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Title: Organisational culture - why is it important?

Nurse students spend 50% of their pre-registration programme gaining practical experience in clinical placements. Very quickly they tune into the 'atmosphere' and make judgements about whether this setting provides quality care and is a 'good' place to work. In essence they are assessing the organisational culture: this is an important indicator of care quality and staff satisfaction. The Francis Report (2013:42) investigated care deficits in one NHS Trust and highlighted that despite significant warning signs 'the Trust's culture was one of self-promotion rather than critical analysis and openness.' Much work has subsequently focused on this area because 'healthy cultures in NHS organisations are crucial to ensuring the delivery of high-quality patient care' (King's Fund, 2014). So what is an organisational culture?

According to Hester et al. (2013) organisational culture is often described as *'the way we do things around here'.* It is apparent in shared routines and rituals; it reflects staffs' values and beliefs, revealed through behavioural norms, that is, the way staff act, talk and think (the latter often apparent in choice of language). It reflects shared team practices and provides meaning and direction for work. The culture is created by people and is not fixed but changes with time and staff diversity. Given this, Thompson (2015) argues that people within the organisation have opportunity to work with others to influence and shape it in order to bring about improvement. To do this however we need to understand some facets of organisational.

Whilst bureaucracy reflects **formal** ways of doing things within organisations, for example structural hierarchy and their roles, culture refers to **informal** ways and is more complex to understand. Indeed Johnson (2005) cited in Hester et al. (2013) describes organsational culture as a web of elements. Six elements are identified: firstly *Routines and rituals* seen within the day to day behaviour and actions of people. These reflect what people **actually** do or say, not what they think they do or say. For example the organisation vision statement may state that 'we deliver person-centred care'; however if in practice team members 'do the washes' and are heard to say 'the dementia in bed 4 is a double' (meaning requires two people to assist them), this signals that in that culture, patients are thought about as objects with diseases that require tasks to be done. Use of language is highly revealing; students whilst uncomfortable with such language are keen to fit in quickly (Cooper and Scammell 2013) and so may conform 'because this is the way we do things round here'.

The second element is *organisawho tional structures* which considers who in reality has power and influence. Students learn about the formal organisational structure and feel supported by empowering nurse leaders acting as positive role models. Sometimes however they find that significant power over care decisions in fact is held by cliques of staff who perhaps work in ways which may not reflect the values espoused by the departmental vision professed by clinical leads. Challenging such groups can be daunting for students as well as junior registered staff.

Power structures are the third element and relates to where power is focused within an organisation; for example this might reflect the hierarchical structure where the Head of Nursing is perceived to have the power to influence practice. However sometimes certain departments or staff groups are perceived as more powerful than others; for example doctors over other disciplines or ITU over wards for older people. This matters because it may influence the equitable allocation of resources. This links to the next element - *Control systems*; for example perceptions of the balance between organisational emphasis upon finance and quality systems might be

apparent through rewards for meeting associated targets. Financial systems are there to support high quality care but Francis (2013) reported that meeting financial targets overly dominated the Trust culture; an emphasis on the 'wrong priorities' resulted in diminished resources for care delivery. *Stories* are the fifth element of the cultural web; the way an organisation reports success for example through staff quality care awards says much about its priorities. Moreover at the 'shop floor' level the events that merit informal staff discussion also tell a story: for example if staff are admired for starting early and not taking any breaks when the ward is busy, this may lead to emulation of unhealthy working practices and an organisational culture with high levels of burnout. Lastly the *Symbols* associated with an organisation also tells a story; if hospital cleanliness is a top priority and adequate refreshment facilities are provided for staff, this tells the outside world something about how patients and staff needs are important in that organisation.

Organisational culture at all levels of healthcare delivery reflects the actions and behaviours of people. It is not fixed but cultural norms can be powerful in shaping the behaviour of new members. An understanding of organisational culture can help us to approach our working environments with an open mind and resist the need to act in order to fit in if we don't agree with certain ways of working. Empowered staff that celebrate quality and challenge concerns is a key feature of a positive organisational culture.

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