <p><i>Participant: “Yeah, probably most of the time unless it needs a formal approach, I try and keep it informal cos it makes the team more willing to come and talk to you and communicate with you. The whole hierarchy thing I don’t really like cos you can come across really unapproachable.” (CS1-N1)</i></p> <p><i>Participant: “Yes, I would never take anything down the formal route unless it really needed it, and that is part of being the manager. So it is about saying you did this which you should not have done, so it is about given them a lesson. So I think that is a big positive thing.” (CNM1)</i></p> <p><i>Participant: “Yes, the informally is more important, when they are talking to you,</i></p>	<p>The final recommendation moves away from formal mechanisms to promote employee voice and instead calls for employee voice to be promoted using more informal channels. Informal channels of communication as a method of promoting voice within this care home is a perspective which was put forward by a significant number of participants. In the extracts provided for this theme, participants to put this view across do so by stating that informal mechanisms are their first port of call within the care home.</p> <p>The first point to note from the extracts provided is that none of the respondents are care workers. This is important because it suggests that higher up in the organisational hierarchy there is a recognition that informal methods of</p>

<p>you know they are relaxed, so no barriers and no professionalism so you can talk, the environment is more relaxing.” (CS1-UM1)</p> <p><i>Participant: “I think the first stage is the informal way. If I have an issue, I would like to first go through my line manager to see if it can be solved, is not then I would like to rise it higher then I would take it to the manager.” (CS1-N3)</i></p> <p><i>Participant: “I think just having more chats with them, just going in and having a chat, I think that would work.” (CS2-N1)</i></p> <p>Researcher: <i>Do you use informal communication voice mechanisms within the working environment?</i></p> <p><i>Participant: “Yeah, I use it, and I think it works, to me if you can’t say what you think to someone, then things are going to build up. I know some people will do that, but I can’t do that.” (CS1-TL1)</i></p> <p><i>Participant: “Yes, I do, I always see it as you can work with someone and teach them something, if they do it wrong, you have to give them a change, if they keep doing it wrong then you might then want</i></p>	<p>communication if not only effective but the first port of call when it comes to voicing themselves within the home.</p> <p>Participants such as CNM1 talked about ‘never take anything down the formal route unless it really needed’ although this participant was second in charge of the home at the time of this study. This would suggest that informal channels as a promoter of employee voice are seen by management as being effective. This is shared by nursing staff as well, as in the case of CS2-N1 in the below extract.</p> <p>In the first extract, CS1-TL1 details a perspective that informal communication channels enable staff to resolve situations before they ‘build up’ which may happen if formal channels were used. In the third extract, CS1-CA1 discussed the use of informal communications by management and concluded that it was most effective when clear boundaries were put in place.</p> <p>Although differing perspectives have been provided in relation to informal communication, there is a consensus</p>
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<p><i>to take it to the team leader and let her deal with it. Sometimes it's better to have a quiet word, and sort it out." (CS2-CA5)</i></p> <p><i><u>Participant:</u> "Yes, I have seen 3 different managers and they have all done the informal stuff, but for me, the most recent one is the only one that is getting it cos he is informal but got a boundary as well." (CS1-CA1)</i></p>	<p>among all the above participants that it represents an effective tool in any effort to promote employee voice within this care home.</p>
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