Cultures of care within the health and social care sector are increasingly receiving national attention alongside demands for change. The Care Quality Commission (CQC) (2012) has stated that quality of care is suffering and that ‘there are cultures in place where the unacceptable becomes the norm’. A dysfunctional and malignant culture of care was one of the main reasons identified that criminal actions towards vulnerable people occurred at Winterbourne View Hospital (Department of Health (DH), 2012a). In Mid Staffordshire the failings of care in hospital were attributed significantly to organisational culture (Francis, 2013).

Earlier this year, the House of Lords Committee’s review of the application of the Mental Capacity Act heavily criticised the way in which care homes and hospitals deprive vulnerable people of their basic freedom. The report blames an attitude of paternalism in the NHS and ‘risk aversion’ in the care sector (House of Lords, 2014).

It is inevitable that further national attention will be directed to people’s poor quality of life in care homes, however, the majority of staff are doing their best. This article focuses on what it really takes to transform cultures of care and the fundamental questions that have to be answered.

Unravelling the 6Cs
In 2012, ‘Compassion in Practice—Our Culture of Compassionate Care’ was launched by the DH (2012b). This launch, aimed at nurses in hospitals and care homes, focused on re-establishing in health and social care the ‘6Cs’—care, compassion, competence, communication, courage and commitment. As a positive initiative it highlighted that ‘Our shared purpose is to maximise our contribution to high-quality, compassionate care and to achieve excellent health and wellbeing outcomes’. The report acknowledged the need for staff to commit to action in six areas:
- Helping people to stay independent, maximising wellbeing and improving health outcomes
- Working with people to provide a positive experience of care
- Delivering high quality of care and measuring impact
- Building and strengthening leadership
- Ensuring there is the right staff, with the right skills in the right place
- Supporting positive staff experience.

This vision is laudable and the majority of health and social care staff will wish to achieve this. However, focusing on individuals without transforming organisations is flawed. Engaging the personal commitment of staff in compassion relies fundamentally on a radical transformation of senior management’s beliefs about care models. Achieving a national culture of compassion in the UK will require a complete unravelling of current confusion. This confusion is about the basic beliefs held by many senior managers on what good care looks, sounds and feels like for people living and working together.

Clinical or congruent: which model are you?
Instead of addressing the core beliefs of senior managers in care home organisations, attention has been diverted onto training the workforce as being the answer to any crisis in care (Knocker, 2014).

The author has learnt, over the course of almost 20 years, if culture change is to be achieved then relying on dementia care training has its limitations (Sheard, 2011). Any delivery of dementia care training needs to be set within an overall programme of organisational development. An organisation wanting to provide a compassionate culture of care has to be prepared for a
significant degree of internal reflection and examination. The nature of the Board and its model of care, the directors’ grasp of new culture belief systems, and the general managers’ leadership style all require scrutiny. If the Government’s 6Cs on a practice level are to be realised, the author believes that the Dementia Care Matters 4Cs model (devised in 2009) has something vital to offer in changing a care home’s culture. Dementia Care Matters is a dementia care organisation providing consultancy, training, resources and research across the UK and Ireland.

Dementia Care Matters has drawn up an analysis of care home cultures, which identifies important features of an organisation’s model of care and its likelihood of being at risk in successfully delivering compassionate care. The organisation can use this analysis to examine primarily where it sits on the spectrum of being a clinical, confused, creative or congruent organisation (Figures 1, 2, 3 and 4). The first step is for the Board of an organisation to appraise which ‘C’ it is and which ‘C’ it aspires to be.

A congruent organisation
The author regularly facilitates enthusiastic groups of staff wanting to achieve positive cultures of care who are often severely held back by the organisation. At a Board level, not only have they often not even analysed itself in relation to the 4Cs model but they also have not addressed the important points below:

- Business—does the Board accept that full occupancy and profits will come from major investment in quality of life?
- Beliefs—does the organisation believe in a true domestic household model of care?
- Culture—does the senior management team want to invest in emotional labour as the primary competency?
- Strategy—does the director of nursing and care really know what feeds a malignant culture of care and how to drive this out?
- Leadership—do directors understand the failings of detached management and grasp what attached leadership is?
- People—does the human resources (HR) director accept that recruitment on competency rather than values will perpetuate malignant cultures?
- Training—does the organisation realise that statutory competency training alone will only deliver task-based care?
- Development—does the organisation see that cultures of care change through coaching and mentoring on a clear model of care?
- Quality—does the Board place its greatest emphasis on measuring the quality of people’s lived experience?
- Marketing—does the organisation believe and tie in its marketing to a household model of care?
- Compliance—does the organisation realise that rather than being driven by external requirements leading on the above internally will achieve external compliance?

A chrysalis of ideas
Managers and staff will always struggle to change cultures of care where at a senior level there is no
clarity on these questions being answered with a concise strategy. Equally, many organisations remain unsure what their core business is in care and which model they should follow. Recognising that there was a real need to demonstrate and model how to change dementia care home cultures, the author began this work in 1995. The same year Merevale House in Warwickshire became the first care home in the UK to adopt the Dementia Care Matters ‘Butterfly Care Home’ approach. The approach has grown nationally with a strong evidence base in what it takes to achieve culture change in a dementia care home. This evidence base grew from ideas in the early stages, which were initially inspired by Tom Kitwood’s (1997) work, such as:

- Get rid of the institution—no us and them features
- Create a family/best friends approach (Bell and Troxell, 2003)
- Fill the place up with mounds of ‘stuff’ to engage with
- Really value people’s life history and recreate parts of this
- Accept people as they are—go with people’s reality
- See the feeling behind expressions and actions
- Involve people in running their own home
- Focus on what people can do and not what has diminished
- Promote a balance of human rights to degrees of risk
- Help families to be less like guests and more ‘at home’.

From these initial ideas, it became clear that they can only flourish when the important elements in achieving a positive culture have been signed up to at the most senior level in an organisation.

Delivering a culture change programme
In the author’s experience of delivering learning and development programmes, it is evident that without project management care homes are limited in achieving the implementation and quality of life outcomes promoted by person-centred and relationship-focused dementia care.

A culture change programme is rigorous; just as it asks fundamental strategic questions at a senior level in an organisation so too it raises fundamental questions about how a dementia care home will be configured in terms of daily practice (Box 2).

Conclusion
Care homes will continue to face national scrutiny. The excellent and life-enhancing support to people in care homes which is already provided needs to be given greater profile and credence. To achieve this the sector will need to limit its own exposure to bad press. The agenda in promoting and evidencing compassionate care is vital. However, the need at a national level to refocus care home organisations core beliefs, values, and culture is critical. Grasping what it takes at a senior level in an organisation to achieve culture change matters even more than just focusing on increasing compassion in individuals. NRC
Box 1. Questions used to implement culture change

- Design—is the home willing to adopt a household model breaking up the home into houses with separate front doors and combined living dining rooms?
- Environment—is the home going to be given permission to fill the houses up with the ‘stuff of life’ rather than marketing a hotel model of care?
- Family like culture—will the home remove all ‘them and us’ features of institutionalisation?
- Specialism—will the home see that people living with different points of dementia need different skilled approaches?
- Matching—will the home agree to group people in houses based on where people are in their level of dementia?
- Emotional intelligence—will the home recruit, train and appraise staff on this as the primary competence?
- Leaders—will the home appoint on values and leadership rather than seniority or nursing skill alone?
- Attached staff—will the home match individual staff to a specific house recognising people’s different skills so that this brings out the best in staff?
- Nursing—will the home demonstrate its value in nurses but agree to modernising their role and adopting more personalised ways of providing nursing care?
- Decentralisation—will the home create housekeepers rather than central domestic services and remove centralised dining?
- Home for life—will the home promote a home for life not house for life agreement with families?
- Intimacy—will the home take a balanced approach to wellbeing while meeting non-restrictive safeguarding processes?
- Quality—will the home accept as its primary qualitative methodology the lived experience of people

Key points

- National attention will continue to focus on poor cultures of care
- Focusing on compassion without transforming organisational cultures is flawed
- Strategic questions have to be answered to unravel confused models of care
- Achieving quality of life in a care home requires a congruent model of care
- Dementia care training only delivers results when linked to a culture change programme