Measuring healthcare workers perceptions of what constitutes a compassionate organisational culture and working environment: Findings from a quantitative feasibility survey.

Abstract

Introduction: Healthcare organisational cultures and working environments are highly complex, dynamic and constantly evolving settings. They significantly influence both the delivery and outcomes of care.

Aim: This paper presents Phase 1 quantitative findings from a larger three phase feasibility study designed to develop and test a Cultural Health Check (CHC) toolkit to support healthcare workers, patients and organisations in the provision of safe, compassionate and dignified care.

Methodology: A mixed methods was applied. The Health Check Healthcare Workers Questionnaire distributed across two National Health Service (NHS) Hospitals in England, United Kingdom. Both hospitals allocated two wards comprising of older people and surgical specialities.

Findings: The newly devised Cultural Health Check Staff Rating Scale Version 1 (CHC –SRS Version 1) questionnaire was distributed to 223 healthcare workers. Ninety eight responses were returned giving a response rate of 44%. The CHC –SRS Version 1 has a significant Cronbach Alpha of .775; this reliability scaling is reflected in all sixteen items in the scale. Exploratory factor analysis identified two significant factors 'Professional Practice and Support' and 'Workforce and Service Delivery'. These factors according to healthcare workers significantly impact on the organisational culture and quality of care delivered by staff.

Conclusion: The Cultural Health Check Staff Rating Scale Version 1 (CHC –SRS Version 1) questionnaire is a newly validated measurement tool which could be used and applied to gauge healthcare workers perceptions of an organisations level of compassion. Historically we have

focused on identifying how caring and compassionate nurses, doctors and related allied health professionals. This turns the attention on employers of nurses and other related organisations.

Implications for nursing management: The questionnaire can be used to gauge the level of compassion with a healthcare organisational culture and working environment. Nurse managers and leaders should focus attention regarding how these two factors are supported and resources in the future.

Key Words

Healthcare, compassion, culture, working environment, organization, quality

Introduction

This article presents the quantitative outcomes of a feasibility study designed to develop and test a Cultural Health Check (CHC) toolkit to support healthcare workers and organisations in the provision of safe, compassionate and dignified care (McSherry et al, 2015).

To explore the complexity of a healthcare organizational and workplace culture as highlighted by McSherry et al, (2015) and to achieve the research aims a mixed methodology was adopted. The original feasibility study comprised of three phases as follows. Phase 1: Quantitative consisted of the Cultural Health Check Healthcare Workers and Patient/Carer Questionnaires. The rationale for this was to obtain anonymous accounts of healthcare workers perceptions, attitudes, values and beliefs surrounding their organisation and workplace cultures. Phase 2: Qualitative: Cultural Health Check Healthcare Workers and Patient One to One Semi-Structured Interviews. These were undertaken to provide real life accounts of healthcare workers experiences of their organisational and workplace cultures. Phase 3: Documentary Analysis was undertaken to review performance data and information. This paper only presents the findings from the quantitative component or phase 1 of the research.

The International Council for Nurses (ICN), 2016) estimates there are 16 million nurses worldwide. A statistic that makes the possibility of the delivery of safe, quality and compassionate care an experience for all patients and carers an unrealistic and unlikely one. Globally nursing's professional bodies like the United Kingdom (UK), Nursing and Midwifery Council (NMC) (2016), United States of America, American Nurses Association (ANA) (2016), Australia, Nursing and Midwifery Board of Australia (NMBA) (2016) and Malaysia, Malaysia Nursing Board (MNB) (2016) aim to assure and guarantee the quality and standards of nursing practice. Furthermore they are reaffirming the importance of 'speaking out' when

an organisational culture and working environment is not conducive to the delivery of safe, quality and compassionate care as highlighted by the Francis Inquiry (2013) in the UK.

The Francis Inquiry (2013) was a Public Inquiry into the appalling failings and neglect to patients, carers and healthcare workers at Mid Staffordshire National Health Service (NHS) Foundation Trust, England. Both the initial Independent and Public inquiries (2009, 2013) confirmed and reinforced that the delivery of care and standards of nursing care within the hospital were well below an acceptable standard. The public inquiry recommended the "use of a tool or methodology, such as a cultural barometer to measure the cultural health of all parts of the system" (Francis 2013, p1397). This is an important recommendation because frontline healthcare workers, managers, leaders and indeed regulators can quickly use the tool to gauge the temperature and/or atmosphere within a given clinical team, department and/or organisation. The primary aim of any cultural barometer, tool and/or methodology must be to avoid the applauding and neglectful standards at the hospital trust. A hospital which "failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care" (Francis 2013, p9).

The idea of a cultural barometer is not new. Indeed Willis's (2012) recommended "the culture of healthcare provider organisations should be routinely assessed, building on ongoing work to develop and standardise a 'cultural barometer' that will help boards ensure that practice settings are suitable learning environments". The development of a cultural barometer McSherry et al, (2013) argue already exists by aligning and applying the major components of 'clinical governance'. Clinical governance is defined as "a framework through which NHS

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organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Department of Health, 1997).

McSherry et al, (2013) illustrate how clinical governance can be used to avoid reinventing the wheel surrounding patient safety and quality improvement. This is achieved by focusing on its key components to design and develop a 'Cultural Health Check Toolkit' that may be used to address some of the major 'culturally enabling and inhibiting factors' identified by the Francis Inquiry (2013) and Willis report (2012).

Literature review

A comprehensive search (Figure 1) identified 36 relevant articles.

Insert Figure 1 here

Following retrieval the 36 articles were subject to Burns and Grove (2011) four phased approach to critically reviewing the literature. Skimming related to reviewing the articles titles, abstracts and references for key words: healthcare culture, organisational culture, cultural barometer, measuring culture, and healthcare organisational culture to include or exclude articles for review. Following this process a total of 20 articles (table 1) were included in the review.

Insert table 1 here

Comprehension pertained to critically reviewing the articles for key concepts and themes. Analysing invoked the skills of critical appraisal as outlined by Crombie (1996) which include reviewing, comparing and contrasting to formulate key concepts and themes. Synthesising

involved clarifying the theming and meaning of all the information gathered as part of the literature review. These are categorised and debated below.

Unpicking the term healthcare organisational culture

Kaufman and McCaughan (2013), Hruschka and Hadley (2008) and Davies et al, (2000) demonstrate that generally culture is defined as "the ideas, customs, and social behaviour of a particular people or society" (The Oxford Dictionaries, 2015). Sanders and Shaw (2015) claim "there are often aspects of an organizational culture that healthcare workers feel are outside of their sphere of influence, whereas the workplace culture is one which they arguably influence directly". Eslola et al, (2016) expand Sanders and Shaw's claims when exploring workplace culture among operating room nurses. They indicate workplace culture includes structures, routines, rules and norms which can ultimately impact on attitude, beliefs and subsequent behaviours. They further argue that the elements of workplace culture centre on job stress, job satisfaction and the practice environment. Dixon-Woods et al, (2013) large multimethod study of culture and behaviour of the National Health Service indicated that organizational culture of which workplace cultures are present comprises of the following. "The shared basic assumptions, norms, and values and repeated behaviours of a particular groups into which new members are socialised" (Dixon-Woods et al, 2013).

Davies and Mannion (2013, p1) suggest that "culture consists of the values, beliefs, and assumptions shared by occupational groups. These shared ways of thinking are then translated into common and repeated patterns of behaviour: patterns of behaviour that are in turn maintained and reinforced by rituals, ceremonies and rewards of everyday organisational life". When exploring a healthcare organizational culture understanding why, individuals, groups, and/or organisations behave in specific ways, is a highly complex and difficulty concept to unpick.

When focusing on measuring a healthcare organisational culture in the context of the recommendation of the Francis Inquiry (2013) pertaining to the Mid Staffordshire National Health Service Foundation Trust located in the West Midlands, England, and United Kingdom. The Trust at the time managed two hospitals: Stafford Hospital –an acute hospital with approximately 350 inpatient beds, and Cannock Chase – a community hospital with approximately 115 inpatient beds. Major concerns regarding the standards of care and services along with higher than expected mortality figures for this type of Trust resulted in both an Independent (2009) and Public inquiries (2013). The major findings of both inquires highlighted harmful and neglectful systemic failures in healthcare governance across numerous organizations to deliver, monitor, assure and safeguard a culture of safety, quality, compassionate care and services.   In light of the public and independent inquiries several important factors pertaining to workplace culture emerge. Firstly, Davies and Mannion (2013), Hesselink et al, (2013), Mannion et al, (2005), suggest that healthcare organisational culture must be reviewed at three levels, i) artefacts, ii) beliefs and values and iii) assumptions.

i) Artefacts – aligned to observable aspects of a culture such as rituals, rewards and ceremonies which have a significant potential to impact on an individual, teams and/or originations behaviour. ii) Beliefs and values which are held and espoused that can influence behaviour and actions within a given setting. iii) Assumptions associated with how beliefs, values and behaviours are shared and experienced. There may also be unspoken, unconscious beliefs and behaviours that exist within the setting.   It is evident from the Francis Inquiry (2013) that any exploration of a healthcare organisational culture and working environment must attempt to establish a mechanism for reviewing these three distinct levels.

Secondly, measuring culture must focus on understanding the beliefs, values and assumption held by the people; healthcare workers, patients and carers and how this impacts on their

patterns of behaviour and subsequent performance and outcomes of care and services. Thirdly, the challenge in demonstrating the impact of a healthcare organizational culture on quality, performance and outcomes is in deriving measures that acknowledges the complexity of the qualitative nature of how people interact and work together alongside the quantitative data. If a mechanism can be devised which collectively explores the qualitative and quantitative aspects of a healthcare organizational culture, assurances surrounding safety and quality which are meaningful and understanding for all stakeholders may be found.

Healthcare organisational culture, governance, safety and quality care is everyone's responsibility

The Department of Health (DH) United Kingdom (UK) through the introduction of clinical governance recognised the importance healthcare organisational and workplace cultures play in creating a safe, quality and caring environment and how this may influence both the delivery and outcomes of care. Clinical governance is about acknowledging the importance of adopting a healthcare organisational culture of shared accountability for sustaining and improving the quality of services and outcomes for both patients and staff. However not all of our healthcare organisations, regulators, commissioners, professional bodies and professionals themselves have achieved the intended outcome of clinical governance. Research is required to establish why this is the case and what is required to ensure that another 'Mid Staffordshire' never happens again in the UK or across the world

Creating a compassionate healthcare organisational culture requires effective leadership and management (Pinakiewicz et al, 2007). Compassionate care within the context of this research is defined as "how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care" (Although time consuming Shaw (2017) like others Beardsmore and McSherry (2017), Eskola

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et al, (2016) and Davies et al, (2016) suggest that healthcare organisational and workplace cultures can be improved and changed through taking some practical steps. Firstly, by educating and training nurse leaders and manager to become more facilitative in encouraging, empowering and enabling individuals and teams to innovate and change (Davies et al 2016). Secondly, strengthening healthcare workers understanding of the principles of sound governance: honesty, openness, transparency and probity (McSherry and Pearce (2016). Thirdly, enabling nurse's leaders and managers to recognise the different expressions of workplace culture and how these manifest themselves in individual's ability to perform their role and responsibility and ultimate job satisfaction. Fourthly, devising simple mechanisms to measure an organisational and workplace cultures, i.e. safe staffing, sickness and absence, statutory, mandatory training and access to professional development, and how these may influence the delivery of safe, quality care and services. Finally devising strategies for supporting, recognising and rewarding a healthcare organizations greatest asset, its staff. Cummings, 2013, p1).

A healthcare organisational culture may indeed lie at the root of many of the service failings of complex organizations. But a more sophisticated understanding of cultural dynamics, together with an appreciation of the role of policy in shaping these are needed if we are to tackle health care failings with any hope of success (Mannion and Davies, 2013).

Creating a safe and caring healthcare organisational culture and working environment

The starting point for developing a safe caring and compassionate healthcare organizational culture is establishing the type of culture within your present organisation and/or team. Francis (2013), Edwards (2013) identify several types of culture, for example, blame, bureaucratic, mistrust, reactive and proactive. The latter is the preferred choice because it encourages learning and development and importantly learning from mistakes like serious incident, events

and celebrating success.   Furthermore it is imperative healthcare organisations have the evidence to demonstrate the impact, performance and outcome of their healthcare organisational culture. Effective leadership and management, resourcing and supporting, education and training along with sound governance and human resources systems and processes all play a vital role in creating the optimal healthcare organizational culture and working environment.

Mechanisms to measure a healthcare organisational culture

According to Lown et al, (2011) the 'Compassionate Care Scale' provides a measure to demonstrate how compassionate healthcare workers and patients perceive the level of care delivered and received. Lown et al, (2011) provide a valuable instrument for measuring the level of compassionate care within a healthcare organisation from the perspective of physician and patients.   In contrast Hesselink et al, (2013) systematic review of measuring care which is a core attribute and characteristics of a culture in hospitals concluded that there is no ultimate standard for measuring care in hospitals. Although Hesselink et al, (2013) do provide a sound review of instruments currently used to measure care in the healthcare organisation. Interestingly these can be broadly themed around the professional practice environment, person-centered care and approaches and care. Hunt et al, (2012) systematic review identified key characteristics and attributes of a healthcare organizational culture which could be constructed in supporting the development of a framework. These are around safety, quality, performance, appraisal, workforce and support. Shwartz (2010) when exploring healthcare organizational factors which have the potential to impact on quality and safety found several important areas as follows: leadership, engagement of staff, alignment through vision and direction, integration and standardization and infrastructure.

Taking Lown et al, (2011), Hesselink et al, (2013), Hunt et al, (2012) and Shwartz (2010) works into account it is important that any cultural barometer needs to combine and/or align existing safety, quality, governance systems and processes with what constitutes an effective healthcare organizational culture. The novel and significance of the research is in focusing on the broader workforce and service delivery i.e. staffing levels and sickness and absence and professional practice and support i.e. job satisfaction, personal and professional development. These factors are important to nursing managers and leaders because they may influence healthcare organizational culture and workplace cultures (Sanders and Shaw 2015 and Mannion et al, 2009). These in turn may also impact on patient safety, quality and outcomes of care. This is demonstrated by Aiken et al, (2014) research into nurse staffing, education qualifications and workloads which highlighted a relationship between these factors and patient mortality rates. Similarly to Aiken et al (2014), Weaver et al, (2013) highlighted through a systematic review the importance of adopting a strategic multidisciplinary interventionist approach to facilitate a safety culture climate which Bikmeyer et al, (2013) measured across twenty two hospitals providing bariatric surgery. The results showed a correlation between a sound safety culture and reductions in the complications from bariatric surgery. They concluded that "interventions targeting safety culture, particular coordination and communication, seem to be important for quality improvement".

This research acknowledges the importance of Aiken et al, (2013), Weaver et al (2013) and Bikmeyer et al (2013) research offering specific tools and instruments that focus directly on reviewing patient safety cultures (Weaver et al 2013) and/or failures to escalate quality deficits due to fear of hierarchy and/or criticism, (Johnstone et al, 2014). This feasibility study seeks to provide a framework of indicators that highlight how an organisational and/or work place culture(s) may impact on healthcare workers ability to create and provide a safe, quality workplace and environment these may also may influence patient outcomes.

Methodology

This article presents the quantitative outcomes of a feasibility study designed to develop and test a Cultural Health Check (CHC) toolkit to support healthcare workers and organisations in the provision of safe, compassionate and dignified care (McSherry et al, 2015). The research question outlined earlier was realised by undertaking a small scale feasibility study as advocated by Arian et al, (2010). This was essential in order to confirm the validity of the newly devised Cultural Health Check toolkit utilizing a mixed methodology combining qualitative and quantitative methods. The qualitative phase 2 of the research was reported in Beardsmore and McSherry (2017).

The research question was realised by utilizing a mixed methodology combining quantitative and qualitative methods. As recommended by Hunt et al, (2012, p231) a mixed methods approach is a sound way of seeking "to address the discrepancies between espoused values and actual practice". In our opinion this endorsed our application of a mixed methods to explore healthcare culture. As indicated in the introduction this paper is only focusing on the design, implementation, ethics and findings from phase 1.

Sample and setting

In keeping with a feasibility study as advocated by Arian et al (2010) a convenience and/or purposive sample defined as a sampling technique that "involves conscious selection by the researcher of certain subject or elements to include in a study" (Burns and Grove 2001, p808) was adopted. This was important in order to develop and test out the healthcare workers questionnaire contained within the CHC toolkit. Two separate general hospitals within each Trust severing similar population sizes, demographics and service delivery models together with similar staffing numbers for the four wards was adopted. Given this was a feasibility study

no sample size calculations and or power analysis was undertaken. To realise the research aim the researchers were guided by the work and recommendation of the National Health Service National Institute for Health Research (NHS NHIR 2017) 'justifying sample size for a feasibility study" (NHS NHIR 2017, p2). The NHS NHIR (2017) suggest using sample sizes of 24-50 for feasibility research studies. Although the remit was to establish if the healthcare workers questionnaire and subsequent aspects of the CHC toolkit could be validated for further research.

A purposive sample included the full spectrum of healthcare workers providing care and services to patients/carers within the wards. These included permeant, bank and agency staff working either full and/or part-time. Registered, non-registered professionals, administrative and supporting positions including senior and junior staff. The range of healthcare workers included: Doctors, Nurses, Allied Health Professionals, Administrative and Support staff.

Phase 1 included the distribution of 223 Cultural Health Check Healthcare Workers Questionnaires to two National Health Service Foundation Trusts in England, UK. Each Trust having two separate hospitals some distance apart. Both hospitals allocated two wards comprising of older people and surgical specialities.

Ethical and Research and Development Approvals

The research obtained research, governance and ethical approval from the following institutions and organisations. A local University, Research and Governance Committee, The National Health Service (NHS) Integrated Research System for a multi-centred research study. The Local Research and Development and Ethics Committees all reviewed and offered favourable approvals for the research project.

Survey Implementation

The data collection covered a three month period from 1st July – 30th September 2014. The distribution and return of the Cultural Health Check Healthcare Workers Questionnaire was as follows. Two NHS Hospital Trusts. Trust 1, ward A n=60, ward B n=60. Trust 2, ward A n=60 and ward B n=43.

Instrument Development

The Cultural Health Check Healthcare Workers Questionnaire builds on the works of McSherry et al, (2013) initial Cultural Health Check Toolkit (CHCT) published in the Nursing Times. The toolkit "identifies six cultural themes and 20 culturally enabling and inhibiting factors that have the potential to help health workers to deliver and sustain patient safety and quality, and to create a safe, caring and compassionate culture. Either singly or collectively these factors should be regarded as a gauge, flag, alarm or warning" (McSherry et al, 2013). Seventeen questions were developed on a four point Likert Scale addressing the following: Often, Sometimes, Rarely, Hardly ever. The questions are provide in table 6.

Data Analysis

A combination of descriptive (response rates and rates by questions) and inferential statistic (correlations, factor analysis) was applied to the data. Data was analysed using Statistical Package for Social Sciences (SPSS) version 22. Detailed inferential statistics of the healthcare workers questionnaire revealed a Cronbach alpha score of .775 for the overall reliability. Individual items ranged from .705 -.775. An exploratory factor analysis was applied to test the 'structure or the number of dimensions underlying a set of variables' (Torres-Reyna, 2014). Exploratory factor analysis was useful in this context in order to examine "interrelationships among large numbers of variables and disentangles those relationships to identify clusters of variables that are most closely linked (Burns and Groves 2001, p532).

Results

A total of 98 completed questionnaires were returned giving a response rate of 44%. The total response rate for Two Trusts was a reasonable 44%. Trust 1 response rate was 29% and Trust 2 was 46%. Trust 1 ward A was 27% and ward B was 52%. Trust 2 ward A was 62% and ward B 23%.

Descriptive statistics showed a response rate by healthcare workers category is depicted in table 2 and by groups table 3 below.

Insert table 2 here

Insert table 3 here

A copy of the questionnaire is presented in appendix 1.

Insert table 5 here

The exploratory factors analysis identified two significant factors. Each factor comprising of several items or clusters within them. These were classified as 'Professional Practice and Support' and 'Workforce and Service Delivery'. The two factors each contain two determinants and have specific questions attributable to each factor table 4. The highest loading value was .919 and the lowest .169.

Insert table 4 here

A analysis of tables 4 reveals the following findings.

Factor 1 determinant 1 'Professional Practice' showed that the majority of healthcare workers felt able to carry out patient care to their level of satisfaction often (n=53/54%) and sometimes (n=38/39%). Only 2% (n=5) indicated they were unable to carry out care to their satisfaction. The vast majority of staff felt supported to undertake professional development and training (n=88/90%). In regard to involvement with multidisciplinary team meetings (n=31/31%) of healthcare workers were rarely or hardly ever involved. Almost 9 out of 10 staff (n=82/ 84%) were of the opinion that discharge planning occurred effectively. All staff felt that the quality of hand hygiene was good.

Factor 1 determinant 2 'Support' highlighted that 73 or 74% of staff had regular planned appraisals with 17% noting their appraisal did not take place at the planned time. A high use of nursing bank and agency staff was reported (n=79/81%). There was sound evidence demonstrating that reported incidents were followed up (n=90/91%).

Factor 2 determinate 3 'Workforce' highlighted that over a 1/3 of healthcare workers planned study leave is cancelled (N=36/37%). An overwhelming 91 healthcare workers (93%) indicated that there was a shortage of nursing staff in the area with a perceived high turnover (n=88/38%). There is almost ¾ (N=70) and/or 72% of healthcare workers were of the opinion that sickness and absence in their clinical area was high.

Factor 2 determinate 4 'Service Delivery' revealed that 56 healthcare workers (57%) indicated that there are unplanned readmissions occurring following discharge. There is a perception of 54 staff (55%) that there is a shortage of medical staff at the current time in the respective clinical areas. The majority of healthcare workers 85 (89%) indicated that the clinical areas are tidy. Fifty percent of the respondents highlighted that patients and/or relatives make complaints.

The family and friends question 17 'I would be happy for my family or friends to be treated in this area' was included as an overall indictor of the healthcare workers confidence of the service delivered. This was included in the scale detailed below. Significantly n=73 (74%) of respondents stated yes, n=17 (17%) were unsure and n=4 (4%) would not be happy for family and friends to be treated.

Formulation of the Cultural Health Check (CHC) – Staff Rating Scale (SRS) CHC-SRS Version 1

The CHC-SRS Version 1 comprises of sixteen items ranging from a minimum score of 1 and a maximum of 4 per item (see table 5). The 16 items are totalled giving a minimum score of 16 and a maximum of 64. There are no weightings attached to the classifications these are simple quartile ratings.

Insert table 5 here

The CHC-SRS Version 1 is categorised into 4 bandings (Table 7 above) these emulate the Care Quality Commissions (CQC) of England (2016) performance ratings. The reliability of the scale was tested through the application of a Cronbach's Alpha test scoring 0.761.

The CHC-SRS Version 1 classifications are indicative of a current health care organisations culture and perceptions, attitudes and beliefs of healthcare workers within the environment. Furthermore how these perceptions, attitudes and beliefs manifest on specific factors in practice is identifiable. The CHC-SRS Version 1 is sensitive in illustrating variations in the factors which collectively impact on the overall cultural environment from inadequate to outstandingly good. The overall mean CHC-SRS Version 1 score across both organisations A and B without accommodating the inclusion of the average mean missing data was 46.7 decreasing to 43.9. The average category score by organisation A and B and Wards including missing data. (Where

data was missing in order to produce the category the average mean was included). The major findings are in table 8.

Table 9 highlights the CHC-SRS Version 1 classification and categorisation scoring is highly sensitive in eliciting the staffs variation in perceptions, attitudes and beliefs associated with the 16 key factors that constitutes the overall rating scale. Hospitals Trusts 1 and 2 had no scores in category 1 with a small number in category 2 with the majority n=75/74% placing the current culture and organisational environment at category 3 good and n=16/17% at outstanding. Significantly and not surprisingly those hospitals whose staff score in the higher categories 3 and 4 is mirrored in the family and friends test table 7.

According to table 7 80% of healthcare workers would recommend their ward to family and friends. Twenty percent of healthcare workers were unsure or would not recommend their respective wards to family and friends. In exploring the factors that influence healthcare workers ability to carry out patient care to their satisfaction several significant correlations are evident table 8.

According to table 8 there is a relationship between healthcare workers satisfaction to deliver care which is influenced by the availability of healthcare workers, utilization of bank/agency staff and a high turner of nursing staff. These factors are indicative of whether patients and/carers are able to make a complaint.

A further analysis of the family and friends test has an indicator for quality against the factors and determinates identified in table 8 revealed the following significant correlations table 8. Table 8 highlights the statistically significant questions within the determinants that influence healthcare workers response to the family and friends test.

Discussion

The response rate for the healthcare workers questionnaire was a reasonable 44%. Trust 1 response rate was 29% and Trust 2 was 46%. Trust 1 ward A was 27% and ward B was 52%. Trust 2 ward A was 62% and ward B 23%. The two wards receiving the highest response rates (both in different hospitals) demonstrated positive responses through all phase of the research. Conversely those with low response (both in different hospitals) rates were negative in their responses. The above finding may be an indicator of the overall level of clinical leadership of the respective ward and hospital managers (Mannion et al, 2005). These findings like those advocated by Mannion et al, (2005) suggest that variability in clinical leadership and management may impact on staff engagement, motivation and healthcare organisational culture.

The emerging factors following the analysis of the healthcare workers questionnaire could be categorised into two broad themes. These are 'Professional Practice and Support' and 'Workforce and Service Delivery'. In relation to professional practice healthcare workers indicated that three key aspects impact on their ability to carry out this aspect of their role effectively. These are having sufficient time to carry out their role and support for Continuing Professional Development (CPD). Along with having the time to regularly attend and be involved in multi-disciplinary team meetings and discharge planning. 'Support' encompasses having regular appraisal and robust development plans, sufficient staffing levels to avoid

reliance on bank and agency service and confidence that appropriate timely action and feedback is provided following the reporting of incidents.

In relation to factor two 'Workforce and Service Delivery' the overriding finding regarding workforce is the fact that where there are shortages of staff resulting in cancelling of study leave culminating in higher turnover of staff and increased sickness and absence. These issues both singularly and collectively may have an impact of safety and quality for patients/carers and healthcare workers. These may subsequently impact upon overall job satisfaction. Service delivery similar to workforce shows a potential relationship between sickness and absence, staff shortages including medical culminating in increased readmissions and patient/carer complaints. These findings concur with those of Hunt et al, (2012).

The significance of the two factors 'Professional Practice and Support' and 'Workforce and Service Delivery is the relationship between these items whether staff would recommend their service to their family and friends. This is particularly significant regarding having sufficient time to perform their role effectively and continuing professional development. Essentially this could be interpreted has how caring and supporting the employer is to the healthcare worker themselves.

Interestingly a statistically significant finding was the fact that staff satisfaction was influenced by shortage of staff, reliance on bank and agency, high turnover of nursing staff and patient/carer complaints. These contributory factors warrant further investigation when looking at the overall safety, quality and care within an area. These could be classed as potential indicators rather than the absolute measures of quality.

Shortages of nursing and medical staff and having regular appraisal and a detailed personal development plan also impact upon staff's decision to recommend the service to family and friends. Overall 1 in 5 staff would not recommend their own ward to family and friends.

A Cultural Health Check (CHC) Staff Rating Scale (SRS) (CHC-SRS Version 1) was formulated by totalling the score for each individual question 1-16 giving a range of scores from 0-64. The range of scores was divided into four quartiles 1, Inadequate, 2 Requires Improvement, 3 Good and 4 Outstanding. The CHC-SRS-Version 1 mean score across both Hospital Trusts was 46.7 indicating that the majority of healthcare workers were satisfied with their healthcare organisations level of care and compassion afforded to them. The CHC-SRS-Version 1 offers useful insights into key factors which influence culture, quality, safety and those which ultimate impact on patient and healthcare workers.

Limitations

The authors acknowledge that the feasibility study was undertaken with a small number of hospital trusts and wards having a limited sample size and population of healthcare workers. The making of any generalisations of the findings are limited to the hospitals and wards who participated in the research. A larger scale study covering different geographical regions is required to further validate the newly developed cultural health check healthcare workers questionnaire incorporating the Cultural Health Check Staff Rating Scale detailed in the research design, methodology and findings.

<div align="center">Conclusion</div>

The research provides a newly validated measurement tool the 'Cultural Health Check Healthcare Workers questionnaire' which contains the 'Cultural Health Check Staff Rating Scale Version 1' (CHC –SRS Version 1). The new tool can be used and applied to gauge

healthcare workers perceptions of a healthcare organisations culture and levels of care and compassion afforded the their workers. These are based on two key factors 'professional practice and support' and 'workforce and service delivery'. Historically we have focused on identifying how caring and compassionate nurses, doctors and related allied health professionals are to their patients. The originality and significance of this research is the shift in direction and focus of attention on employers of nurses and other related healthcare workers in highlighting how compassionate they are their healthcare workers. These factors ultimately impact on the culture quality, safety and patients along with healthcare workers health and wellbeing.

Implications for nursing management

The novel and significance of this research is in supporting nurse mangers and leaders on several fronts. Firstly, highlighting two major factors 'workforce and service delivery' and 'professional practice and support' and how these may influence performance of workplace and organizational cultures both positively and negatively. Secondly, the newly constructed CHC –SRS Version 1 questionnaire could be regularly used and applied to gauge healthcare workers perceptions of an organisations level of compassion. Thirdly, the CHC –SRS Version 1 questionnaire could be used prior to and post change projects to illustrate the impact of change on a team, division and organisation performance. Fourthly, the questionnaire is short, easily distributed, easy to complete and analysed. Fifthly, the research raises some important questions as follows. Are we all sufficiently aware of how we and/or our team members individually and/or collectively create, contribute to and influence the performance and outcomes of our working environment and workplace/organizational culture(s) in which we work? How often do we ever consider the facts that our organization and workplace culture and working environment could be impacting on ours and/or our patients/carers physical,

psychological, emotional, social, spiritual, mental health and wellbeing along with the delivery of safe, quality care and services? Finally, familiarising yourself with these important questions and devising ways to demonstrating the impact and outcomes of these important factors on your organizational and workplace culture and working environment for healthcare workers and patients/carers should be given urgent priority in the future.

Acknowledgements

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