The Development and Adoption of an Innovative, Sustainable Quality Improvement Model in a Private Healthcare Firm

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Demetri James Sideras

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Abstract

Currently, UK healthcare is encountering an unprecedented quality crisis, especially considering the overwhelming challenge of improving patient care in the face of growing demands and limited resources. Although past efforts to adopt Total Quality Management (TQM) initiatives have failed to produce desired results, this thesis investigates the limitations of TQM applicability and explores the development of an innovative Quality Improvement model germane to a healthcare context. By integrating TQM with concepts from Corporate Social Responsibility (CSR), Complexity Theory (CT) and Knowledge Management (KM) a novel TQM conceptual framework, called EALIM—Ethical, Adaptive, Learning and Improvement Model—was devised.

Using an Action Research (AR) study, EALIM was implemented within a private healthcare firm by working collaboratively with organisational members over a period of eighteen months. The study included gathering qualitative data in three AR cycles: 1) pre-implementation, 2) implementation and 3) post-implementation. The first cycle involved gathering data to form a baseline assessment of the organisation, which was used to provide feedback to top management on areas for improvement. In the second cycle, an action plan was developed with top managers and EALIM's implementation was examined. In the third cycle, further data were gathered and findings were evaluated against the baseline assessment from the first cycle to identify the overall impact of EALIM on the organisation.

Findings indicated that EALIM's adoption generated a moral perception of the organisation, a learning culture, increased organisational commitment and an improvement in patient self-advocacy and independence. Factors that contributed to these outcomes were top management commitment, employee empowerment, the use of trans-disciplinary groups and practice-based training. However, other findings indicated that poor leadership and staff nurses' use of managerial control created variability in service quality. These findings suggest that while EALIM can lead to organisational improvement, the commitment of all internal stakeholders is required to achieve sustainable quality patient care.

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My hope is that other research students reading this doctoral thesis will be inspired to achieve their research goals. After all, who am I? If I can achieve such an accomplishment, they can too!

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List of Abbreviations

AD:	Affinity Diagram
AI:	Appreciative Inquiry
AR:	Action Research
ASD:	Autistic Spectrum Disorder
CAS:	Complex Adaptive System
C&R:	Control and Restraint
CB:	Challenging Behaviour
CDA:	Critical Discourse Analysis
CEO:	Chief Executive Officer
COO:	Chief Operational Officer
CQC:	Care Quality Commission
CQI:	Continuous Quality Improvement
CSR:	Corporate Social Responsibility
CT:	Complexity Theory
CTK:	Collective Tacit Knowledge
DBA:	Doctorate in Business Administration
DOH:	Department of Health
EALIM:	Ethical Adaptive Learning and Improvement Model
EHRC:	Equality Human Rights Commission
HR:	Human Resources
HRM:	Human Resource Management
KM:	Knowledge Management
LD:	Learning Disability
MARS:	Medication Administration Record Sheet
MDT:	Multi Disciplinary Team
NGT:	Nominal Group Technique
NHS:	National Health Service
PD:	Personality Disorder
PDSA:	Plan Do Study Act
PhD:	Doctorate in Philosophy

PPP:	Public Private Partnerships
QC:	Queens Counsel
QI:	Quality Improvement
RATER:	Reliability Assurance Tangibles Empathy Responsiveness
RTK:	Relational Tacit Knowledge
SERVQUAL:	Service Quality
SOVA:	Safeguarding of Vulnerable Adults
STK:	Somatic Tacit Knowledge
SQC:	Statistical Quality Control
TA:	Template Analysis
TQM:	Total Quality Management
TQS:	Total Quality Service
UK:	United Kingdom
USA:	United States of America
VOC:	Voice of the Customer

Chapter One: Introduction to the Thesis

1.1 Introduction

In the current climate of failing UK healthcare services (Public Inquiry, 2013b; Siriwardena, 2011; Wilkinson, 2014), this thesis addresses the need for an innovative and sustainable quality improvement (QI) model that could support the delivery of quality patient care. This chapter begins by explaining the origin of the study and my professional reasons for choosing this research. I then explicate the context and purpose of the research, followed by my argument for its significance to the field of healthcare. The research questions are outlined and the study itself, which includes my methodological choices and a chronicle of the research, is summarised. Finally, the structure of the thesis is described followed by a conclusion of the key points of this chapter.

1.2 Origin of the Research Study

During my 23 years experience in the healthcare field, I have always held an interest in the provision of quality patient care. However, my interest in Total Quality Management (TQM) was not spawned until 1993, after attending a lecture at Enfield College London where I discovered the philosophy and principles of W.E. Deming, regarded as one of the chief gurus of TQM theory (Besterfield et al., 2003). His principles of removing barriers that rob people of pride of workmanship, creating a climate of innovation, encouraging education and self-improvement for everyone (Deming, 1986), significantly influenced my thinking and professional practice. This was perhaps because I perceived his theories to be the antithesis of my experience of the prevailing managerialism within healthcare and its use of punitive classical quality control methods. This research study is therefore a culmination of Deming's influence and my personal ambition to develop an innovative TQM model germane to my own organisation and practice as a quality consultant in the private healthcare field.

1.3 Research Context and Purpose

Despite a plethora of public policy and quality initiatives over the last thirty years (McSherry and Pearce, 2007), healthcare in the UK is currently facing an unprecedented crisis (Siriwardena, 2011; Wilkinson, 2014). In addition, the recent spate of reported scandals and failures in both public and private healthcare sectors (e.g., EHRC, 2011; Patients Association, 2012; Public Inquiry, 2013a), have cast doubt on the quality of healthcare provision in the UK. Although the reported success of TQM programmes within manufacturing spawned a quality revolution in the 1980's, (Besterfield et al., 2003), TQM efforts in healthcare failed to deliver expected results (Kanji and Moura e Sá, 2003; Yasin et al., 2004), leading to their rapid decline by the late 1990's (Jefferson, 2002). Consequently, the purpose of this research is to critically investigate the applicability and limitations of TQM, then use those findings to inform the development and adoption of an innovative QI model germane to a private healthcare setting.

1.4 Significance of the Research

Although many TQM models exist, few TQM models have been adapted for use in healthcare contexts (Mosadeghrad, 2013; Nwabueze and Kanji, 1997; Ring, 2001). Moreover, there is a dearth of research with regards to the implementation and evaluation of such healthcare-specific TQM models. It follows that this research presents an opportunity to address this paucity and produce an innovative QI model, which could be added as an original contribution to the stock of TQM theory.

Devising a novel QI model for use in my own healthcare organisation presents an opportunity to inform my practice as a quality consultant and make a creative contribution to the professional practice of my colleagues. In a wider context, this study could inform healthcare executives and practitioners elsewhere, of key factors that could improve the delivery of quality patient care, which is especially important in the current climate of failing healthcare services. Finally, the QI model devised from this research could be taken up by other researchers in exploring its

potential use in other applicable contexts, i.e., the NHS and social care organisations.

1.5 Development of Research Questions

This research project has been guided by a number of questions, although some of them have changed as the research progressed. These changes were influenced by my experience of being a student within the DBA programme where I explored my identity as a practitioner-researcher, juxtaposed with developing my research knowledge from the literature. This resulted in my seeing the world and my research questions from an alternative perspective – a process that involved thinking about my own underpinning assumptions, which Johnson and Duberley (2000) describe as reflexivity. For example, one of my initial research questions included developing a QI model that would yield superiority over clinical governance, but after some reflexive thinking, I became aware this question connoted a positivist assumption of seeking to prove something (Johnson and Duberley, 2000). This outcome underscores the role of reflexivity in research, which some authors argue can lead to better research praxis, since it exposes one's thinking to critique (Alvesson, 2011; Haynes, 2012). Accordingly, this reflexive turn enabled me to shape my research toward a more exploratory approach, which culminated in the following research objectives and questions:

1. Review the applicability of TQM in a healthcare context.

2. Explore and develop an innovative QI model that is ethical and applicable to a healthcare setting.

3. Implement the developed QI model within a private healthcare setting and explore what (if any):
    a. Changes were needed to its conceptual framework;
    b. Acceptance and resistance participants exhibited;
    c. Impact the model had on organisational culture;
    d. Impact the model had on organisational improvement.

While this study was guided by the research questions, I was careful to keep them continuously open to review during the entire research process, as this could allow the data to lead me into areas of inquiry I had not previously considered. Continuous reflection is therefore acknowledged as part of my advancement and identity as a researcher, which remains explicit throughout this thesis.

1.6 The Research Study

Guided by the research purpose, I adopted an inductive approach, as this seemed to fit the exploratory nature of the research questions articulated in 1.5. After I reviewed the TQM literature, a wider study of the organisational literature was carried out and a QI model was devised. An Action Research (AR) methodology was chosen, since it appeared to possess features congruent with my professional practice and the participatory context of implementing the devised QI model within my own organisation. This methodology embodies a number of theoretical perspectives, which are explored and discussed in detail in chapter four. A qualitative strategy of gathering data was used, because this seemed more appropriate for understanding contextual factors and explaining the internal logic of human action in response to interventions (Coghlan and Brannick, 2010; Gill and Johnson, 2010).

The methods used to gather data included qualitative interviews, participant observation and focus groups, which fall within the data generation methods of qualitative research (Symon and Cassell, 2012). In addition, I kept a reflexive diary, which enabled me to critically explore the subjective thinking behind my interpretations and provide greater understanding of the impact my methods had on the social setting (Johnson and Duberley, 2000; Nadin and Cassell, 2006). Using a combination of qualitative methods can illuminate different facets of phenomena (Johnson and Duberley, 2000) and add rigour, breadth and richness to the inquiry (Silverman, 2011). For example, qualitative interviews allowed me to gain insights into participants' perceptions, experiences and espoused values, while participant observation generated understanding of the natural flow of every day life and the interaction participants had with others (Silverman, 2011). On the

other hand, focus groups were used to provide a more focused inquiry around particular themes (Kandola, 2012), as well as to plan and review the implementation of the devised model.

This study involved 91 participants from my own organisation. They were selected from different disciplines and hierarchical positions using non-probability techniques (i.e., opportunistic, convenience and snowballing) – techniques congruent with participatory research (Bryman and Bell, 2011). The broad selection of participants allowed me to gain insights into the divergent perceptions and experiences of organisational members and generate a broad in-depth analysis of organisational culture. Data were generated over an eighteen-month longitudinal period in three AR cycles, 1) pre-implementation, 2) implementation and 3) post-implementation. The first cycle involved gathering data for four months prior to the adoption of the devised QI model and was critical for developing a baseline assessment of the organisation, as well as constructing a collaborative action plan with top management. In the second cycle, the QI model was implemented over a twelve-month period and data were gathered with a focus on examining changes to the model, participants' acceptance and resistance to its interventions, along with its impact on organisational improvement, if any. In the third cycle, data were gathered over a final three-month period and findings were evaluated against the baseline assessment from the first cycle. This allowed me to identify the overall impact the model had on organisational culture and improvement.

1.7 The Structure of the Thesis

A critical review of the literature is presented in the next chapter. It begins with a description of the history of key quality initiatives in UK healthcare policy and documents some major scandals leading up to the current healthcare crisis. The chapter explores the origin of quality and the emergence of TQM, followed by a critical review of TQM theory and its applicability in manufacturing, services and healthcare contexts. The review closely examines the limitations of TQM and its problematic adoption in a complex healthcare environment and concludes with a

summary of findings that inform the development of a new QI model in the following chapter.

In Chapter Three, the theory building process begins with a philosophical discussion on the kind of QI model I wish to develop. This leads to a coherent set of underpinning QI commitments, which I used to select other organisational theories that could be integrated with TQM to redress its limitations. Reasoned arguments are then given for my selection of three organisational theories (i.e., CSR, CT and KM) and their conceptual links and differences are discussed. The philosophy and tenets of my devised QI model are presented and workable methods are chosen to form a coherent conceptual framework, explained and illustrated with the aid of tables and figures. Finally, conclusions are presented on the development and content of the model, along with its relevance and implications within a healthcare context.

Chapter Four gives details of the research methodology deployed. It begins with a reflexive account of how I developed my research philosophy, followed by reasoned arguments for the adoption of an AR methodology and a qualitative strategy. I then argue my choice of qualitative methods and discuss other considerations such as research ethics, the concepts I chose to explore and my role in the target organisation. Finally, I chronicle my research journey and the methods I deployed during all three AR cycles, including the emergent action strategies used to implement the devised QI model.

Chapter Five encompasses the first AR cycle and represents my baseline assessment of the target organisation prior to the implementation of the devised QI model. Findings are organised in accordance with the chronology of empirical accounts, as this seemed the most appropriate way to communicate the sequence of practice and reflection as an action researcher. Each account also contains a reflexive entry that chronicles how my attitudes and thoughts changed during my fieldwork. Key findings from this cycle are then structured and discussed to inform

my research questions and conclusions are presented on the main outcomes of my baseline assessment.

Chapter Six provides a detailed account of the second AR cycle and involves the implementation of the devised QI model. Since a large volume of data was generated during this cycle, empirical findings are structured in themes, followed by a discussion that relates these findings to the literature. This chapter concludes by summarising the key outcomes and limitations of the model during its adoption.

Chapter Seven represents my evaluation of the QI model's impact after its implementation at the target organisation. Key findings from the data gathered are evaluated against the baseline assessment in chapter five. The focus of this chapter is to examine and explain differences between the two accounts and to draw conclusions about the overall impact the adopted QI model had on organisational culture and improvement.

Chapter Eight concludes the thesis with a summary of key outcomes from this study and its contribution to practice and knowledge. This chapter also reviews the implications and limitations of the research and makes a number of recommendations for taking the devised QI model forward. Finally, this chapter ends with a personal reflection on my entire research journey, especially in regard to its impact on my professional practice and personal life.

1.8 Conclusion

This research is taking place at a point in history where healthcare within the UK is facing an unprecedented quality crisis, despite a plethora of public policy initiatives introduced over the last thirty years. As such, an innovative and sustainable QI model is called for and this research sets out to explore and develop such a model. Through an extensive literature search, a QI model was devised and implemented within a private healthcare firm. The study chronicles this journey by assessing the organisation prior to the implementation of the devised QI model, reviewing findings during its implementation and evaluating the impact of the QI model after its adoption. Conclusions are then drawn and recommendations made to guide researchers, practitioners and policy makers elsewhere, with reference to quality improvement in healthcare or other applicable contexts. In the next chapter, I review the literature that forms a foundation for understanding this research.

Chapter Two: Literature Review

2.1 Introduction

In this chapter, I review the literature concerned with TQM and its applicability within a healthcare environment. Towards this end, I adopt qualitative methods of analysis purported by Golden-Biddle and Locke (2007), which include: constructing intertextual coherence, i.e., focusing on key contributions and forging connections between theories and secondary research findings; problematising the literature, i.e., identifying key issues that have not been addressed and presenting arguments for alternative perspectives.

The beginning of this chapter sets the scene by describing key quality initiatives in UK healthcare policy over the last thirty years, followed by a number of high profile healthcare failures during the last several years leading up to the current crisis. The origins of quality, the emergence of Total Quality Management (TQM) theory and its applicability in both manufacturing and services are then explored. This is followed by an investigation into the applicability and limitations of TQM in a complex healthcare environment, which identifies key factors that could enable its adoption. The chapter concludes with a summary of findings that inform the development of a novel and sustainable Quality Improvement (QI) model germane to a healthcare context.

2.2 Key Quality Initiatives in UK Healthcare

Over the last three decades, many changes to improve British healthcare have been made, which have imposed a plethora of demands on public and independent (voluntary and private) service providers, with arguably limited or no improvement to patient care (Jefferson, 2002; Kanji and Moura e Sá, 2003; Siriwardena, 2011; Som, 2005). Walshe (2003) argues healthcare reforms have often been driven by political pressure from successive governments to stamp their own authority through policy changes that have the appearance of important and immediate change. Parkin (2009, p.2) argues the politically inspired attempts to reform the UK healthcare environment have turned it into a 'laboratory of

experimentation' that has failed to produce desired results. According to McSherry and Pearce (2007), some of these key quality initiatives have been:

- The NHS Griffiths report (Griffiths, 1983), whose author advocates a philosophy of efficiency and effectiveness, suggesting quality assurance become a primary part of the management task within the NHS;
- The white paper – *Working for patients* (DOH, 1989), proposed the creation of a purchaser/provider split and drew the attention of NHS Management to be more business-like with more emphasis on quality care for patients;
- The Patients Charter – *Raising the Standards* (DOH, 1992), distributed to all UK householders, setting out the rights and standards patients should expect as consumers of healthcare services;
- White papers – *The New NHS: Modern, Dependable* (DOH, 1997) and *Quality in the New NHS* (DOH, 1998), proposed that clinical quality have parity with managerial and financial aspects of healthcare;
- Clinical governance (Scally and Donaldson, 1998), introduced as the main vehicle for delivering QI in the NHS, with the aim of creating an environment where 'excellence in clinical care will flourish' (p.61).

Since its inception, clinical governance has emerged as a mandatory requirement for QI within the NHS, with its concepts equally applying to voluntary and private healthcare poviders under National Minimum Standards (DOH, 2002) and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. According to McSherry and Pearce (2007), clinical governance is a complex framework that combines a number of key elements, including risk management, performance management, clinical audits, evidence based care as well as education and training. While some authors have criticised the role of clinical governance as just another government imposed initiative (Goodman, 1998; Som, 2005; 2009), its efficacy in yielding QI has rarely been challenged in the literature despite a marked increase in the number of inquiries into healthcare failures since its inception (McSherry and Pearce, 2007; Som, 2009; Walshe, 2003). Although Ring (2001) contends exploring an alternative QI framework in healthcare would be fraught with difficulties, it is of great importance that this challenge be met to

improve patient care.

2.3 The Current Quality Crisis in UK Healthcare

Currently, UK healthcare is encountering an unprecedented quality crisis, especially considering the overwhelming challenge of improving patient care in the face of growing demands and budget constraints (Barker, 2014; Siriwardena, 2011; Wilkinson, 2014). To complicate matters further, over the last several years UK healthcare services (public and private) have been negatively affected by a number of high profile scandals and failures, which have garnered strong reactions from patient groups and government ministers alike. These scandals and failures include the following:

- In Feb 2010, the first public inquiry report into 1,200 premature deaths at Mid Staffordshire NHS Trust between January 2005 and March 2009 was published. Whilst the findings of this inquiry are too numerous to mention here, some include inadequate patient safety, wholly unacceptable personal hygiene practices, lack of a caring attitude toward patients and lack of hydration and nutrition (Public Inquiry, 2010).
- In the spring of 2011, a BBC Panorama investigation exposed appalling levels of staff abuse toward learning disability patients at Winterbourne View, a privately run hospital in Hambrook. Some of the abuse involved slapping patients, pinning them under chairs and chastening them with cold showers. The Care Quality Commission (CQC) subsequently closed the hospital and in Oct 2012, six former staff were handed custodial sentences (Curtis and Mulholland, 2011; Holt, 2012).
- In Nov 2011, the EHRC (Equality Human Rights Commission) published a damning report, which found widespread failures in home care for the elderly. The investigation involved 1,000 older people and carers, many of whom reported cases of physical and financial abuse, disregard to privacy and dignity, as well as basic human rights violations (EHRC, 2011).
- In Nov 2012, the Patients Association (2012) published thirteen cases of patient neglect which included lack of help going to the toilet, lack of access

to pain relief, lack of nutrition and one case of a dementia patient who was found drowned in a nearby river.

- In Feb 2013, the final public inquiry reports were published from the 2010 Mid Staffordshire NHS inquiry (Public Inquiry, 2013a). The inquiry chairman Robert Francis QC made 290 recommendations and in a press statement, he said 'Regrettably, there was a failure of the NHS system at every level to detect and take the action patients and the public were entitled to expect' (Public Inquiry, 2013b, p.2).

2.4 The Origins of Quality

Whilst UK healthcare is undoubtedly facing an unprecedented quality crisis, the origin of its adoption of quality management can be traced back to the introduction of the 1983 Griffiths report, which suggested quality assurance become a primary part of the management task. This document placed high importance on the need for a customer focused service – a concept at the heart of quality management theory (Jefferson, 2002; Nwabueze, 2001a).

The concept of quality is not a phenomenon that emerged in the healthcare industry, but essentially has a long history traced back to the guilds, involving craftsmen across medieval Europe taking long periods of training. The guilds developed strict rules for product quality (Besterfield et al., 2003). Membership in a guild was considered an honour in society, with members forming strong trade communities and political alliances to guarantee standards among their crafts and ensure goods were sold at a fair price (ASQ, 2013). However, this approach to quality was only dominant until the industrial revolution, which commenced in the latter part of the 18th century when a factory system was introduced, dividing craftsman's trades into specialised labour forces. Workers only became involved in producing a part of a product, resulting in a reduction in workmanship and skills, along with a decline in workers' empowerment and autonomy (ASQ, 2013; Besterfield et al., 2003).

In the early part of the 20th century, the de-skilling and de-humanisation of workers exacerbated after the introduction of scientific management by engineering stalwarts such as Fredrick W. Taylor in 1911, whose concepts caused unrest among workers. His concepts encouraged powerful managers to treat workers as machine parts and exercise control over them through the use of pay rates, stop watches and benchmarking sheets (Grey, 2013; Sureshchandar, Rajendran and Anantharaman 2001).

2.5 The Birth of Modern Quality Control

Although Taylor's concepts increased productivity and output, the emphasis on efficiency and division of labour decreased product quality until more complicated industrial products emerged, requiring greater quality control (ASQ, 2013). During this period of modernity, a classical system of inspection emerged as the norm for spotting items requiring rework or scrapping after manufacture (Besterfield et al., 2003). However, this system was costly and produced much waste. By the mid 1920s, Walter Shewhart – an Amercian statistician for Bell Laboratories, developed statistical control charts for controlling variables within the actual manufacturing process in an effort to improve both efficiency and quality (Besterfield et al., 2003). Whilst Shewhart's methods of Statistical Quality Control (SQC) became apparent by 1942, they were not recognised in the USA because manufacturing companies continued to rely on traditional methods of inspecting finished products rather than building quality into the manufacturing process (Besterfield et al., 2003).

2.6 The Emergence of TQM

In the 1940's, W. Edwards Deming – a statistician with the United States Department of Agriculture, became a proponent of Shewhart's SQC methods and developed his own philosophy and concepts that proponents later described as Total Quality Management (TQM). Deming summarised his philosophy and principles into 14 points, which he argues, could be applied to management processes beyond manufacturing (Besterfield et al., 2003; Siriwardena, 2011). Some of his precepts include, employee collaboration and education, driving out

fear, creating trust and a climate of innovation, eliminating numerical quotas and management by objectives, self-improvement for everyone and removing barriers that robbed people of pride of workmanship (Deming, 1986). His precepts were a departure from the principles of scientific management and flew in the face of the machine-like approach of the ubiquitous assembly line (Besterfield et al., 2003). In fact, considering the economic backdrop and industrialised landscape of such a time, Deming's ideas were regarded as so revolutionary, they were rejected in the United States (Fotopoulos and Psomas, 2009).

In the late 1940s, ravaged by the effects of World War II, Japanese political and business leaders were looking for answers on how to rebuild Japan's industries. Whilst many western business leaders deemed Deming's QI philosophy as fanciful, in August 1950 Deming presented his ideas in a seminar of 21 presidents of leading Japanese industries. In contrast to American industrialists, the Japanese leaders were innovative enough to try Deming's ideas (Fotopoulos and Psomas, 2009). Within a few years, Japan emerged from a broken post war economy that produced inferior quality goods, to a strong industry whose name was synonymous with quality, resulting in Japanese penetration of United States markets, particularly in the automobile industry. According to Gibbs (2014), the Japanese firm Toyota is still the world's largest automaker, selling over 9.98M vehicles in 2013 compared with General Motors, which sold 9.71M.

2.7 The Popularisation and Decline of TQM

By the late 1970s, old-fashioned quality control methods were influential in turning successful companies in both the United States and Europe into ineffective operations. As a consequence, American and European managers were making frequent visits to Japan to learn more about the methods leading to what had become known as the Japanese Miracle – a phenomenon others attribute to the work of Deming (Besterfield et al., 2003). Whilst Deming's work eventually found popularity, other quality gurus emerged who included Joseph Juran, developer of *quality trilogy;* Philip Crosby, *the four absolutes*; Armand V. Feigenbaum, *total quality control*; Genichi Taguchi, *loss function*; and Kaoru Ishikawa, *quality circles*

– all of whom contributed to the stock and promulgation of TQM concepts (Besterfield et al., 2003; Sureshchandar, Rajendran and Anantharaman, 2001). From the mid 1980s to the early 1990s, TQM theories were being well publicised in academic and trade journals, spawning a quality movement in organisations across the world, even penetrating the thinking of managers in service sectors and healthcare establishments (Besterfield et al., 2003; Oakland, 1993; Rahman, 2004). As a consequence, a golden age of quality management had arrived (Dahlgaard-Park, 2011), as companies such as Proctor and Gamble, Motorola, Ford and Xerox integrated TQM concepts into their corporate strategies in an effort to increase organisational performance and competitiveness (Rahman, 2004). In 1990, the UK Department of Health set up various pilot schemes endorsing TQM principles in line with its Working for Patients policy (Nwabueze, 2001a) and TQM values became apparent in its literature and organisational mission statements (Jefferson, 2002). Although various other organisations did not overtly define their quality efforts as a TQM approach, they nevertheless included underlying TQM principles within their quality management drives (Dahlgaard-Park, 2011; Nwabueze, 2001a).

From the mid 1990s a plethora of empirical investigations into TQM firms were published, asserting TQM efforts had failed to boost organisations' abilities to compete, which undermined the value of TQM (Beer, 2003). By early 2000, opponents and critics had grown, claiming TQM was dead and pointed to the need to focus on more contemporary management approaches (Dahlgaard-Park, 2011). Nevertheless, many authors have attributed TQM failures to the way managers put TQM into practice, not to the TQM philosophy (Ahire, Golhar and Waller, 1996; Beer, 2003; Nwabueze, 2001a). Therefore, in order to examine the validity of some of these claims and pursue the development of a sustainable QI framework, a critical review of both TQM theory and its implementation is required.

2.8 A Critical Review of TQM Theory

Whilst TQM has also been referred to as CQI (Continuous Quality Improvement), most authors agree the terms are used interchangeably because of their shared history and assumptions (Zabada, Rivers and Munchus, 1998). Willging (2003) contends, no matter the name, TQM and CQI share the same key principles that begin and end with the customer. Since these interchangeable terms posit quality at the centre, examining what the main gurus meant by their concept of quality is useful (Oakland, 1993, p.5): Juran – defines quality as 'fitness for purpose,' Deming – as 'quality should be aimed at the needs of the consumer, present and future,' Feigenbaum – as 'product and service in use will meet the expectation by the customer' and Crosby – as 'conformance to requirements.' Examining these different quality definitions leads to a simple conclusion – namely, quality is primarily concerned with satisfying consumer needs. The literature is also voluminous, with different TQM definitions from different authors. A sample of these include:

- 'A participative, systematic approach to planning and implementing a continuous organisational improvement process' (Kaluzny, McLaughlin and Simpson, 1992, p.257),
- 'Total – everyone associated with the company is involved, Quality – customers expressed and implied requirements are fully met, and Management – executives are fully committed' (Ho, 1995, p.4),
- 'An organisation-wide commitment to getting things right' (Atkinson, 1990, p.11).

While these definitions succinctly describe TQM, the following from Besterfield et al. (2003, p.1) appears more comprehensive and meaningful: 'TQM is defined as both a philosophy and a set of guiding principles that present the foundation of a continuously improving organisation. It is the application of quantitative methods and human resources to improve all the processes within an organisation and exceed customer needs now and in the future.' Besterfield et al. also assert the golden rule of TQM is to 'Do unto others as you would have them do unto you' (p.1), which connotes an underlying ethic to its philosophy. Although Lawler (1994)

argues TQM has no single theoretical framework or definitive shortlist of methods, James (1996) contends that a common theme exists among all of them. My examination of the definitions above, suggests the common theme of TQM is a management approach that includes everyone in the process of continuous improvement toward meeting the needs of external customers. A key aspect of TQM theory is Shewhart's PDSA cycle i.e., Plan, Do, Study and Act – a linear and iterative sequence of steps, used by Deming to illustrate his concept of continuous process improvement (Besterfield et al., 2003).

2.8.1 TQM principles

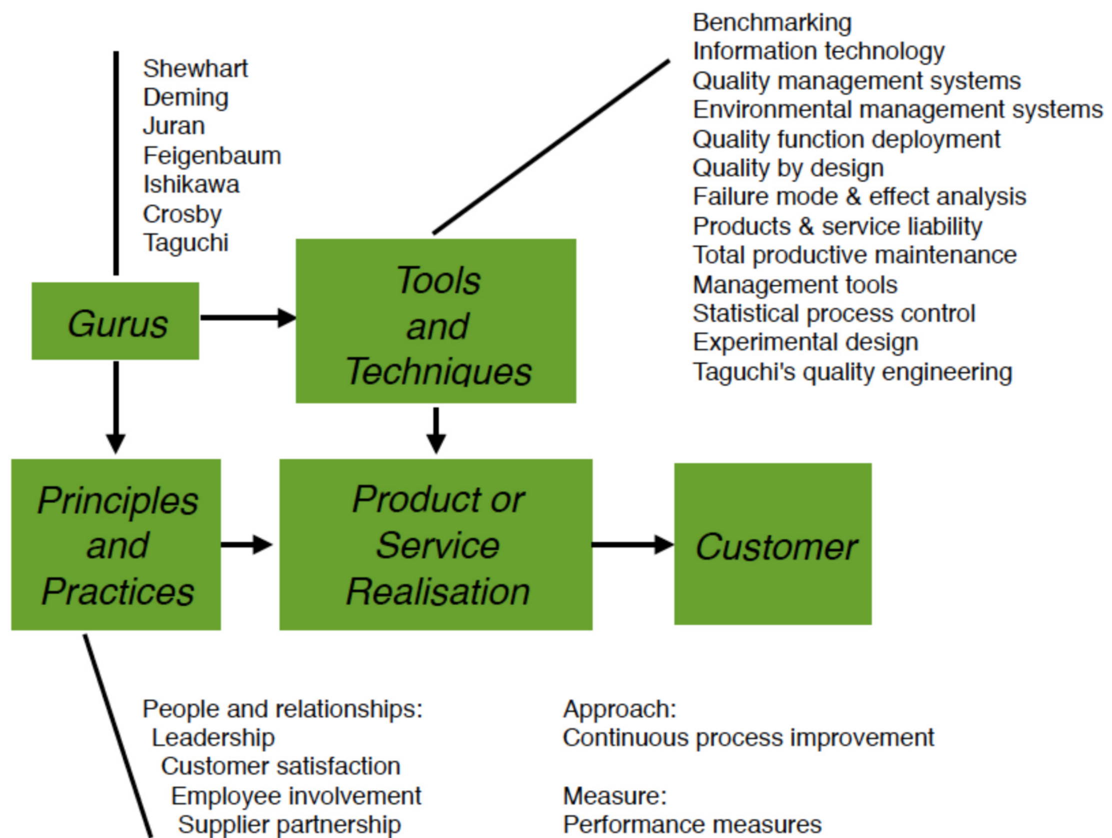
Unlike the many TQM definitions, my literature search shows little disagreement on its principles (Oakland, 1993; Shin, Kalinowski and El-Enein, 1998; Soltani, Lai and Gharneh, 2005). Other aspects authors appear to agree on include, there are no short cuts to quality, improvement requires the full support of top management and involvement by all employees (Soltani, Lai and Gharneh, 2005). Of the numerous studies that outline a range of TQM principles, the following tenets by Zabada, Rivers and Munchus (1998, pp.60-61) seem to capture the range of constructs deemed critical by TQM authors:

- Top management leadership
- Creating a corporate framework for quality
- Transforming corporate culture
- Customer focus
- A collaborative approach to process improvement
- Employee education and training
- Benchmarking
- Quality measurement and statistical reporting
- Recognition and reward

2.8.2 TQM's conceptual framework

Taking TQM principles as a point of departure, we can begin to examine its key methods and techniques. The framework in figure 1 is useful in presenting the diversity of techniques the main quality gurus contributed:

Figure 1: TQM Framework (reproduced with permission from the authors)



Source: Besterfield et al. (2003, p.6)

Oakland (1993) purports that whilst the gurus espouse divergent TQM theories and techniques, they share the same language and goal of continuously improving common business activities. However, what the framework shown in Figure 1 fails to clearly illustrate is the dichotomy of soft and hard factors associated with TQM methods. For example, Oakland (1993) created a TQM model involving a synergistic blend of hard and soft factors, which he argues is critical for its successful implementation. Other authors also discuss this dichotomy and agree a balance between soft and hard approaches must be achieved for effective TQM implementation (Rahman, 2004; Thiagarajan and Zairi, 1997c; Wilkinson and Witcher, 1992). For instance, techniques like Failure Mode and Effect Analysis (FMEA), Statistical Process Control (SPC) and Taguchi's quality engineering are considered hard factors, while soft factors relate to behaviour and attitude such as

leadership, employee involvement, empowerment, commitment and teamwork (Prajogo, 2005; Sureshchandar, Rajendran and Anantharaman, 2001). Soft factors have also been described as internal marketing approaches (Wilkinson and Witcher, 1992) and considered paramount in attaining organisation-wide support for TQM (Thiagarajan and Zairi, 1997c).

Oakland's (1993) TQM model also involves the concept of a customer-supplier interface (also known as the quality chain), which regards employees as internal customers. He argues, as each organisational member interfaces with their own immediate internal customers and suppliers, myriads of quality chains are formed across an organisation. To achieve total quality, all employees must communicate and obtain what they need from their immediate internal suppliers for the purpose of satisfying the process needs of the next internal customer in the chain (Oakland, 1993). However, Oakland warns that if a chain is broken at any point, this failure can lead to more failure down the line, ultimately affecting the external customer at the end of the chain (Oakland, 1993). Although the quality chain concept has a sanguine ring to it, Legge (1999) argues that if employees are to be regarded as rational customers, they must have their choices listened to and needs satisfied. She suggests quality chains can only succeed in high-trust working environments where employees are treated with respect and are empowered with flexibility and discretion to exercise choice. According to Silvestro (1998), another caveat of the internal customer concept is the risk of quality chains forming internal bureaucracies that are counterproductive to meeting the needs of external customers. The preceding arguments from Legge and Silvestro give insight into the problematic issues associated with implementing TQM.

2.9 A Critical Review of TQM Applicability in Manufacturing and Services

Various authors (e.g., Beer and Nohria, 2000; James, 1996) argue TQM requires a revolution in the way people think and carry out their work in organisations, which has generally proved elusive to management. Numerous studies on TQM initiatives report high failure rates. For example, Kearney (1992) concludes that only 20% of those surveyed in 100 UK companies thought their quality programmes had achieved substantive results. Furthermore, Beer (2003) reports that senior managers in 60 to 70% of companies surveyed did not believe their QI initiatives succeeded in boosting competitiveness and where they had succeeded, this was after a 5-year implementation period. The notion that TQM is a long-term process is supported by Hendricks and Singhal (1999), who after examining the financial performance of 600 publicly traded companies over a ten year period, found TQM quality award winning companies outperformed non quality award winners, but only after a 6 year QI implementation period.

The above studies suggest TQM requires long-term organisational transformation and as a consequence, executives seeking short-term gains may end up disappointed. Furthermore, the high failure rates of TQM indicate there are many obstacles to its adoption, which may explain why TQM efforts were disbanded. While a number of proponents argue TQM failures are caused by implementation issues (e.g., Beer, 2003; Shin, Kalinowski and El-Enein, 1998), other authors are more critical, pointing to limitations with TQM theory and method. For example, Steingard and Fitzgibbons (1993) argue that because TQM's concept of quality is predicated on satisfying external customers, i.e., consumer capitalism, it fails to adequately address the quality of experience and relationships of those working in organisations, resulting in a lack of regard for their 'financial welfare, job security and stress levels' (p.28). To gain a better understanding of factors influencing the success and failure of TQM adoption and in what contexts, I closely examined various papers and research studies in both manufacturing and service industries. However, these factors were so numerous, I narrowed my selection to those that appeared the most in the literature, which I documented in tables 1 and 2 (in no particular order of priority).

Table 1: Key factors for successful TQM adoption

Key Factor 1	Top management commitment and visible involvement
Context	Top managers holding consistent discussions with employees and customers. Affording respect to employees and acknowledging their suggestions. Top management involvement in giving and receiving training. A visible CEO who engages with employees.
References	Axline, 1991; Black and Porter, 1996; Coulson-Thomas, 1992; Fotopoulos and Psomas, 2010; Thiagarajan & Zairi, 1997a; Zairi, 1994.
Key Factor 2	**Top management have a clear understanding of TQM**
Context	A clear definition and understanding of TQM. Formation of clear concepts and goals, with top management actively communicating and explaining them.
References	Coulson-Thomas, 1992; Nwabueze, 2001a; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a, 1997b; Zairi, 1994.
Key Factor 3	**Commitment to education and training**
Context	Training should be immediate and ongoing, with a clear commitment to learn from top executives to shop floor workers. Organisational members quickly applying what is learnt so knowledge is not lost. Training on QI methods are cascaded to employees. Managers attend courses then design and run in-house training for explicit knowledge sharing.
References	Garvin, 1993; Black and Porter, 1996; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a; Tsang and Antony, 2001.
Key Factor 4	**Total workforce participation**
Context	Active participation by all employees with each member sharing ideas and best practices. Encouraging bottom up emergence of innovation. Problem solving through cross-functional teams, which avoids the limitations of managing through vertical functions. Formation of quality chains across the organisation by all organisational members.
References	Fotopoulos and Psomas, 2010; Nwabueze, 2001a; Oakland 1993; Powell, 1995; Thiagarajan & Zairi, 1997a; Wilkinson and Witcher, 1992.
Key Factor 5	**Employee empowerment**
Context	Empowering employees with greater responsibility so decision-making is pushed down to the lowest possible level.
References	Powell, 1995; Talib and Rahman, 2010; Thiagarajan and Zairi, 1997a; Wilkinson and Witcher, 1992.
Key Factor 6	**Middle management buy-in**
Context	Creating meaningful roles for middle managers in the implementation process. Involving middle managers in the design and promotion of TQM.
References	McAdam, Leitch and Harrison 1998; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a.
Key Factor 7	**Effective communication**
Context	Effective communication up and down the hierarchy and across teams. Use of posters, management briefing meetings, brochures, newsletters, slogans, measurement charts, question and answer sessions.
References	Black and Porter, 1996; Powell, 1995; Thiagarajan and Zairi, 1997a, 1997b; Wilkinson and Witcher, 1992a.

Table 2: Key factors for the failure of TQM adoption

Key Factor 1	**Lack of top management commitment and ethics**
Context	TQM message is incongruous with the behaviour of management. Conflict between the espoused message of TQM and its practice. TQM is implemented as an add-on programme with high expectations for quick results.
References	Axline, 1991; Beer, 2003; Ghobadian, Gallear and Hopkins, 2007; Nwabueze, 2001b; Shin, Kalinowski and El-Enein, 1998; Smith and Offodile, 2008; Thiagarajan and Zairi, 1997a, 1997b.
Key Factor 2	**No stakeholder approach**
Context	Emphasis on customers and suppliers at the expense of other stakeholders the organisation depends on, i.e., employees. Managers failing to recognise their organisational responsibility to society.
References	Beer, 2003; Hazlett, McAdam and Murray, 2007; McAdam and Leonard, 2003; Thiagarajan and Zairi, 1997a; Zink, 2007.
Key Factor 3	**Lack of adaptability to changes and unintended outcomes**
Context	Lack of spontaneity to change and unpredictable events. Slow response to changing customer needs, which creates market drift.
References	(Berry, 1991; Dooley, Johnson and Bush, 1995; Nwabueze, 2001b; Rahman, 2004; Thiagarajan and Zairi, 1997a)
Key Factor 4	**Too much focus on the hard aspects of TQM**
Context	Too much focus on the technical and analytical aspects of TQM. Statistical Process Control (SPC) is inadequate for evaluating metaphysical attributes such as: attitudes, motivation, tone of voice, warmth, care, etc. Failure to consider the personal ambitions and desires of individual workers.
References	Fotopoulos and Psomas, 2009; McAdam, Leitch and Harrison 1998; Nwabueze, 2001b; Powell, 1995; Rahman, 2004; Thiagarajan and Zairi, 1997c; Wilkinson and Witcher, 1992.
Key Factor 5	**Lack of regard of contextual and cultural factors**
Context	Top managers holding taken for granted assumptions about controlling culture. TQM's dogma and framework is applied as a universal approach without regard to cultural or organisational fit. Desired changes are not anchored in organisational culture and therefore do not become rooted as social norms.
References	Nwabueze, 2001b; Rahman, 2004; Shin, Kalinowski and El-Enein, 1998; Smith and Offodile, 2008; Thiagarajan & Zairi, 1997a; Yasin et al., 2004.
Key Factor 6	**Resistance by middle managers**
Context	Middle managers lack involvement and hold too much reliance on a quality manager or department. TQM is perceived as a political threat to their authority. Failure to shift from an authority-based position to a knowledge-based position. Lack of following up employee suggestions.
References	Beer, 2003; Coulson-Thomas, 1992; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a; Zink, 2007.
Key Factor 7	**General lack of commitment toward learning**
Context	Lack of learning culture. Failure to apply what is learnt. The application of TQM is limited to single loop learning. Managers fail to learn how their leadership methods and actions contribute to implementation problems.
References	Beer, 2003; Garvin, 1993; Thiagarajan and Zairi, 1997a; Zabada, Rivers and Munchus, 1998.

2.9.1 Conclusions on TQM's limitations in manufacturing and services

Although TQM adoption has yielded some success in improving organisational performance, research suggests most TQM efforts yielded undesirable results. The factors I have identified (from table 2) that contribute to its failure are associated with the use of formal rationality (i.e., simple means-ends decision-making) and single loop learning (i.e., learning limited to corrective action towards one's goals), with no substantive rationality (i.e., ethical and value orientated decision-making) and double loop learning (i.e., questioning one's thinking and goals) (Argyris, 1977; Weber, 1920). Moreover, the underlying technocratic and utilitarian ideology of TQM seems to ignore improvements to the relational, emotional and psychological wellbeing of employees. It follows that adopting a Habermasian approach of communicative rationality could be used to attain a more ethical and morally sensitive culture of improvement (Ahmed and Machold, 2004; Hazlett, McAdam and Leonard, 2003; McAdam and Murray, 2007). What is also evident is that the use of TQM as a bureaucratic device has little resemblance to Deming's TQM philosophy (Senge, 2006). Perhaps this is because both the theory and praxis of TQM is associated with the latter phase of industrialisation, where the emphasis was on managerialism and the efficient use of the labour resource to achieve commercial goals (i.e., utilitarian rationality) – a view supported by Boje and Winsor (1993) who argue TQM embodies aspects of Taylorism. However, with the emergence of postmodernism and increased market uncertainty, the world is a different place today due to a greater emphasis on pluralism, employee knowledge and autonomy, as well as organisational flexibility and interdependence (Berg, 1989; Hatch, 2013; McAuley, Duberley and Johnson, 2013; Stacey, 2010). This change in emphasis suggests TQM theory and method require modification.

2.10 The Uniqueness of Service Organisations

Another criticism of TQM is that because it largely emerged within manufacturing, TQM frameworks exclude key characteristics distinguishing service firms, (Silvestro, 1998; Sureshchandar, Rajendran and Anantharaman, 2001). For example, a manufactured product is physically measurable and standardised in its specification, but a service product is governed by non-physical characteristics such as care and responsiveness, making quality harder to standardise (Prajogo, 2005; Silvestro, 1998; Sureshchandar, Rajendran and Anantharaman, 2001). Although Deming (1986) suggests TQM could be applied beyond manufacturing, Zeithaml, Parasuraman and Berry (1985) describe four characteristics that differentiate a service from a manufactured product, making the extrapolation of TQM principles and techniques even more challenging (Prajogo, 2005). These service characteristics are intangibility (lacks physical existence), heterogeneity (varies in detail and from day to day), inseparability (simultaneous production and consumption) and imperishability (cannot be stockpiled or frozen).

Given the unique characteristics of services, measuring service quality that is abstract, transient and psychological, is arguably more difficult than measuring the quality of goods that are concrete, physical and permanent (Gupta, McDaniel and Herath, 2005). In an attempt to address this disparity, Parasuraman, Zeithaml and Berry (1988) developed a measurement concept called SERVQUAL, designed to measure the gap between customers' expectations and their experiences. SERVQUAL holds five aspects of service quality: reliability, assurance, tangibles, empathy and responsiveness (RATER).

Proponents of SERVQUAL argue it has superiority because it measures the gap between customers' expectations and service experiences, whereas other tools tend to limit measurement to customer experience (Gupta, McDaniel and Herath, 2005). However, Lim and Tang (2000) contend, understanding customer expectations is an arduous task as customers often do not know what to expect from an intangible service, or they may have difficulties making their expectations fully explicit. Furthermore, SERVQUAL is heavily criticised for being overly

complex and too statistical (Sureshchandar, Rajendran and Anantharaman, 2001) and Buttle (1996) argues that SERVQUAL cannot be universally applied to service firms because services differ from each other. I therefore posit it is too facile to assert a universal measurement tool like SERVQUAL can improve the quality of service firms because of variability in service contexts and processes.

To avoid imposing a universal framework onto an incompatible service context, Silvestro (1998) advocates a contingent model of TQM – that is to say, a model adopting a selection of components to fit a context specific service. Towards this end, various authors argue a TQM framework that emphasises soft factors is vital to its applicability to service contexts (Gupta, McDaniel and Herath, 2005; Prajogo, 2005; Ueno, 2008). For example, Powell (1995) asserts the adoption of hard factors like statistical process control is less effective compared to soft factors such as leadership commitment and employee empowerment.

In an attempt to make TQM more compatible to service environments, Sureshchandar, Rajendran and Anantharaman (2001) and Gupta, McDaniel and Herath (2005) developed their own Total Quality Service (TQS) framework, which they claim holds the potential for increased customer satisfaction and sustainable competitive advantage. A review of their conceptual frameworks indicates a malleable form of TQM with greater orientation toward elements that fall under the aegis of human resource management (HRM) such as visionary leadership, customer focus, employee commitment and employee involvement. However, from a Marxist perspective, HRM could be viewed as a means of extracting high commitment from employees toward the end of gaining a competitive advantage (Legge, 1999), which brings the whole issue of ethics to the fore concerning the utilitarian use of the labour resource (the subject of which will be discussed in the next chapter). Although Sureshchandar, Rajendran and Anantharaman (2001) emphasise the need for a strong service culture that can focus employees on morals and beliefs to guide behaviour, they give little indication of any coherent set of values, nor do they provide a well-formulated idea on how these values could be internalised. Furthermore, by their own admission, Gupta, McDaniel and Herath

(2005) suggest the successful adoption of TQS might be too long range, with firms only partaking of its rewards after many years of 'hard work' (p.392).

A recent study of TQM in service organisations was carried out by Talib and Rahman (2010), which involved an extensive literature survey of more than 30 quality management studies. They identified nine generic critical success factors ranked in order of importance, which they coalesced to form a TQS model. These were: top management commitment; customer focus; training and education; continuous improvement and innovation; supplier quality; employee involvement; employee encouragement; benchmarking; and quality information and performance measurement. Although these nine components seem to form a coherent model conducive to improving services, Silvestro (1998) purports that because of asymmetries between service sectors, methods appropriate in one sector might not be appropriate for another. Consequently, the transferability of a generic TQM model across the vast milieu of services is questionable – especially healthcare, which Ring (2001) argues must be adapted because its culture lends itself to heroism rather than meeting commercial goals. As such, a greater understanding of the contingencies and critical success factors of a healthcare environment is required.

2.11 The Applicability of TQM in a Healthcare Environment

In this subchapter, I address the complex nature of healthcare services and examine research findings of seminal TQM studies across the USA, Europe and the UK.

2.11.1 The complex nature of healthcare services

The complexity of healthcare services along with their bureaucratic and departmentalised structures, make them relatively unique compared to other service sectors (Nwabueze, 2001a). Healthcare services consist of a complex amalgamation of specialist, diagnostic, therapeutic and logistical processes, requiring a high degree of organisation to successfully deliver high service quality (Mosadeghrad, 2013). This service environment is further complicated by a high

number of different stakeholders, each with their own expectations and conflicting interests (Jefferson, 2002). Stakeholders include customers (patients), service purchasers (health and local authorities), service providers (i.e., hospitals, care homes), frontline staff (i.e., doctors, nurses, care workers), carers (relatives of patients), statutory bodies (i.e., care quality commission), case managers (agencies monitoring placements) and those who ultimately pay for the services (i.e., tax payers) (Gomes, Yasin and Yasin, 2010). It is therefore no wonder this mesh of complex interdependent relationships creates challenges in establishing any commonly agreed upon strategies, goals, methods and performance measures.

The complex myriad of stakeholders with their divergent attributes and interests is what prompted Øvretveit (1992) to ask, 'Who is the customer?' (p.27). Moreover, the managerialism and bureaucracy represented in the plethora of public healthcare policies, national standards and inspection regimes places greater accountability on what matters most to the state and to employers, than to patients themselves (Ring, 2001). Øvretveit (1992) suggests that because of such bureaucracy and complexity, healthcare services are differentiated from any other service sector. Parkin (2009) argues implementing change in healthcare is difficult because it operates in a milieu of organisational complexity, where individuals and groups act in unpredictable and diverse ways – where conflict and paradox generate power struggles concerning what takes priority and who gains the most. It is therefore quite understandable why some authors oppose the notion that TQM theory can directly improve the quality of patient care. Ring (2001) argues that because of the complex nature of healthcare, TQM must be adapted for use if it is to succeed.

2.11.2 TQM in healthcare across the USA and Europe

One of the largest TQM studies in the USA was carried out by Shortell et al. (1995) and involved collecting primary data from 7000 individuals across 61 US hospitals. This study examined the perceived impact of TQM programmes and reported a significant amount of hospitals used a combination of TQM methods to develop

their own eclectic approach, as opposed to adopting all the criteria considered essential. Key findings from the study indicated TQM implementation was positively associated with greater perceived patient care outcomes and an approach emphasising empowerment and decentralisation was more likely to succeed than a traditional approach of bureaucracy and centralised control. However, this study does not appear to indicate what the exact perceived improvements were in regard to patient outcomes and which particular TQM components were effective in generating these improvements.

In Europe, one of the most successful hospital wide TQM projects was that of Reiner de Graaf Gasthuis in the Netherlands during 1994, involving a 12-step Juran approach (Øvretveit, 2000). Key findings indicate a multidisciplinary team approach to process analysis was a key component to the success of the project, resulting in greater cooperation among professionals and a better understanding of how their work interrelated with one another (Øvretveit, 2000). Although findings from this study suggested an improvement in collaboration, there was no indication of any direct improvement in patient care as a result of the TQM project. Findings from other TQM studies indicate similar outcomes. For example, Øvretveit (2000) reports that in 1997, a TQM programme was implemented in a Norwegian hospital to reduce surgery cancellations. Although findings from this study indicate a reduction in cancelled operations, TQM processes were not directed at improving diagnosis and treatment because of professional resistance, a common finding of TQM adoption in healthcare (Kanji and Moura e Sá, 2003; Øvretveit, 1997).

2.11.3 TQM in UK healthcare

Although the introduction of the 1983 Griffiths report made the management of quality a central concern across the NHS, it was not until some years later that healthcare policy makers garnered interest in TQM, coinciding with its promotion in national road shows funded by the DTI as part of the Government's Enterprise initiative (Jefferson, 2002). According to Zairi and Matthew (1995), other reasons why TQM gained prominence in UK healthcare include a rapid increase in

healthcare expenditure, evidence that high-quality care is less costly than poor-quality care and greater emphasis on patient choice through the advent of the Patients Charter (DOH, 1992). While the UK Department of Health set up TQM pilot sites during the early 90's and endorsed TQM concepts as the desirable way forward (Nwabueze, 2001a; 2004), its pilot programme disbanded by the mid 1990's because of difficulties in sustaining TQM. By the end of the 1990's, TQM initiatives across UK healthcare services rapidly declined, especially after the introduction of clinical governance in 1998 (Jefferson, 2002).

After a literature search of TQM studies in UK healthcare, the following two cases are explored, since they closely relate to my research study. The first is by Potter, Morgan and Thompson (1994) from Cardiff Business School, involving an Action Research (AR) project in 3 NHS Hospital departments (operating theatres, x-ray and medical record departments), with the central aim of investigating the implementation of CQI and its impact on quality. Their methods include interviews with heads of department, survey questionnaires, observations and focus groups with participants from different disciplines to define problems and discuss how quality could be improved. Although heads of department reported high satisfaction with the outcomes of the AR project, the study shows mixed results, which includes the following key findings:

- A significant prerequisite to success was effective departmental leadership toward involving employees in the development of quality initiatives. Bottom-up strategies like quality circles, had a more positive affect on staff attitudes and behaviour than top-down strategies involving the imposition of ideas through the hierarchy. Although reflection encouraged operational staff to generate ideas toward improving the service, they often felt powerless to make changes. This seemed exacerbated by managers and clinicians practicing a 'blaming culture' (p.25) toward operational staff, which led to staff resentment and withdrawal of their creative input.
- Multi-disciplinary groups were a major success in producing different perspectives on problem solving. These groups generated cooperation among members, ownership of proposals and greater understanding of

each other’s roles, especially when clinicians and middle managers were involved. However, clinicians as a whole showed the least interest in adopting quality initiatives and changing their working practices, which the authors attribute to messages given by professional bodies. The resistance from clinicians restricted the flow of ideas and change efforts from other staff, resulting in relational issues.

- Middle managers treated quality as a discrete and episodic activity, rather than integrating it as a priority in every day responsibilities. The conflicting demands between running their own units and the expectations from higher management and senior clinicians, made middle managers feel like ‘piggy in the middle’ (p.26).
- Many staff believed there was a ‘right way’ (p.24) to perform a task and showed low commitment toward critically appraising their perceptions and actions. For example, staff were reluctant to consider patients as customers whose needs should be systematically explored and met. Also, staff had a low appreciation of the customer-supplier concept (i.e., were not sensitive to serving the needs of internal clients), which generated a high number of internal complaints from those receiving services from other departments.
- The ‘degree of authoritarianism’ (p.25) reported by staff, was damaging to the quality improvement effort of the project. As a consequence, the authors recommend a participative and democratic management approach that places high trust in staff and to facilitate the development of an informal organisation.

Although the above AR study is useful in identifying key factors for the successful implementation of CQI, (e.g., employee involvement, bottom-up strategies and multi-disciplinary groups), its findings suggest a stark variance between the rhetoric of CQI and the problematic reality of its implementation within a multi-disciplinary context.

The next study is by Joss (1998) from the Centre of Evaluation of Public Policy and Practice at Brunel University. The study was funded by the Department of

Health (DOH) and examines differences in quality improvement over 3 years within a sample of thirty-one TQM NHS pilot sites, 4 non-TQM NHS sites and 2 TQM commercial sites. Research methods involve semi-structured interviews, non-participant observation and feedback workshops. The results of the study are by no means consistent as only 2 TQM NHS pilot sites successfully adopted TQM. However, the 2 TQM commercial sites outperformed all sites in the sample. Key findings from the study include:

- Success in the 2 TQM NHS pilot sites is attributed to collaboration between top managers and senior clinicians in the development of TQM implementation plans.
- Success in the 2 TQM commercial sites is attributed to a commitment from a wide cross-section of staff and the integration of TQM principles within every day processes at different levels in the organisation.
- The common success factors for all 4 sites that successfully adopted TQM are the adaptation of TQM to the systems and professional values of each site's specific context and extensive pre-planning before the launch of TQM, including an assessment of pre-existing issues.
- TQM NHS pilot sites made more progress toward organisational improvement than non-TQM NHS sites, largely because change was driven by patient views and individual teams were more empowered to make quality improvements.
- The lack of progress in the other TQM NHS pilot sites was mostly related to top management's lack of visible commitment to TQM efforts and resistance from clinicians who perceived TQM methods as a threat to their professional discretion.
- Having a quality coordinator with easy access to the CEO was seen as essential in galvanising support and driving implementation forward.
- Although a quality team should centrally coordinate the early stages of implementation, accountability for TQM in the long term should remain with line managers and other staff. Sites following this approach made more progress in getting TQM ideas to front-line staff.

- The simplistic application of commercial TQM models was problematic in a complex professionally managed public service like the NHS.

Findings from Joss (1998) suggest that although TQM NHS pilot sites made more progress on improving quality than non-TQM NHS sites, the organisational improvements in the two commercial TQM sites surpassed all sites in the sample. Joss asserts this is because the integration of quality management in the NHS is far more challenging than commercial organisations. This point leads to the question – what are the systemic and cultural differences between public and private healthcare sectors?

2.12 Similarities and Dissimilarities of Public and Private Healthcare Firms

According to Nwabueze (2004), public healthcare firms are driven by greater bureaucracy and external politics than private healthcare firms, because they have lost sight of patient requirements due to being funded by the state and not the customer. However, Owusu-Frimpong, Nwankwo and Dason (2010, p.204) disagree with the idea of a distinction between public and private healthcare firms, arguing the NHS is a 'giant monolith with amorphous functions blurring into public and private healthcare.' They assert a long relationship exists between public and private healthcare sectors, especially since the government granted public doctors the right to practice simultaneously in both sectors. After the advent of Public Private Partnerships (PPP) schemes and the Patients Charter in 1992, patient choice improved through the competition of a pluralism of private healthcare firms funded by public purchasing authorities to provide services not immediately available within the NHS. As such, both public and private sectors are subject to similar vicissitudes, with the state exercising regulatory powers over both (Owusu-Frimpong, Nwankwo and Dason, 2010).

Despite the similarities between public and private providers, Rod and Ashill (2010) contend that public sector hospitals are often criticised for their lack of speed and QI, owing to their inflexible traditional hierarchies. Various research studies indicate private hospitals generally perform better in terms of service

quality, physical facilities, waiting times and admission procedures, largely due to differences in organisational culture and managerial style (Rod and Ashill, 2010). For example, Midttun (2007) asserts physicians working in the private sector have more time to focus on patient care compared to public physicians who spend more time on administration. In a large study of 27 public and private healthcare organisations in Australia, Badrick and Preston (2001) found TQM was generally implemented quicker in private for-profit organisations compared to their public counterparts, especially where professional bureaucracies were not featured. They contend the major difference with public sites is associated with external influences such as imposed changes, major restructuring and budget uncertainty – the effects of which generated a lack of motivation, increased cynicism and uncertainty among staff at all levels. Badrick and Preston assert the main barriers to TQM involve a lack of management commitment, autocratic professional bureaucracies and tripartite structures consisting of medical, nursing and administration staff. Nwabueze (2004) argues the failure of NHS management to deal with such barriers, generated a loss of impetus in TQM projects that eventually led to its decline in UK healthcare.

2.13 Limitations of TQM and Obstacles to its Adoption in Healthcare

According to Kanji and Moura e Sá (2003), even in cases where TQM was reportedly successful in healthcare, at best, change efforts only resulted in restructuring and alteration of written procedures. Reasons why TQM initiatives have failed to directly improve healthcare are numerous and have been the subject of much study over many years by a plethora of researchers. One of the most recent and rigorous studies of TQM obstacles in healthcare was completed by Mosadeghrad (2013) who carried out a meta-analytic review of 16 empirical articles, covering 9 countries over a 21-year period. He identifies 39 barriers to the implementation of TQM in healthcare, which he narrowed down to the 10 most frequently reported environmental related reasons, prioritised in rank overleaf (p.153):

1. Lack of employees, particularly physicians' involvement
2. Lack of consistent top management support
3. Poor leadership and management
4. Lack of quality-oriented culture
5. Insufficient education and training
6. Inadequate resources
7. Lack of a robust monitoring and measurement system
8. Employee shortage
9. Lack of a plan for change
10. Poor communication

According to Nwabueze (2004), many TQM implementation problems stem from healthcare managers using conflicting strategies, methods and performance measures derived from their own individual subjective experiences, as opposed to using a comprehensive framework underpinned by TQM theory. Gomes, Yasin and Yasin (2010) and Zabada, Rivers and Munchus (1998) advocate a similar view when they suggest the existence of many stakeholders with divergent concepts of quality and opposing interests makes the application of TQM in healthcare problematic. Furthermore, other authors argue TQM theories and models may improve organisational functions like Human Resource Management (HRM) and Finance, but not clinical areas – a view derived from a belief that patient care is held firmly in the hands of professional clinical staff. Since clinicians have historically made decisions that govern most aspects of hospital activity, any impetus for change by management is usually seen as an encroachment on their independent clinical judgment (Shortell et al., 1995).

2.13.1 Paradigmatic conflicts between healthcare professionals and TQM

Achieving sustainable commitment from clinical staff is a notable and paradoxical challenge to the adoption of TQM, as it is impeded by an adverse culture of professional bureaucracies holding greater commitment to professional bodies than to a strategy of empowerment and collaboration (Badrick and Preston, 2001; Kanji and Moura e Sá, 2003; Nwabueze, 2001a). The comparative analysis in

table 3, succinctly summarises the paradigmatic conflicts between health professionals and TQM concepts:

Table 3: Conflicts between healthcare professionals and TQM concepts

Professional	TQM
Individual responsibilities	Collective responsibilities
Professional leadership	Managerial leadership
Autonomy	Accountability
Administrative authority	Participation
Professional authority	Participation
Goal expectations	Performance and process expectations
Rigid planning	Flexible planning
Response to complaints	Benchmarking
Retrospective performance appraisal	Concurrent performance appraisal
Quality assurance	Continuous improvement

Source: Short and Rahim (1995, p.261)

The paradigmatic conflict between healthcare professionals and concepts of TQM has similarities with the theories of Kegan and Lahey (2001), who argue competing commitments are at the very heart of a person's or group's resistance to change, derived from assumptions about how people see themselves and the world around them. They suggest when people perceive a reality threatening their self-identity or sensemaking, their need for self-preservation causes resistance that blocks change. These underlying assumptions are formed by deeply held beliefs that not only give order to the world, but also inform people how the world can go out of order, serving to wittingly or unwittingly maintain the status quo (Kegan and Lahey, 2001). Schein (2010) argues that since the human mind needs cognitive stability, any perceived challenge posing a threat to basic assumptions, triggers anxiety and defensiveness. Whilst Argyris (1977) asserts that crisis or potential crises can stimulate double loop learning resulting in changes to one's sensemaking, he also warns this could work the other way, whereby the critical reflection required to generate double loop learning triggers defenses that block learning (Argyris, 1991). Examination of this kind of sensemaking — the way individuals socially construct reality within their minds in the form of maps and

images of experience (Hatch, 2013) — appears to be rarely discussed in the TQM literature. I therefore argue, a better understanding of the deep psychology of individuals and groups can illuminate the mental constructs that block new ways of thinking and acting (Argyris, 2010; Gabriel, 1999).

Another perspective that can explain why people resist change is espoused by Chris Arygris (2010). In short, his theory suggests that people say one thing, do another, then deny they are doing so – which he claims is a universal human predicament (Argyris, 2010). Argyris argues people are trapped by using what he calls model I – defensive reasoning, when trying to espouse model II – productive reasoning, then deny they are doing so. The values governing human behaviour of model I – defensive reasoning are (Argyris, 2010, p.63):

1) Being in unilateral control
2) Win and do not lose
3) Suppress negative feelings
4) Behave rationally

The aim of defensive reasoning is to protect one's self from harm, embarrassment, or changes perceived as threatening. Argyris (1994) asserts that because TQM theory is predicated on linear, single loop learning (e.g., PDSA cycle), it fails to address obstacles created by 'individual defensive reasoning and organisational defensive routines' (p.80). In contrast, the governing values of model II – productive reasoning are entirely different, which are (Argyris, 2010, p.64):

1) Seek valid (verifiable) information
2) Create informed choice
3) Monitor vigilantly to detect and correct errors

Argyris (2010) claims when people are competent in using productive reasoning, they will become more constructive individuals who are proficient at double loop learning, allowing them to be truthful and open to addressing their own defensive routines and causal responsibilities. However, when people espouse model II whilst practicing model I, they often resist change and create traps for themselves.

For example, some may say they are democratic and trusting, but unconsciously act in ways that undermine these values (Argyris, 1993; 2010). This inconsistency resonates with the opinion of Bovey and Hede (2001) who purport defensive mechanisms are triggered when new thoughts and feelings in the conscious mind conflict with pre-existing thought patterns, feelings and intentions in the unconscious mind – a phenomenon known as intrapsychic conflict (Bovey and Hede, 2001). Bovey and Hede also suggest these unconscious forces can hold more power over an individual's actions than consciousness does, consequently diverting energy away from changing one's behaviour. In other words, intra-psychic conflicts can produce psychological traps that are anti-learning and anti-corrective of the errors that people create. Argyris (2010) claims traps not only inhibit change processes and the learning of new methods, but also 'represent the next big challenge to raising the level of performance by individuals, groups, organisations and societies' (p.3).

Those who fail to properly consider the role of psychodynamics of individuals and groups can overlook intra-psychic conflicts causing maladaptive defensive mechanisms toward change programmes (Bovey and Hede, 2001; Gabriel, 1999). A failure to consider psychological traps may also indicate naive assumptions by managers implementing TQM, when they presuppose little resistance to its philosophy and that results will be forthcoming in the short-term. Kanji and Moura e Sá (2003) argue that when immediate results of TQM are not quickly evident, disbelief and distrust can surface, which tends to reinforce the status quo of 'things should be done the way they have always been done' (Nwabueze, 2001a, p.664).

2.13.2 Paradigmatic conflicts between clinicians and managers

In addition to conflicts between healthcare professionals and TQM concepts, deep differences exist in the ways clinicians and managers think, which Parkin (2009 p.57) aptly calls the 'hub and the rub of healthcare management.' The paradoxical and unavoidable conflict between the reductionist approach of medicine and the deeply political world of managerialism can cause deep tensions between

clinicians and managers (Jefferson, 2002). Table 4 illustrates some of the competing commitments clinicians and managers hold.

Table 4: Conflicts between clinicians and managers (reproduced with permission from the author)

Clinicians	Managers
Patient outcomes	Patient experience
Focus on individual patients	Emphasis on populations/organisation
Optimum care for each patient	Trade offs between competing claims
Need for professional autonomy	Need for public accountability
Desire for self regulation	Preoccupied with systems
Use of evidence based practice	Fair allocation of resources
Tendency to personal responsibility	Tendency to delegation

Source: Parkin (2009, p.57)

Differences between clinicians and managers often manifest in a lack of cooperation and consensus on roles, responsibilities and priorities, as well as in disagreement on improvement methods and performance measures (Gomes, Yasin and Yasin, 2010; Jefferson, 2002). Bovey and Hede (2001) argue that people who feel internal anxiety from interpersonal tensions with others, often project blame instead of accepting responsibility for their own impulses. In an effort to reduce these tensions, Parkin (2009) exhorts managers and clinicians to learn from each other, highlighting important similarities between the two groups such as a concern for ethics, a propensity toward action and a belief in continual training.

A convergence between clinician and manager is symbolised in the role of a nurse, who has historically managed at operational levels. However, nurses were excluded from management under the Griffiths report (1983) because of questions over their leadership competence, but in the NHS plan (DOH, 2000), the role of nurse manager was reclaimed through the re-constitution of the modern matron. This plan set out new roles for nurses to manage localised healthcare services as strong leaders with transparent authority (Parkin, 2009). However, some authors

argue an incompatibility exists between the attributes of nurses and managers due to a clash of two different ideologies (Parkin, 2009), suggesting there are no easy solutions toward ameliorating the tension between the business of managing quality and the professionalisation of clinicians. However, Mosadeghrad (2013) points us in the right direction by asserting TQM values and principles need adapting to a strong professional healthcare setting. His argument suggests that if a set of commonly held values could be identified among managers and clinicians, this could serve to diffuse their differences.

2.13.3 Changing organisational culture

Zabada, Rivers and Munchus (1998) purport that among all the barriers to TQM adoption in healthcare, cultural obstacles are the most difficult to overcome, asserting deep cultural change will be necessary for the internalisation of TQM philosophy among organisational members. This assertion seems to correspond with those of other TQM authors (e.g., Mosadeghrad, 2013; Nwabueze, 2001a) who argue a total reorientation or transformation of values and beliefs are required.

Since organisational culture is a complex phenomenon that is the subject of vast discussion and debate in the literature, I could not do it justice here. Nevertheless, a rudimentary understanding of organisational culture can be drawn from various authors who succinctly define it as ‘The way we do things around here’ (Deal and Kennedy, 1982, p.4), ‘…the pattern of shared beliefs and values’ (Davis, 1984, p.1) and ‘…the collective programming of the mind that distinguishes the members of one group or category of people from others’ (Hofstede, Hofstede and Minkov, 1991, p.6). Schein (2010) argues that culture implies a sense of how people ought to think, feel and act, taught through socialisation as a way of maintaining stability. According to Schein (2010, p.24) culture has three levels: ‘artefacts’ (i.e., observable behaviour), ‘espoused beliefs and values’ (i.e., commonly accepted ideals and convictions) and ‘basic underlying assumptions’ (i.e., taken for granted assumptions or governing values). In other words, culture is a powerful phenomenon – expressed in behavioural norms and espoused values, shaped by

deep cognitive constructs within the human mind that have been learned through social experiences. It is therefore no wonder the proposition of managing corporate culture is contested in the literature.

From a postmodern perspective, one could argue the question of whether organisational culture can be changed is largely a modernist ideology, predicated on assumptions of managerial control (Hatch, 2013). Although modernists assume managers are influential because power structures provide them a platform to be heard and seen, post modernists contend that managers are limited in their efforts to change organisational culture due to employees' deeply entrenched and unquestioned beliefs, derived from their own particular socio-historic milieu (Hatch, 2013). The idea of employees' unquestioned beliefs are difficult to change, corresponds with those of Rassin (2008) who argues that healthcare staff bring into the care setting their own sets of values and beliefs learned during early socialisation, which shapes caregivers perceptions, decisions and interactions with patients. On this basis, it is perhaps no surprise organisational culture is an obstacle to the adoption of TQM, typically implemented through modernistic rationalisations involving the socialisation of employees through training courses, along with management by objectives and rewards intended to motivate desired performance (Hatch, 2013; Senge, 2006).

While much of the literature suggests TQM requires adaptation to professional healthcare values, there is little mention of any set of values healthcare firms should adopt. Carney (2006, p.112) asserts 'not a single moral model' or guiding set of values exist in healthcare management, arguing for the urgent need to develop a moral strategy embracing guiding ethical virtues. If an intrinsic set of values could be developed and widely held within healthcare organisations, such a norm could become a 'substantive hyper-norm,' acting as a moral foundation to guide human behaviour, not control it (Carney, 2006, p.112).

2.13.4 Defining healthcare quality

According to Nwabueze (2001a), the first step toward TQM implementation should be to agree the meaning of quality. Although this seems sensible, no commonly held definition exists due to differences between numerous healthcare disciplines and divergent stakeholder views (Zabada, Rivers and Munchus, 1998). It would therefore seem prudent to rely on one of the most widely known efforts to define quality in healthcare, made by Donabedian (1988), who proposes healthcare quality is comprised of three interrelated components (pp.1743-1744):

- Technical care – the extent to which clinical processes meet predefined specifications, i.e., what care is delivered.
- Interpersonal relationships – characteristics of interaction between the provider and service user, i.e., how care is delivered.
- Amenities of care – the quality of facilities provided, i.e., locations of where care is delivered.

Bell (2004) argues the dominant paradigm used within healthcare quality management focuses on the technical or clinical components of care quality, resulting in less emphasis on the interpersonal experiences of service users. Interestingly, using a conceptual model based on Donabedian's work, research carried out by Chang et al. (2006) on 236 vulnerable patients suggests patients value interpersonal communication more highly than they value the technical aspects of care. Chang et al. also found, better interpersonal care can contribute to greater patient satisfaction, which corresponds with other studies whose authors conclude that patient satisfaction is an affective construct, indicating the importance of the emotional experiences of patients (Owusu-Frimpong, Nwankwo and Dason, 2010). Bell (2004) asserts much can be learned from healthcare firms adopting a TQM approach in which the focus is firmly placed on the customer dimension to define quality, but claimed not enough has been done to include the experience of service users in improving services. The issue of customers having little or no part to play in shaping their healthcare services has been a reoccurring criticism in the literature (Jefferson, 2002). Owusu-Frimpong, Nwankwo and Dason (2010) assert clinicians generally resist incorporating the views of patients in

determining service quality because they deem patient views to be too subjective to be of any use. However, to ameliorate the lack of patient involvement in shaping care services, Bell (2004) recommends the use of focus groups or quality circles where patients could be empowered to express their expectations, suggest improvements and influence the services they receive. Such groups may be particularly useful for vulnerable patients or people with mental illness, who typically have limited opportunities to contribute to their own lives (Bell, 2004).

2.13.5 Some problems with high regularisation and bureaucracy

The issue of empowerment is not only problematic for patients but also for staff. For example, various authors argue the devolution of power to frontline staff is difficult in a highly regularised context, driven by public policy, arbitrary standards and copious inspection audits (Jefferson, 2002; Parkin, 2009) – the antithesis of Deming's philosophy (Siriwardena, 2011). Litaker et al. (2006) suggest that because past attempts to set out rules governing healthcare have failed, the response by government agencies has been to create even more rules, taking the whole industry in the wrong direction. Nwabueze (2004, p.11) argues quality in healthcare is often judged by the 'thickness of the manual,' which serves to strengthen a procedure-laden management approach, seen as the 'belt and braces of control.' Nwabueze (2004) also purports this kind of technocratic managerialism disempowers individuals from making a creative contribution and inhibits the learning of root causes to problems, consequently fueling a continuous cycle of fire-fighting. This quandary poses questions for both public and private healthcare firms regarding how adaptive and innovative they can be in a climate that engenders such bureaucracy and control.

The myriad of externally imposed procedures, standards and codes of professional conduct, cause another predicament – namely, they encourage care practitioners to adopt a rules or obligation-based ethic, which strips away the virtue ethic of healthcare advocated by nursing pioneers such as Florence Nightingale (Armstrong, 2006). Nightingale was against a healthcare practice dominated by bureaucracy, scientific knowledge and technical skills, arguing in favour of a

practice founded on intrinsic human values (Rassin, 2008). Edwards (2011) purports an obligation-based ethic is externally imposed and presupposes that individuals must first rationalise what obligations they have toward the other, before acting in a way which complies with those requirements. In contrast, a virtue-based ethic is internally derived from a caring disposition toward the other (i.e., altruism), which Armstrong (2006, p.112) argues is a crucial trait for healthcare professionals to deliver sustainable 'morally good care.' Sellman (2010) suggests the organisational imperative of meeting externally imposed targets and regulatory requirements are instrumental in nature and distort nursing practice by undermining substantive caring values. In other words, voluminous codified rules and formal care standards seem to create a healthcare culture that places greater emphasis on the 'external goods' of healthcare (i.e., compliance, social status), than the 'internal goods' of excellence (i.e., virtues sustaining healthcare practice) (MacIntyre, 2007, p.190).

The other issue with having a plethora of demands from external agencies is these create institutional pressures of conformance to win social acceptance and organisational legitimacy. Although the acceptance of conventional norms make an organisation look good and sustain short-term survival, the same norms can constrain quality improvement and innovation, consequently harming an organisation's long-term survival (Hatch, 2013).

2.14 Conclusion

Despite a plethora of quality initiatives and imposed public policy changes over the last thirty years, UK healthcare has experienced a marked increase in failures and as a consequence, is currently facing an unprecedented quality crisis. Although TQM emerged with some success in manufacturing industries across USA and Europe in the 80's, its applicability into the healthcare sector during the 90's was reportedly less successful, resulting in the UK Department of Health disbanding its TQM pilot programme.

An investigation of TQM applicability within a healthcare context found many obstacles, largely relating to its modernistic assumptions and technocratic application, lack of visible commitment from top management, lack of democratic leadership and defensive behaviours of clinicians. It follows that a participative and democratic management approach that yields increased trust and informality among organisational members could facilitate the adoption of TQM. Furthermore, an examination of TQM theory and method suggested the application of a manufacturing based TQM model is problematic in a complex and professionally driven healthcare environment. As a consequence, TQM will require adaptation to the context and professional values of healthcare practitioners, with a particular emphasis on soft TQM factors, i.e., employee empowerment and teamwork. Finally, the myriad of externally imposed targets, formal standards and professional codes of conduct within the healthcare industry, not only creates institutional pressures of conformance, but also undermines innovation and substantive caring virtues, crucial for sustainable quality healthcare. Therefore, to achieve sustainable quality improvement, an innovative TQM model will need to be devised that can hold a set of core values necessary to deliver morally good care. In the following chapter, I consider the theory building process underlying my research of a novel QI model and present EALIM, a modified and expanded TQM model.

Chapter Three: Theory Building and Model Development

3.1 Introduction

Drawing from the key findings of the literature review in chapter two, this chapter involves the theory building process used for the development of an innovative and sustainable Quality Improvement (QI) model germane to a healthcare context. A number of variant TQM models have been adapted for use in healthcare from other contexts (Claus, 1991). However, rather than build new theory through comparatively analysing these existing models, this chapter begins with a reflexive examination of the main underlying assumptions of TQM theory and adoption, followed by a philosophical discussion on the kind of QI model I wish to devise. This approach is supported by the work of Cassell and Lee (2011), who argue an insufficient attention to philosophical underpinnings has led to lost opportunities for theory building and that attempts to develop insights from current conceptual frameworks only lead to variants of the same existing themes. This philosophical discussion leads to the emergence of a coherent set of underpinning QI commitments, which I used to select and integrate three other organisational theories with TQM to redress its limitations. These organisational theories were corporate social responsibility (CSR), complexity theory (CT) and knowledge management (KM). Reasoned arguments are given for their selection and their conceptual links and differences with TQM are discussed.

I then explicate the philosophy of my devised QI model (EALIM), provide definitions for its four organisational concepts and develop a set of ten tenets that underpin its four concepts. This is followed by a discussion of the QI model's core values and the common linkages among its four concepts, synergistically arranged to form an iterative cycle of learning and improvement. Next, workable methods and techniques are chosen for the devised QI model to form a coherent conceptual and cultural framework, explicated and illustrated with the aid of tables and figures. Finally, conclusions are presented on the development and content of the model, along with its relevance and implications to the field of healthcare.

3.2 Toward a More Sustainable Quality Improvement Model

In this subchapter, I describe and explain the reflexive process I used to critically examine the main underlying assumptions of TQM theory and adoption, then philosophically discuss the kind of QI model I aim to develop.

3.2.1 A reflexive turn

The process I used to examine the underpinning assumptions of TQM theory and adoption was spawned by a reflexive learning approach. According to Johnson and Duberley (2000, p.178), reflexivity has a Kantian emphasis on rational reflection that 'entails the researcher attempting to think about their own thinking…and in some cases transforming the meta-theoretical assumptions they deploy.' Although a number of authors have devised their own approaches and models of reflexivity over recent years, these commonly involve critically examining how their own thinking came to be and constantly revising how their schemas shape and are shaped by their engagement with the world (Symon and Cassell, 2012). Tosey, Visser and Saunders (2011) suggest reflexivity entails both double and triple loop learning. Double loop learning involves examining the underlying assumptions of one's goals, beliefs and behavioural norms (Argyris, 1993), while triple loop learning involves transforming one's being in the world that often includes a concern for the emancipatory interest, i.e., freeing people from various forms of domination (Flood and Romm, 1996; Nielson, 1993).

My adoption of double and triple loop learning (Flood and Romm, 1996), transformed my mental paradigm because I challenged my own meta-theoretical assumptions about managerialism and the use of power in organisations. Furthermore, after reading various textbooks on organisational theory, I adopted critical theory and symbolic interpretivism, since these perspectives allowed me to ask deeper questions about the goals and methods of organisations and the symbolic meaning of people's communicative interaction (Hatch, 2013; McAuley, Duberley and Johnson, 2013). During this process, I gained a deep attraction to the duty ethic espoused by Immanuel Kant (1724-1804), perhaps because it mirrored my own personal belief about how I intrinsically value people.

Consequently, as I began to see through these newfound lenses, I developed a concern for the ‘development of organisations that enable people to be fulfilled emotionally and intellectually’ (McAuley, Duberley and Jonson, 2013, p.330). This concern essentially changed the way I saw organisations and the kind of QI model I sought to devise. In the next four subsections, I philosophically discuss various considerations for the development of a new QI model that could redress TQM’s limitations.

3.2.2 A problem with managerialism

A significant limitation underscored by authors (e.g., (Boje and Windsor, 1993; Steingard and Fitzgibbons, 1993), has been TQM’s preponderance on managerialism. Deming (1994, p.15) was against what he called ‘the prevailing style of management’ because he perceived it as tyrannical, even describing it as a ‘prison’ controlling the way people interact. According to a letter written to Peter Senge, Deming stopped using the terminology of TQM because he felt it symbolised a superficial system of ‘tools and techniques’ used by managers to manipulate workers (Senge, 2006, p.7). Conversely, Deming’s philosophy was predicated on the ideal for ‘everybody to win,’ not just the management elite (Deming, 1994, p.15), implying the problem with TQM is perhaps not so much with its original philosophy, but with its modernistic methods and technocratic application (Beer, 2003).

McAdam, Leitch and Harrison (1998, p.51) argue that in some respects, TQM has evolved as a way of ‘duping’ employees to accept elements of Taylorism, i.e., achieving maximum business efficiency. I too arrived at this conclusion after critically reading various textbooks by exponents of TQM (e.g., Besterfield et al., 2003; Hoyle, 2007; Oakland, 1993). In them, I perceived a constant use of the same cliché grand narratives of managerialism, performance and productivity, which expose taken for granted assumptions of investment capitalism, managerial control and formal rationality – a perception shared by other authors (e.g., Boje and Winsor, 1993; Steingard and Fitzgibbons, 1993). This perception led me to ask deeper questions about the nature of organisations and larger issues in

society concerning power and control (McAuley, Duberley and Johnson, 2013). It follows that such ethical issues must be addressed in my quest to develop an innovative and sustainable QI model.

3.2.3 A clarion call for better ethics

Although dominant organisational theories are embellished with various euphemisms, their underlying assumptions of capitalist formal rationality still pervade, with few adopting Max Weber's ethical concept of substantive rationality (Weber, 1920). In his essay published in 1920, Weber wrote, 'The more the world of the modern capitalist economy follows its own inevitable laws, the less accessible it is to any imaginable relationship with religious or ethic of brotherliness' (cited from McAuley, Duberley and Johnson, 2013, p.356). Weber's thoughts on capitalism are not dissimilar to criticisms Deming had of western style management, with its emphasis on short-term profit, accounting-based performance measures and financial reward (Deming, 1986; 1994). Even in today's ostensibly developed society, employees are still being managed in a machinelike fashion through the sharpened performance tools of modernism, designed to extract maximum efficiency from the workforce for the benefit of shareholders (Grey, 2013). This raises the question of whose interests corporations should serve? I argue that instead of executives imposing a corporate vision on others, employees need a vision they can believe in – a shared vision that holds wider interests than those of executives and shareholders – a point TQM theory fails to address (Steingard and Fitzgibbons, 1993). Such a vision could create a sense of pride among employees and generate a sense that their work is producing a far greater end for the human race (Senge, 2006).

What I am referring to here is a way of organising that rests on a Kantian duty of ethics (Kant, 1788), which could be used to address TQM theory's preponderance on formal and utilitarian rationality (Steingard and Fitzgibbons, 1993). The adoption of a Kantian ethic could enable workers to understand their jobs are not merely a means to an end (i.e., being used to generate shareholder wealth) and produce a sense of shared respect among managers and workers. However, a

Kantian ethic may not be achieved if managers expect workers to simply cooperate with their diktats – a criticism of TQM application (Axline, 1991; Ghobadian, Gallear and Hopkins, 2007). I therefore posit that all stakeholders (including workers) become both the means and the end. However, shareholder wealth should not be seen as a contradiction to a Kantian ethic as long as it benefits other stakeholders through socially responsible initiatives (Kotler and Lee, 2005). But one could ask, who financially benefits the most? In most cases, shareholders do if the organisation prospers, but if it fails, they could also lose the most. It therefore stands to reason that shareholders receive a premium for the investment risks they take (Carroll and Shabana, 2010).

While shareholders should receive a return on their investment, I posit a Kantian ethic would make people the core value of an organisation and provide an ethical compass that guides the management of employees, i.e., management based on humane values, not authority (McAdam and Leonard, 2003). Furthermore, a Kantian ethic grounds the requirement of healthcare practitioners to be patient-centered (Sellman, 2010). Equity, fairness, care, social action and philanthropy can flow from this core value. Besides, the shared vision and social conscience of their employer could enable employees to engage toward ethical goals because employees' realise the impact of their personal work is a noble one that makes a contribution toward society (Senge, 2006). However, a critical view of this kind of corporate social responsibility (CSR) is taken by Banerjee (2008). He argues CSR is an ideology used to consolidate the power of organisations, serve the corporate interest and regulate the behaviour of stakeholders. Conversely, Carroll and Shabana (2010, p.92) assert a 'win-win' CSR approach could allow a firm to pursue its operations and at the same time, satisfy the demands of stakeholders. I therefore posit that adopting a win-win CSR approach could turn shareholders into semi-philanthropists, without harming their ability to create wealth (Kotler and Lee, 2005).

Although a win-win CSR approach appears noble, one can see the harm of this approach if used as a superficial marketing device by self-serving executives

whose only interest is to cajole employees and boost competitiveness – an allegation posed by Banerjee (2008). Not only would this surreptitious use of CSR undermine a Kantian ethic, but also break the golden rule of TQM, 'Do unto others as you would have them do unto you' (Besterfield et al., 2003, p.1). On the other hand, if people are seen as the core value and the motive is a Kantian one, a win-win CSR approach could allow shareholders to ethically generate wealth and at the same time, make a social impact – providing sustainable economic and social value (Carroll and Shabana, 2010).

I should make clear the CSR approach I am purporting here is not one limited to environmental sustainability, but one that includes human sustainability. Another criticism of CSR is that its locus is on protecting the ecosystem at the expense of ignoring the physical, mental and emotional wellness of employees (Pfeffer, 2010). Although environmental sustainability is important, Pfeffer argues a socially responsible business should also consider the effects of business practices on employee health and wellbeing. Lay offs, long working hours, work-family conflict, work related stress and inequality, are often overlooked in both the CSR and TQM literature (Pfeffer, 2010; Steingard and Fitzgibbons, 1993). It follows that a CSR approach which includes both human and environmental considerations could enable greater corporate sustainability (Haugh and Talwar, 2010) and generate other positive outcomes, some of which are discussed in the next section.

3.2.4 Organisational idealism

Adopting a strong corporate social ethic that cares for both people and the planet could generate a high perceptive value of the organisation in the minds of workers and create opportunities for commitment and action (Kotler and Lee, 2005; Stacey, 2010), a concept not dissimilar to organisational ideal theory. Drawing on the theories of Sigmund Freud, Schwartz (1987) describes the organisational ideal as a conceptualisation of organisational fantasies that colonise an individual's ego ideal, i.e., an image people aspire to. Furthermore, the organisational ideal represents a fusion of both object and subject, acting as a means of returning to narcissism – 'being the centre of a loving world' (p.330). Consequently, when a

corporation becomes an organisational ideal in the minds of workers, it could produce an organisational identity that acts as an object of security, trust, or even love, generating a kind of corporate ego (Hatch, 2013).

Another implication of adopting a strong corporate social ethic is it could connect stakeholders to values judged as intrinsically good, resulting in profound feelings of pride and powerful motivations to act toward the good of the organisation (Stacey, 2010). However, corporate social values may only have motivational impact if they have shared meaning among organisational members – that is to say, when particularised in each action situation, especially by managers (Stacey, 2010). However, the adoption of corporate social values could be both constructive and destructive. For instance, they could be constructive if daily human interactions are reflective of corporate social values, i.e., management practice what they preach; and destructive if the inter-subjective experience of workers is not expressive of these corporate social values (Stacey, 2010). As such, to achieve any kind of organisational ideal, executives and managers should lead by empowering workers and serving their needs, a notion purported by Deming (1986; 1994) in his philosophy. Organisational democracy is an approach that supports this kind of ideal, which could be adopted to promote ethical decision-making and redress power imbalances between managers and workers (Harrison and Freeman, 2004) – a criticsm of TQM adoption (Beer, 2003).

3.2.5 The case for a democratic organisation

Whilst one crucial aspect of critical theory is to bring emancipation and enlightenment, another of its aspects is to make organisations more democratic (McAuley, Duberley and Johnson, 2013). In an organisational context, democracy is regarded as an ideology of egalitarianism and pluralism and a style of management allowing members autonomy to participate in the process of organising and governing (Harrison and Freeman, 2004). As noble as this may sound, democracy comes with a caveat, in that any attempt by management to move the state of an organisation to a more autonomous one could be precarious, because employees do not always consider others when left to themselves in their

journey toward newfound freedom (Kets de Vries, 2004). Although democracy can allow employees to be more autonomous, psychoanalyst Kets de Vries argues its ideal does not negate leadership because employees still need a heroic figure who can act to solve difficult problems, especially in times of crisis. Although workers may have different needs than leaders, working democratically should mean less communicative distortion, more mutual understanding and a genuine regard by leaders to respond to everyday forms of domination and conflict (McAuley, Duberley and Johnson, 2013).

A democratic ideal could be realised successfully when there is a balance between social value and shareholder value, as has been the case in Scandinavian countries (Byrkjefolt, 2003). As such, organisational democracy can be thought of as aligning human benefits with business benefits, which Johnson (2006) asserts can bring major advantages to the development of the organisation. Organisational democracy, along with other key points from the preceding philosophical discussion and literature review, are used to underpin the development of a new QI model in the next subchapter.

3.3 Model Development

My critical analysis of TQM led me to closely examine other organisational theories that could be integrated with TQM theory, to form a coherent conceptual framework. Some of the theories I examined included corporate social responsibility, stakeholder theory, organisational learning / knowledge management, complexity theory, actor network theory and organisational aesthetics theory, to name but a few. However, in order to narrow my selection I framed some QI commitments, which I used to filter, select and combine a set of organisational theories that could redress TQM's limitations. The following QI commitments embody a Kantian perspective and are underpinned by critical theory. I deemed my QI model should be committed to:

- Precluding the dominant discourse of management theory, meaning the exclusion of investment capitalism, instrumental rationality and managerial control.
- A Kantian view of humanity, i.e., seeing people as both the means and the end.
- A corporate social ethic with an altruistic concern for people and the planet.
- Generating pride and affection among workers toward the organisation, through ethics of virtue, values of care and mutual trust.
- A Habermasian approach of open communication, mutual understanding and organisational democracy.
- Enabling explicit and tacit knowledge sharing to foster innovation, transformation and double loop learning.
- An adaptive approach to dynamic change and unpredictable events.
- Enabling improvement of healthcare processes and practice through a conflation of incremental and breakthrough improvements.

The QI commitments enabled me to select three divergent organisational theories that could be integrated with TQM: corporate social responsibility, complexity theory and knowledge management. A description of these theories and my reasoning for choosing them are stated in the next three subsections.

3.3.1 Corporate Social Responsibility (CSR)

The role of CSR is a multifaceted approach covering areas including employee welfare, environmental issues, corporate sustainability, stakeholder management and philanthropy (McAdam and Leonard, 2003). As such, CSR is not only congruent with my QI commitment of generating a corporate social ethic, but also addresses TQM theory's lack of consideration toward social development and ecological sustainability (Ghobadian, Gallear and Hopkins, 2007; Steingard and Fitzgibbons, 1993). Another limitation of TQM theory is it encourages a corporate vision that is ideologically engineered to serve the interests of executives and external customers (Boje and Winsor, 1993). However, integrating CSR with TQM could redress this limitation, since CSR supports a shared vision through collaboration with stakeholders concerning the shared reality they wish to create (Porter, 2008). By combining the instrumental activity of TQM and the ethical approach of CSR, a balance can be struck between profit-seeking activities and the interests of wider stakeholders, resulting in improvements to the quality of life of a broader community (Boje and Winsor, 1993; Ghobadian et al., 1998; Wood, 1991) – an approach that could overcome TQM theory's preponderance on investment and consumer capitalism (Steingard and Fitzgibbons, 1993). However, from a Kantian perspective, executives using CSR as a means of gaining competitive advantage would be a beguiling use of philanthropy. To avoid this situation, executives should address social and environmental issues from an altruistic concern for people and the planet.

3.3.2 Complexity Theory (CT)

CT has been used by scientists to explain how small changes can produce large non-linear effects. Proponents of CT commonly assert that the dynamic interaction of inter-dependent variables generate bifurcation at the edge of chaos, leading to unpredictability and emergence (Dooley, Johnson and Bush, 1995; Stacey, 1996; Sterman, 2000). Since TQM theory was largely designed through a Newtonian paradigm of reductionism, objectivism and linear causality (Dooley, Johnson and Bush, 1995; Sanford, 1992), it fails in its contingency toward chaos, unpredictability and non-linear events of major change (Sitkin, Sutcliffe and

Schroeder, 1994). As an organisation increases its propensity toward chaos (i.e., disequilibrium), integrating CT could overcome TQM's Newtonian limitations by supporting new decision-making capabilities, allowing organisational members to adapt and self-organise in the face of major change (Dooley, Johnson and Bush, 1995; Senge, 2006; Stacey, 1996).

Although there are a number of complexity theories in the literature, I selected Professor Ralph Stacey's complex responsive process theory (Stacey, 2007; 2010), largely because he adopts an interpretivist view of organisational life that has its locus on human interaction and regards a corporate social ethic as a durable quality, which fits well with critical theory (Stacey, 2010). Whilst various authors use systems thinking to understand organisational complexity (Senge, 2006; Plsek, 2001), Stacey (2010) objects to systems thinking and notions of holism due to their reductionist and mechanistic assumptions. However, he does regard an organisation as though it were a system, but not in actual terms. This is an important point, because to view an organisation as an actual system implies human choices are determined by the system's formal causality, negating the possibility of people acting autonomously or self-emerging. Instead, Stacey (2010) predicates his view of organisational reality in local communicative interaction between people, in which they construct patterns of power relating that reflect their ideologies and identities, with no causality outside human interaction. It follows that Stacey's approach provides a more humane perspective of organisational complexity than a systems approach, i.e. complex adaptive system (CAS).

3.3.3 Knowledge Management (KM)

KM is generally regarded as a body of theory entailing all the processes involving sharing, creating and applying explicit and tacit knowledge to advance organisational objectives (Hislop, 2009; Newell et al., 2009; Ribiere and Khorramshahgol, 2004). For the purpose of clarity, explicit knowledge is knowledge made 'explicable' and tacit knowledge 'is that which has not or cannot be made explicit' (Collins, 2013, p.85) – or as Polanyi (1966, p.18) put it, 'we can know more than we can tell.'

Since TQM heavily relies on a codified approach of collecting and disseminating explicit knowledge through formal processes (Ribiere and Khorramshahgol, 2004), it fails to properly consider tacit kinds of knowledge typically shared through experiences, practice, story telling and informal networks (Newell et al., 2009). It follows that adopting tacit knowledge sharing methods would allow individuals to acquire 'know-how, expertise, experience and savoir faire' – tacit aspects that are difficult to acquire through a codified approach (Ribiere and Khorramshahgol, 2004, p.40). The underpinning assumption of a codified approach is that knowledge is an objective and discrete object people possess and transfer through purely cognitive processes (Hislop, 2009; Newell et al., 2009). However, from a knowledge-as-practice perspective, knowledge cannot be 'simply transferred from sender to receiver' like data (Newell et al., 2009, p.155), because knowing involves interpretation that is highly variable and inseparable from human activity (Hislop, 2009; Stacey, 2003). Therefore, integrating practice-based learning within a TQM framework would allow employees to acquire tacit knowledge through relationships, guidance and inter-subjective understanding located in praxis (Collins, 2013; Hislop, 2009; Newell et al., 2009).

Although tacit knowledge is fundamental to acquiring know-how and expertise, Collins (2013) asserts there are three different kinds of tacit knowledge, seldom differentiated in the literature – 'relational, somatic and collective' (p.3). According to Collins, relational tacit knowledge (RTK) is acquired through human relationships, shared experiences and guidance over an extended period of time, similar to a master-apprentice type relationship that craftsman had in the guilds (Hislop, 2009). On the other hand, somatic tacit knowledge (STK) involves the use of individuals' physical bodies and is more difficult to explicate, since it is derived through demonstration and physical contact with others – analogous to practice-based learning (Collins, 2007; 2013). The third kind, collective tacit knowledge (CTK), is a domain of knowledge with a strong resistance to being made explicit, since it involves learning social conventions and nuances (i.e., savoir faire) that are only acquired by embedding one's self in society. Since this kind of tacit knowledge is largely located in language, Collins (2013) argues that CTK can also

be acquired by individuals submersing themselves in the explicit language world of practitioners – a concept he describes as 'interactional expertise' (p.62). From this perspective, there is merit in adopting KM methods that promote explicit knowledge sharing among social groups and networks.

Finally, another reason for selecting KM is because its body of theory supports double and triple loop learning, as opposed to TQM's one-dimensional approach of single negative loop learning, which restricts individuals to correcting actions towards one's goals (Argyris, 1994; Dooley Johnson and Bush, 1995; Sterman, 2000).

3.3.4 Conceptual links between TQM and the other three concepts

Although there are differences between TQM and the other three organisational theories I selected, my search of the literature indicated some conceptual links between them and TQM exist. These links are discussed in the following three subsections.

3.3.4.1 Conceptual links between TQM and CSR

McAdam and Leonard (2003) argue TQM's focus on quality has affinity with CSR, in that both are founded on ethics of respect for customer needs. Philosophically, quality gurus – Deming, Crosby, Juran and Ishikawa, advocate ethical regard for both employees and wider stakeholders. For example, Deming's principles of driving out fear, creating trust and removing barriers that rob people of pride and workmanship, imply a corporate climate where interactions with managers and employees can be practiced on an ethical basis (McAdam and Leonard, 2003). Other examples include Crosby, who places importance on integrity and Ishikawa who asserts the first concern for any organisation should be the happiness of people associated with it, somewhat implying an Aristotelian ethic (Hazlett, McAdam and Murray, 2007). Therefore, TQM can exist in an interdependent relationship with CSR, since they share the common principle of 'doing the right things right' (Hazlett, McAdam and Murray, 2007, p.672).

Although principles like employee empowerment, responsibility and collaboration have resonance with both TQM and CSR (Ghobadian, Gallear and Hopkins, 2007; Hazlett, McAdam and Murray, 2007), other authors contend that CSR's moral philosophy is incompatible with quality models using rational economic principles (Ahmed and Machold, 2004). However, I argue the integration of these two organisational theories could create a balance between shareholder wealth and stakeholder value (Ghobadian, Gallear and Hopkins, 2007). Furthermore, the integration of TQM and CSR is already seen in the EFQM Business Excellence model (EFQM, 2014) and the Baldridge Performance Excellence Program (Baldridge, 2014), which include socially responsible goals and practices. Hazlett, McAdam and Murray (2007, p.679) assert that rather than looking at TQM and CSR as separate phenomena, TQM could provide a 'strong foundation' in which to embed CSR values and behaviours, enabling a return to the 'quality roots' espoused in the philosophies of the quality gurus.

3.3.4.2 Conceptual links between TQM and CT

Although TQM's Newtonian and linear concepts have paradigmatic differences with CT's ideology of non-linear causality and unpredictability, some links can be made between the two. Dooley, Johnson and Bush (1995) argue TQM soft factors such as collaboration and empowerment have affinity with CT, in that they can allow emergence and self-organisation. For example, collaboration can enable divergent and emergent thinking on the alternative routes individuals can take at bifurcation points, and empowerment can allow individuals to spontaneously make decisions on their own when faced with an unpredictable organisational reality. Another link can be found in the way TQM cross-functional team members interact to innovate products in the face of changing customer needs, which has similarity with CT's focus on the interaction of organisational variables as a source of influence (Dooley, Johnson and Bush, 1995). Although Sitkin, Sutcliffe and Schroeder (1994) assert TQM is contingent on equilibrium and CT on disequilibrium, Stacey (1996) contends the tension between the two is necessary. Stacey asserts that managers should be effective in both paradigms because organisations exist in a paradox of predictability and unpredictability, certainty and

uncertainty. From this perspective, a TQM and CT paradigm can coexist, as both are not mutually exclusive.

3.3.4.3 Conceptual links between TQM and KM

According to Zhao and Bryar (2001), some of the common principles of KM have affinity with TQM in respect of the way information is taken as inputs and processed with applied knowledge to produce outputs. Although McAdam, Leitch and Harrison (1998, pp.48-51) describe TQM as more 'mechanistic' compared to the 'living system' of KM, Zhao and Bryar (2001) contend that TQM and KM both share principles of empowerment, collaboration, teamwork and customer centricity, principles contingent on top management support and cultural change. Furthermore, the KM strategy of *'getting the right knowledge to the right people at the right time'* (Ribiere and Khorramshahgol, 2004, p.43), could enable a more durable approach to TQM's aim of continuous improvement and customer satisfaction. It follows that KM could be used as a 'missing piece of the quality puzzle' (Ribiere and Khorramshahgol, 2004, p.45) and support the removal of some of the barriers of TQM implementation, such as insufficient education and training (Mosadeghrad, 2013) and the lack of a learning culture (Thiagarajan and Zairi, 1997a).

3.4 EALIM – Ethical, Adaptive, Learning and Improvement Model

This subchapter sets out the philosophy of my devised QI model, definitions for each of its four organisational concepts and its main tenets.

3.4.1 The philosophy of EALIM

EALIM is an innovative and sustainable QI model composed of four distinct, yet interrelated organisational concepts, i.e., CSR, CT, KM and TQM. EALIM not only addresses the way quality is improved, but also the very nature of organisations and how we see them. The model denotes more than simply getting the job done but conveys the substantive rationality often neglected in organisational theory, which is what the job should be, how it gets done and how people are affected by the way it gets done (Grey, 2013). The nexus of its four interrelated concepts

epitomise a philosophy that is not only a way of organising, but also a way of seeing and living in the world. EALIM reflects an ideal that values people and the planet above short-term gain or fast capitalism and a social virtue that ultimately connects people to an ethic judged as intrinsically good (Stacey, 2010). EALIM's philosophy embodies an approach to learning that is not facile but acknowledges the world as a complex place to live and work – where one cannot assume control over every variable – and by being reflexive, one can learn to adapt and be innovative and spontaneous in the face of unpredictability (Senge, 2006; Stacey, 2010; Sterman, 2000).

The following title and acronym of EALIM captures the meaning of its four concepts and the next subsection provides a definition for each of them.

Ethical: Denotes a CSR approach, driven by a Kantian view of humanity that treats people as both the means and the end.

Adaptive: Adopts a CT perspective of emergence and self-organisation in an environment of dynamic change.

Learning: Connotes KM concepts of triple loop learning, knowledge sharing and knowledge creation.

Improvement: Typifies a TQM approach to organisational improvement and the delivery of quality patient care.

Model: Presenting these four ways of thinking in a clear transferable framework that people can understand and follow.

3.4.2 Definitions

The following definitions for each organisational theory have been adapted from the literature to fit EALIM's overarching philosophy.

- **Corporate Social Responsibility:** An organisational approach that demonstrates genuine care and ethical regard for people, society and the planet, and contributes resources to sustain and improve quality of life (Kok et al., 2001; Kotler and Lee, 2005; Pfeffer, 2010).
- **Complexity Theory**: Where local human interactions produce organisational, societal and global patterns that are linear and non-linear, predictable and unpredictable, certain and uncertain. (Senge, 2006; Stacey, 2010).
- **Knowledge Management**: Providing an enabling context for the transformation of people and organisational processes by sharing and creating explicit and tacit kinds of knowledge, through human relationships, actions and collective experiences (Collins, 2013; Newell et al., 2009; Polanyi, 1966; Senge, 2006).
- **Total Quality Management:** Working toward excellence by improving the quality of every aspect of an organisation for the purpose of satisfying internal and external customer needs (Besterfield et al., 2003; Deming, 1986; Oakland, 1993).

3.4.3 EALIM's ten tenets

The following interrelated ten tenets are principles that rest on EALIM's philosophy and bilaterally link to its four organisational concepts:

1. **Moral anchor**: ethical values that ground the requirement of healthcare practitioners to be patient-centred, as well as guide decision-making and behaviour (Carney, 2006; Mosadeghrad, 2013; Sellman, 2010; Senge, 2006).
2. **Exemplary leadership**: servant leadership that role models service and trust (Russell, 2001; Sendjaya and Pekerti, 2010).

3. **Boundaryless collaboration**: removing boundaries both internally and externally (Pande, Neuman and Cavanagh, 2000; Porter and Derry, 2012).
4. **Empowerment and democracy**: devolving power, removing conflicts and finding democratic ways of working (Deming, 1994; Harris and Freeman, 2004; Talib and Rahman, 2010).
5. **Emergence and self-organisation**: allowing patterns of social order and organising to evolve through local human interaction (Espinosa and Porter, 2011; Stacey, 2003: 2007).
6. **Learning communities and team working**: sharing existing explicit and tacit (relational and collective) knowledge, as well as creating new knowledge to produce innovation (Collins, 2013; Hislop, 2009; Newell et al., 2009; Senge 2006).
7. **Practice-based learning**: learning derived in and through practice, allowing organisational members to develop and share somatic tacit knowledge (Collins, 2013; Hislop, 2009; Newell et al., 2009).
8. **Continuous improvement**: applying kaizen steps and break through improvements to support the delivery of quality care (Besterfield et al., 2003; Deming, 1986; Maurer, 2004).
9. **Quality chain**: customer-supplier concept (Lim and Tang, 2000; Oakland, 1993; Thiagarajan and Zairi, 1997b).
10. **Customer satisfaction**: satisfying the needs of internal and external customers (Besterfield et al., 2003; Deming, 1986; Oakland, 1993).

These ten tenets are not only interrelated, but also act as guiding principles that underpin, and are underpinned by each organisational concept. In the next subchapter, I discuss EALIM's core values and explicate EALIM as a process model that can be applied as an iterative cycle of learning and improvement.

3.5 EALIM as an Iterative Cycle

In addition to the conceptual links between TQM and the other three organisational concepts (discussed in subsection 3.3.4), there are also process links between CSR and CT, CT and KM, KM and TQM, which are explained in subsection 3.5.2 – the process of EALIM. Driven by core values of altruism, democracy and reflexivity, the synergistic arrangement of these organisational concepts create a process that can be applied as an iterative cycle of learning and improvement, as illustrated in Figure 2.

Figure 2: EALIM's iterative cycle

3.5.1 EALIM's moral anchor

EALIM's three core values of altruism, democracy and reflexivity, not only drive its organisational concepts, but also act as a moral anchor that binds each organisational concept to ethical norms. Various authors of TQM literature have suggested a significant barrier to its adoption is the lack of corporate morals and ethics (Axline, 1991; Ghobadian, Gallear and Hopkins, 2007; Thiagarajan and Zairi, 1997a), which pose a conflict for healthcare practitioners who see moral values as a prerequisite for human flourishing (Armstrong, 2006; Sellman, 2010). However, adopting EALIM's moral anchor could ameliorate this conflict, since it

could connect internal stakeholders to values acting as an arbiter for human behaviour.

Altruism is pivotal in forming a strong healthcare culture that can guide, rather than control employee behaviours (Sureshchandar, Rajendran and Anantharaman, 2001) and supports the golden rule of TQM, 'Do unto others as you would have them do unto you' (Besterfield et al., 2003, p.1). While Sellman (2010) asserts that altruism is commonly associated with the caring profession, he also warns it would need a secure base to avoid being eroded by institutional pressures of conformance and instrumental rationality, i.e., efficient means of achieving an end. According to a study by Rassin (2008) involving 323 nurses, altruism was rated lower than instrumental values such as social recognition, ambition and self-esteem. This finding is a worrying concern because it may indicate that altruism, regarded by many as the most important nursing value, is being eroded by narcissism (Rassin, 2008). The moral erosion of altruism is perhaps indicative of a much larger social trend, since MacIntyre (2007) argues that morals are generally being lost in society. I therefore argue that a return to altruism is fundamentally required in healthcare practice, so managers and clinicians can be motivated by a selfless concern to serve others (i.e., internal goods of excellence), rather than a desire to achieve 'something for personal evolution and identity' (Rassin, 2008, p.625).

As previously discussed, organisational democracy is an ideal that could create more mutual understanding with less distortion of communication (McAuley, Duberley and Johnson, 2013). Although opponents of organisational democracy argue it can encumber decision-making processes – resulting in reduced efficiency, proponents contend that democratic values and processes can lead to greater stakeholder participation and value creation – benefiting both society and organisations (Harrison and Freeman, 2004). Adopting organisational democracy also holds potential to generate employee empowerment and collaboration between managers and clinicians – success factors of TQM adoption in healthcare (Joss, 1998; Shortell et al., 1995), as well as reduce authoritarianism and

bureaucracy – factors that damage QI efforts in healthcare (Nwabueze, 2004; Potter, Morgan and Thompson, 1994).

Another core value of EALIM is reflexivity, which Driscoll (2007) argues could enable healthcare practitioners to transform their practice. This involves both double and triple loop learning (Flood and Romm, 1996), which could stimulate the use of substantive rationality – that is, where decision-making is value-orientated and subject to ethical norms (Weber, 1920). A criticism of TQM theory has been its limitation to single loop learning (Dooley, Johnson and Bush, 1995), meaning the detection and correction of errors without questioning the underlying values of a system (Argyris, 1977; 2010). Although TQM preoccupies itself with 'doing the right things first time' (Oakland, 1993, p.31), triple-loop learning involves challenging what is right, which creates potential to change the quality of one's awareness (Flood and Romm, 1996; Romme and Van Witteloostuijn, 1999). Furthermore, reflexivity could enable managers to critically examine the partisan nature of their motives and utilitarian assumptions, allowing them to reshape their own values and goals as well as those they project into employees (Johnson and Duberley, 2000). As a consequence, reflexivity creates potential for individuals to transform their practice, develop a concern for the emancipatory interest (Argyris and Schön, 1978; Flood and Romm, 1996; Nielson, 1993) and break down cultural obstacles that are particularly prevalent in healthcare contexts (Zabada, Rivers and Munchus, 1998).

Despite their positive implications, EALIM's core values may not transform practice if they are not particularised by managers in their local interactions with others. Towards this end, managers would need to exemplify servant-leadership virtues in their everyday encounters with staff. However, servant leadership poses a challenge to the dominant paradigm of leadership, in that, it is not a style one chooses for utilitarian purposes, but 'a conviction of the heart that constantly manifests whenever there is a legitimate need to serve in the absence of extenuating personal benefits' (Sendjaya and Pekerti, 2010, p.645). When practised, servant leadership can empower followers to flourish and become

healthier, more autonomous individuals, as well as form trusting, sustainable relationships (De Sousa and Van Dierendonck, 2010; Sendjaya and Pekerti, 2010). However, Russell (2001) suggests servant leadership is no easy task, since leaders must be constantly aware of whether they are leading from a power or servant base and be committed to change. From this perspective, commitment to servant leadership will be critical to the adoption of EALIM's moral anchor. Anchored by three core values, EALIM's four organisational concepts (CSR, CT, KM and TQM) include process links, which are explicated in the next section.

3.5.2 The EALIM process

The EALIM process should begin with a commitment from top management to engage in a shared CSR vision that contributes to social and ecological sustainability, so workers can realise the impact of their personal work beyond the organisation's primary task. Forming a shared CSR vision is essentially a democratic and interpretive process involving collaborative discussion with stakeholders to identify their meaning of sustainability, their perception of the common good and the shared reality they wish to create (Porter, 2008). This process could generate corporate social virtues that connect stakeholders to a common ethic, creating powerful motivations toward the good of the organisation (Porter, 2008; Stacey, 2010). Porter and Derry (2012) espouse that CSR is essentially a collaborative stakeholder approach in which boundaries are crossed, allowing spontaneous network forming, self-organisation and emergence – qualities that link to EALIM's adaptive concept. For example, Espinosa and Porter (2011) suggest self-organisation and emergence are critical to an organisation's survival in a complex environment, factors particularly pertinent for healthcare firms due to their aggregate complexity, i.e., multiple dynamic interactions (Litaker et al., 2006).

One barrier to TQM implementation has been the lack of organisational adaptability to sudden change (Dooley, Johnson and Bush, 1995; Rahman, 2004), which poses a particular challenge for healthcare firms with high levels of bureaucracy (Parkin, 2009). In fact, several authors describe healthcare

environments as complex adaptive systems – where individuals act in unpredictable ways and whose actions are interrelated so that one person's behaviour changes the context for others (Begun, Zimmerman and Dooley, 2003; Litaker et al., 2006; Plsek, 2001). Caregivers' unethical behaviours toward patients are particularly relevant here, as these can result in large effects on organisations and societies. For example, the abuse of vulnerable adults by a small group of care workers at Winterbourne View sent shockwaves throughout the care industry, causing increased CQC inspections across the UK and a nationwide government review on the placement of informal patients in secure hospitals (Curtis and Mulholland, 2011; Holt, 2012). This example illustrates an underlying principle of complexity theory, commonly known as the butterfly effect – in which small changes in one part of a complex environment produce major changes in a remote part because of amplifying feedback loops (Porter and Derry, 2012; Stacey, 2010). Therefore, by adopting a complexity perspective, individuals could develop greater awareness of the importance of sustaining ethics, the unintended consequences of their actions and the potentially 'destructive processes one may be caught up in' (Stacey, 2010, p.11).

A complexity way of thinking also calls for leaders and managers to adopt a courageous approach toward dismantling bureaucratic processes that slow down an organisation's ability to adapt, emerge and self-organise (Ashkenas, 2011; Litaker et al., 2006; Stacey, 2010). Smith and Humphries (2004) contend a few simple rules are necessary to avoid organisations plunging into complete chaos, but too many rules can stifle self-emergence, creativity and innovation. This approach is similar to what Stacey (1995, p.481) referrs to as 'bounded instability.' He argues that because organisations exist in a paradoxical state of stability and instability, a recognisable organisational structure may determine outcomes in the short-term but not in the long term due to non-linear, amplifying feedback loops, making outcomes unpredictable. Accordingly, managers taking a 'hands-off' approach (Smith and Humphries, 2004, p.94) with small amounts of control could enable organisations the space needed to stimulate innovation and adaptability without falling into disintegration or anarchy (Smith and Humphries, 2004; Stacey,

1996). However, being hands off is no easy task, especially in a healthcare context in which the dominant perception of achieving success involves copious rules and procedures (Litaker et al., 2006; Parkin, 2009; Smith and Humphries, 2004). Stacey (1995, p.492) casts a psychoanalytic perspective on this point, when he asserts 'managers use such routines and procedures to defend themselves against the anxiety which great uncertainty provokes.'

The job of every manager, starting with the CEO, should be to reduce the internal complexity of rules so organisations can quickly respond to unanticipated events with greater adaptability and new ways of working (Ashkenas, 2011). This adaptive approach is similar to Plsek's (2001, p.316) who advocates creating 'conditions for self-organisation through simple rules under which massive and diverse experimentation can happen.' This approach allows the application of knowledge from learning communities and links to EALIM's learning concept regarding sharing and creating knowledge through tacit and explicit communicative interaction (Nonaka and Takeuchi, 1995; Polanyi, 1966; Senge, 2006).

EALIM's practice-based approach supports somatic tacit knowledge sharing, which is socially constructed and inseparable from human activity (Collins, 2013; Hislop, 2009). This approach closely corresponds with the views of Stacey (2003) who claims learning emerges as an activity of interdependent people making sense of their practices and power relations, through patterns of local human interaction. In other words, learning is a social process that emerges through patterns of conversing, relating and experiencing with others, producing 'shifts in meaning' (Stacey, 2003, p.8). In a knowledge environment, these patterns of communicative interaction can take the form of communities of practice (i.e., homogeneous groups that are practitioner-based and best practice orientated) and project teams (i.e., heterogeneous groups that are trans-disciplinary and innovative) (Newell et al., 2009). These kinds of groups not only support relational and collective tacit knowledge sharing, but can also generate bottom-up strategies, shared understanding, creativity and multi-disciplinary perspectives to problem

solving (Collins, 2013; Newell et al., 2009) – success factors of QI initiatives in healthcare (Joss, 1998; Øvretveit, 2000; Potter, Morgan and Thompson, 1994).

While creativity can determine new directions, Stacey (1996, p.171) argues they are inherently subversive, causing 'creative destruction' to dominant schemas and current rational ways of behaving. He asserts creative destruction can arouse anxiety in the minds of organisational members, manifesting in the form of defensive mechanisms toward new ideas and methods. Furthermore, because rationality is rooted in dominant schemas, paradigmatic conflicts cannot be solved in 'technically rational ways' (p.185). Instead, Stacey (1996) proposes a new way of managing, which paradoxically engages in 'ordinary management' – where members use single loop learning that is linear, incremental, rational and formal; and 'extraordinary management' – where members adopt a self-organising process of double loop learning that is non-linear, creative, intuitive and informal (pp.192-193). From this perspective, only when organisations engage in both paradigms of management can they occupy the space needed to face the tension between control and autonomy (Stacey, 1995; 1996).

This dual management approach is not dissimilar to that of Newell et al. (2009, p.234), who assert 'Management therefore have to find approaches to organising that they believe will deal with the tension that exists between the autonomy demanded by knowledge workers and organisational efficiency.' They suggest in a knowledge environment, a command and control culture must be decentralised so workers can be empowered to use their experience and knowledge to develop solutions that confront them – a management approach recommended by various authors of TQM research in healthcare (e.g., Joss, 1998; Nwabueze, 2001a; Potter, Morgan and Thompson; Shortell et al., 1995). Since employees are often closest to the dynamic changes in a business environment, their tacit understanding of how outcomes should be achieved can be more relevant than their managers (Newell et al., 2009). This ideology is congruent with TQM principles of employee empowerment, collaboration and quality circles – principles that link to EALIM's Improvement concept. Ju et al. (2006) claim TQM principles

play a vital role in supporting KM value chains that include knowledge creation, knowledge sharing and knowledge application. Ju et al.'s notion seems to correspond with that of McAdam, Leitch and Harrison (1998), who suggest KM principles like experimentation, best practice and transformational knowledge are best realised through TQM mechanisms. In other words, both TQM and KM can work in a symbiotic way to enable both continuous improvement and innovation (Ju et al., 2006; Ribiere and Khorramshahgol, 2004; Zhao and Bryer, 2001).

Developing KM (formal and informal) boundary spanning networks across disciplines support improvement and innovation, as these networks can generate relational and collective tacit knowledge, inter-subjective understanding and novel solutions to problems (Collins, 2013; Hislop, 2009; Newell et al., 2009). Furthermore, boundary spanning could help ameliorate the lack of cross-functional collaboration, a limitation of TQM applications in healthcare (Nwabueze, 2001b; Øvretveit, 2000; Shortell et al., 1995). Although disciplinary groups have paradigmatic differences, the adoption of reflexivity and corporate social virtues could galvanise people from across disciplines to alter their governing values so they can work toward the common good of the organisation (Flood and Romm, 1996; Johnson and Duberley, 2000; Stacey, 2010). Therefore, the conflation of KM and TQM could allow the knowledge sharing and creation activities of interdependent people to be leveraged toward novel problem solving and organisational transformation (McAdam, Leitch and Harrison, 1998; Zhao and Bryar, 2001).

A plethora of espoused TQM techniques to solve problems and enable service improvements exist. The Nominal Group Technique (NGT) and Affinity Diagrams (AD) are particularly useful as they utilise the knowing capability of groups and are congruent with EALIM's democratic ideal. NGT involves individuals collaborating together to understand common causes to errors, whilst AD allows teams to creatively construct a large number of ideas and rationally group them for problem understanding and solutions (Besterfield et al., 2003). Both these techniques can

stimulate creativity, break down barriers, facilitate breakthrough improvements and generate ownership of the process (Besterfield et al., 2003; Oakland, 1993).

Other TQM techniques such as the Pareto principle, five whys and force field analysis could also be used within EALIM. Although these specific techniques do not necessitate group interaction, they can help equip individuals to locate the most vitally required changes, identify root causes and reduce inhibitors to service quality (Besterfield et al., 2003; Oakland, 1993). However, customer requirements can rapidly change, especially in a dynamic healthcare environment that has many external influences (Parkin, 2009). To avoid a slow response to changing external customer requirements, adopting a method of monitoring customer needs and trends is critical. Such a method is Voice of the Customer (VOC), which uses targeted multi-level interviews, discussions and focus groups to analyse the voices of external customers (Pande, Neuman and Cavanagh, 2000).

Although breakthrough improvements and solutions are needed to solve chronic problems in key business areas, incremental improvements involving small kaizen steps should be given equal value (Besterfield et al., 2003; Pande, Neuman and Cavanagh, 2000). Maurer (2004) advocates that small kaizen steps allow people time to build neural connections in the brain, engage in creative thought and help circumvent the fear response and anxiety often generated by seemingly insurmountable challenges. However, kaizen and breakthrough approaches should not be seen as a mutually exclusive dichotomy, but as a multifaceted continuous improvement strategy that keeps the wheels of quality turning in complex environments like healthcare (Pande, Neuman and Cavanagh, 2000). Whilst EALIM is primarily designed for organisational improvement, individuals can also use the model for their own heuristic learning and improvement. This idea is discussed in the following subchapter.

3.6 EALIM as a Heuristic Learning Model

EALIM holds greater potential for learning and improvement than Shewhart's PDSA cycle, i.e., Plan, Do, Study and Act. Although the PDSA cycle includes reflection in its study phase, this follows in a linear sequence to doing (Besterfield et al., 2003), consquently separating reflection from action. Conversely, EALIM's practice-based approach treats reflection and doing as constant conjunctions, allowing individuals to take swift corrective steps during action, in accordance with the principles of action learning (Hislop, 2009). As a consequence, EALIM could generate existential awareness of one's own behaviour and problem situations, because action learning involves a 'cyclical iterative process of action and reflection on and in action' (Zuber-Skerritt, 2001, p.2).

Since Shewhart's PDSA cycle is based on a Newtonian paradigm of linear causality, another of its limitations is its enactment of single loop learning (Dooley, Johnson and Bush, 1995). According to Dooley, Johnson and Bush, single loop learning can sometimes restrict individuals in framing the right questions, especially in an environment of disequilibrium in which causality is not always clear or linear. To overcome this limitation, they propose the adoption of a complexity perspective to allow the use of different mental paradigms. Seeing that EALIM adopts a complexity perspective and posits reflexivity at the core of its cycle, individuals adopting EALIM can constantly reflect on and challenge their own mental models, goals and methods to produce new ways of thinking and doing in each phase of EALIM's cycle. Consequently, EALIM can be used as a heuristic tool in which reflection is a recursive and constant process, as illustrated in figure 3. In the next sub-chapter, specific methods that can be used in accordance with each EALIM concept are discussed.

Figure 3: EALIM as a heuristic learning model

3.7 EALIM's Methods

This subchapter provides details of the methods I selected for each of EALIM's four organisationsal concepts. These methods have been carefully chosen to provide a synergetic blend of soft and hard factors within its overall framework. The soft factors reflect the people-oriented elements of organisational culture, i.e., leadership, people and communicative interaction, whilst hard factors relate to the analytical and technical processes people use (Oakland, 1993). Choosing a balance of soft and hard factors provides a dyadic approach that generates a higher probability of success than selecting just hard factors (Kirk, 1995; Wilkinson and Witcher, 1992). Moreover, Fotopoulos and Psomas (2009) purport that QI is often more influenced by soft TQM factors. Whilst some analytical methods have been chosen, these have been purposefully selected to invoke team collaboration, interaction and learning. The following tables describe and explain my selection of methods, some of which overlap due to their common links.

Table 5: CSR methods

Method	Description and explanation	References
Corporate credo	Publication of company ideals and ethics that connect stakeholders to values judged as intrinsically good, which could generate inspiration and motivation.	Hatch, 2013; Stacey, 2010.
Shared vision	A CSR vision that is commonly shared by stakeholders, as opposed to one imposed by management. This could create social legitimacy and enable employees to realise the impact of their personal work beyond the organisation's primary task.	Porter, 2008; Senge, 2006.
Stakeholder approach	Crossing boundaries between internal and external stakeholders through collaboration in order to create mutual trust and wide organisational support.	Hatch, 2013; Porter, 2008.
Corporate philanthropy	Discretionary cash contributions direct to charities and social causes, which can be a source of significant support to community projects and enhance peoples quality of life.	Kotler and Lee, 2005.
Corporate social marketing	Promotion of behaviour change campaigns that can improve public health and safety.	Kotler and Lee, 2005.
Community volunteering	Employees volunteering their time and talents toward social causes, in order to enable integration with community organisations and to effect positive change in the world.	Kotler and Lee, 2005.
Socially responsible business practices	Business practices that support human and ecological sustainability, in order to protect the wellbeing of employees and the environment.	Kotler and Lee, 2005; Pfeffer, 2010.

Table 6: CT Methods

Method	Description and explanation	References
Complexity mental model	A mental model that welcomes disorder as a partner, uses instability positively, sees change as a necessity and understands that complexity is unavoidable.	Senge, 2006; Stacey, 1995: 2010.
Planned strategy	A long-term business strategy that enables stable and incremental change.	Stacey, 1995: 1996.
Emergent strategy	Spontaneous strategies that allow the organisation to adapt to uncertainty and engage in revolutionary change.	Stacey, 1995: 1996.
Ordinary management	Rational, formal and analytical management methods that enable single loop learning.	Stacey, 1995: 1996.
Extraordinary management	Creative, informal and intuitive management methods that allow double loop learning.	Stacey, 1995: 1996.

Table 7: KM Methods

Method	Description and explanation	References
Triple loop learning	Single, double and triple loop learning that allows individuals and groups to engage in: - Improvement, by learning new ways of doing, - Reflection, by learning new ways of thinking, - Transformation, by learning new ways of learning.	Flood and Romm, 1996.
Communities of practice	Practitioner based (homogenous) groups for mutual support, knowledge sharing and learning of best practice.	Hislop, 2009; Newell et al., 2009.
Project teams	Intra-disciplinary (heterogeneous) teams for specific projects, problem solving, knowledge creation and building innovation.	Hislop, 2009; Newell et al., 2009.
Story telling and narratives	The use of story telling and narratives among organisational members for the purpose of creating identity, deep meaning and tacit knowledge sharing.	Gabriel, 1999; Newell et al., 2009; Senge, 2006.
Knowledge brokers / boundary spanning	Organisational members who act as sources and facilitators of knowledge, due to their interaction with different communities of knowledge and discipline.	Hislop, 2009; Newell et al., 2009.

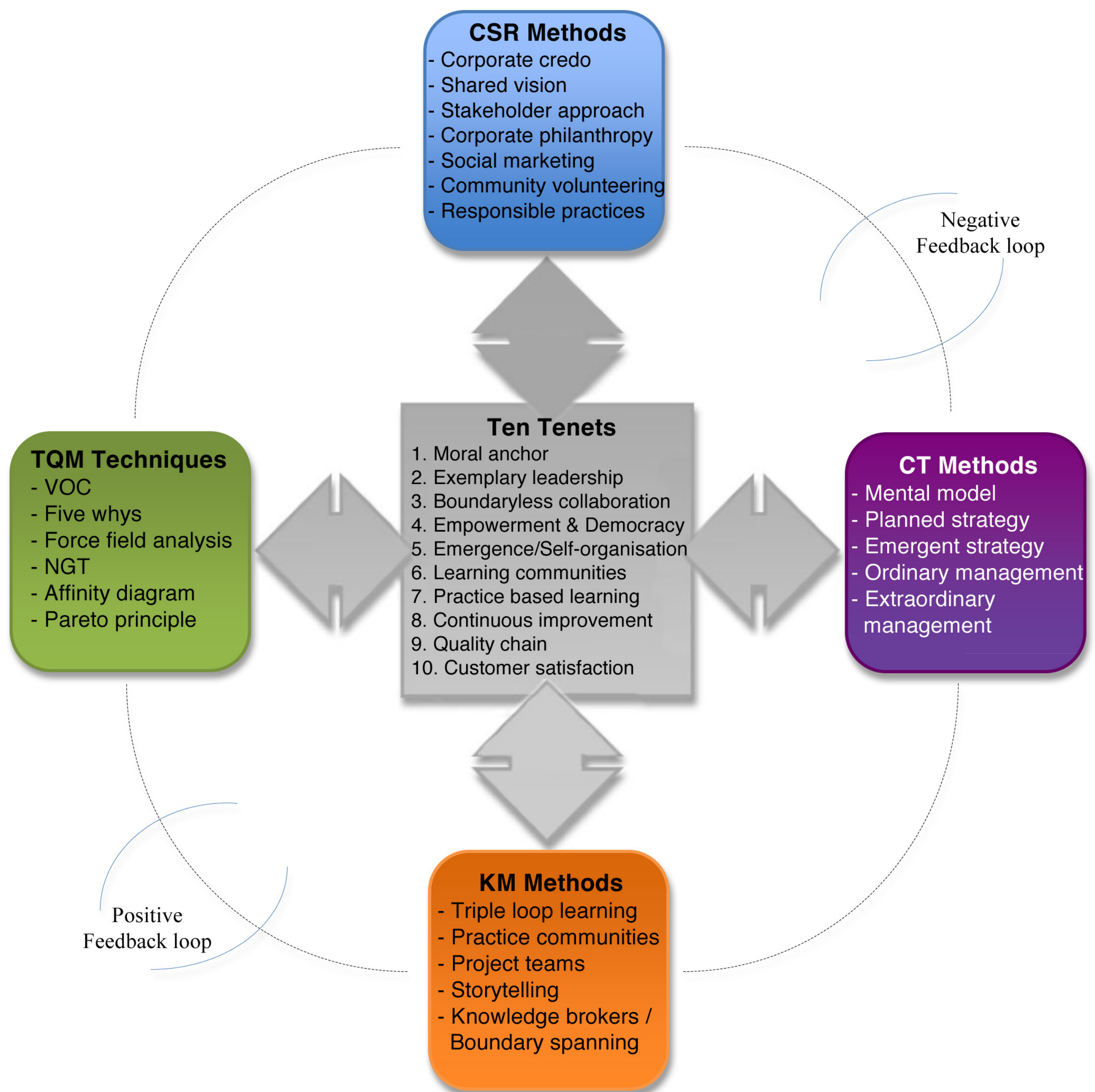
Table 8: TQM Methods

Method	Description and explanation	References
VOC - Voice of the Customer	Continuous monitoring of dynamic customer requirements, so changes can be rapidly identified in order to avoid market drift.	Pande, Neuman and Cavanagh, 2000.
Five whys	A technique for finding root causes to problems, which supports sustainable troubleshooting.	Besterfield et al., 2003; Oakland, 1993.
Force field analysis	Identification of factors that support a problem (restraining forces) and factors that enable a change or solution (driving forces).	Besterfield et al., 2003; Oakland, 1993.
NGT - Nominal Group Technique	A democratic technique for acquiring group ideas for the detection and correction of errors.	Besterfield et al., 2003; Oakland, 1993.
AD - Affinity Diagram	Collaboratively arranging a large number of ideas into groups for review and analysis, to stimulate creative improvement.	Besterfield et al., 2003; Oakland, 1993.
Pareto principle	Data analysis of the 'vital few and the useful many,' which helps identify the biggest problems to solve.	Besterfield et al., 2003; Oakland, 1993.

3.8 EALIM's Conceptual Framework

The conflation of EALIM's four organisational concepts, ten tenets and associated methods, form an integrated and coherent conceptual framework as illustrated in figure 4. The framework's permeable boundary has two meanings: first, it symbolises the removal of barriers to team work through collaboration (Pande, Neuman and Cavanagh, 2000) and second, it represents the boundaryless connection and reciprocal flow of influence between an organisation and its external environment (Senge, 2006). The dynamics between these two domains emerge from two types of feedback loops: negative (self-correcting) loops that balance change and positive (self-reinforcing) loops that amplify change (Senge, 2006; Stacey, 1995; Sterman, 2000). The bi-directional arrows between the ten tenets and four concepts connote how they shape and are shaped by each other, allowing the model to emerge and adapt reflexively.

Figure 4: Conceptual framework of EALIM



As previously discussed in this chapter, integrating these four organisational concepts into one conceptual framework, presents advantages that address TQM's limitations. Table 9 presents a summary of these limitations and the elements of EALIM that hold advantage over them.

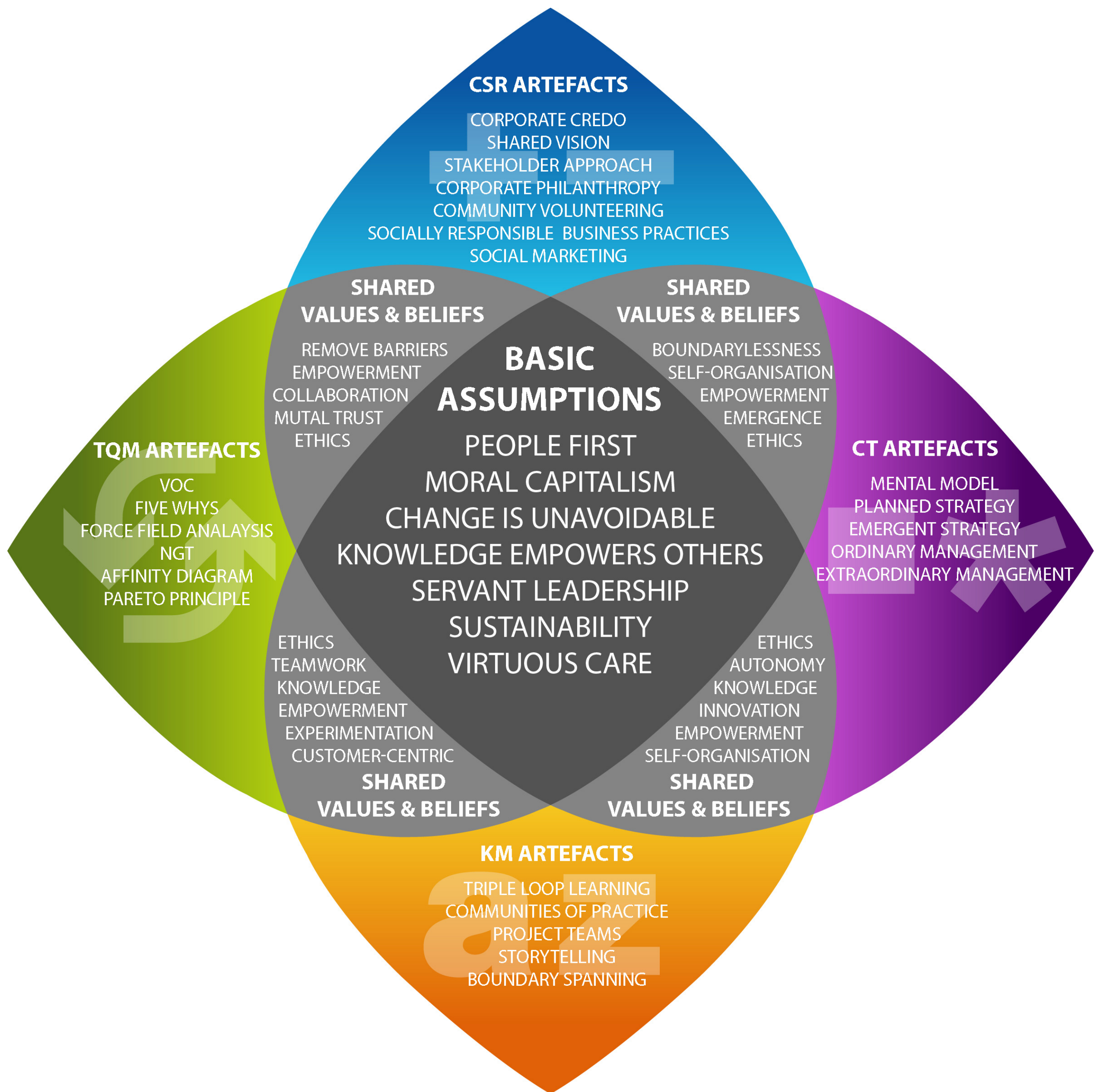
Table 9: Limitations of conventional TQM addressed by EALIM

Conventional TQM	EALIM
Investment and consumer capitalism	Moral capitalism
Formal rationality	Substantive rationality
Utilitarian rationality	Kantian rationality
Executive vision	Shared vision
Technocratic ideology	Humane ideology
Single loop learning	Triple loop learning
Newtonian paradigm	Complexity paradigm
Codified and explicit knowledge sharing	Explicit and tacit knowledge sharing
External customer focus	Stakeholder focus

3.9 EALIM's cultural framework

When the process of EALIM's cycle becomes recursive, i.e., applied iteratively, its organisational concepts and associated methods are adopted concurrently in linear and non-linear ways. Once this process is realised, EALIM can be used as content model where its interrelated constituents blend and overlap to produce a cultural framework. The diagram in figure 5 depicts EALIM through Schein's (2010) three layers of culture (i.e., basic assumptions, shared values and beliefs, and social artefacts), illustrating the shared relationship between EALIM's constituents. The four overlapping lenses (or oval shapes) within the diagram symbolise EALIM's four organisational concepts, each with their own set of methods, i.e., social artefacts. Although these lenses have their own distinct organisational perspectives, they also share values and beliefs, depicted by the grey space between each lens. Finally, the overlap of all four lenses at the centre of the diagram embodies EALIM's basic assumptions, symbolising the essence of its cultural framework.

Figure 5: EALIM's cultural framework



3.10 Conclusion

Adopting a reflexive and philosophical approach to theory building played a critical role in devising EALIM. This approach allowed me to examine the underpinning assumptions of TQM theory and adoption from the literature and develop a set of QI commitments that were used to filter, select and integrate other organisational theories into TQM. Conflating TQM with divergent concepts emerged as an eclectic form of theory building, allowing the development of a novel QI model that could overcome TQM's limitations and some of the common barriers to its adoption. Whilst other authors have produced models that integrate TQM with divergent organisational theories, to the best of my knowledge, no QI model exists in the literature that conflates CSR, CT, KM and TQM into one coherent conceptual framework. EALIM therefore constitutes an innovative and sustainable QI model that can be added as an original contribution to the stock of quality improvement theory.

Furthermore, EALIM's moral anchor is congruent with intrinsic caring values, enabling managers and healthcare professionals to avoid the distortion of altruistic values by institutional pressures of conformance and instrumental rationality. In summary, EALIM's adoption could support healthcare organisations to achieve a balance between social and shareholder value, empower its members to practice values that reduce the risk of harm to others, as well as, enable reflexive learning and practice improvements. As such, the implementation of EALIM poses an exciting challenge for both the researcher and researched, in exploring opportunities to experiment with new ideas and discover new ways of learning and acting. My remaining research questions involve implementing the model within a private healthcare setting, to explore what (if any):

a. Changes were needed to its conceptual framework;
b. Acceptance and resistance participants exhibited;
c. Impact the model had on organisational culture;
d. Impact the model had on organisational improvement.

Chapter Four: Research Methodology

4.1 Introduction

This chapter provides details of the methodology employed within the research, for the purpose of exploring the adoption of my devised QI model (EALIM) within a private healthcare context. Since researchers philosophical commitments ultimately shape their methodological choices (McAuley, Duberley and Johnson, 2013), I begin the chapter with a reflexive account of the research philosophy I adopted. Here I consider my own taken for granted assumptions about the nature of reality – ontology, as well as what constitutes valid knowledge of that reality – epistemology (Bryman and Bell, 2011). These considerations led me to explore alternative perspectives from the literature, culminating in my adoption of a research philosophy that combines hermeneutic-interpretivism with pragmatic critical realism.

This is followed by a discussion of qualitative research, with reasoned arguments for its selection as my research strategy. Although Layder (1993) suggests the distinction between quantitative and qualitative research is somewhat blurred, Bryman and Bell (2011) argue they each hold a very different set of philosophical paradigms that influence the kind of data researchers gather.

My choice of action research (AR) is then explained, followed by arguments against other methodologies I rejected within the qualitative tradition. Whilst a multiplicity of available research methods exist, I discuss my choice of employing qualitative interviews, participant observation and focus groups, as these would illuminate different facets of phenomena being investigated (Johnson and Duberley, 2000). I also address other data in the form of my own reflexive diary, which allows me to note and critique my own pre-understandings that shape my interpretations of empirical material, leading to better research praxis (Johnson and Duberley, 2003). Although combined qualitative methods are employed within my study, I state my case for rejecting a mixed methods approach, i.e., blending qualitative and quantitative methods, because any quantitative method is unlikely

to add value in understanding the nature of human behaviour (Gill and Johnson, 2010).

After describing the target organisation, I discuss my dyadic role as both consultant and insider-researcher, along with the various political and ethical issues that should be considered. These considerations are especially important in the context of AR, because it involves a subversive process of organisational change that threatens existing organisational norms (Coghlan and Brannick, 2010).

I then discuss the key concepts I selected as categories for exploring data that answer the research questions (Bryman and Bell, 2011). While the key concepts I selected include some a priori (pre-defined) themes, these were flexible to allow themes to emerge from the data (King, 2012). Led by the particular techniques to most appropriately answer the research questions (Saunders, 2012), I explicate my methods for selecting participants.

I chronicle how I went about gathering data in my fieldwork during each of the three AR cycles – before, during and after the EALIM's implementation. These chronicles also include some of the action strategies that emerged for its adoption. These accounts are followed by a discussion of the analytical methods I used, which include my justification for choosing them. Since methodological choices ultimately have practical consequences for the way research is carried out, holding an appropriate set of indicators to evaluate research quality is paramount (Johnson et al., 2006). Towards this end, I describe and explain my selection of evaluative criteria, based on 'choice points' taken from Reason and Bradbury (2006, pp.343-350). Finally, the chapter concludes with a summary of the most important aspects of the methodology employed, along with its efficacy and limitations in answering my research questions.

4.2 Philosophical Underpinnings

This subchapter details the reflexive approach I used to develop my own research philosophy, which is stated at the end of this section.

4.2.1 Reflexivity in research practice

Engaging reflexively can allow researchers to explore alternative commitments outside the mainstream way of thinking, which could lead to methodological choices that generate deeper understanding of the empirical world (Johnson and Duberley, 2000). Towards this end, some of the questions I asked myself early on in the research process included, how do I see the world? what are my knowledge constituting assumptions? and what other meaningful alternatives are there? Answers to these questions were by no means easy, but were informed by a reflexive study of the philosophical branches of ontology and epistemology.

A reflexive examination of my own taken for granted assumptions made me aware of unquestioned positivist assumptions embedded in my way of thinking, supporting the notion of Johnson and Duberley (2000, p.11) that positivism is 'virtually an aspect of our common sense.' For example, I thought my observations of the world were objective (i.e., neutral and value free) and that methods of natural science could be unproblematically applied to social science (i.e., methodological monism). This awareness prompted me to explore alternative research philosophies I could compare and consider, for the purpose of making an informed choice about the nature of reality and what I should regard as valid knowledge. Some of the research philosophies I considered include neo-positivism, critical realism, critical theory, symbolic interpretivism, hermeneutic-interpretation and post-modernism.

4.2.2 My research philosophy

This reflexive, explorative journey culminated in the inductive selection of a research philosophy that combines hermeneutic-interpretivism with pragmatic critical realism. Not only does this philosophy enable me to form a reasoned justification for warranted knowledge, but also allows me to understand how I

should go about answering my research questions (Saunders, Lewis and Thornhill, 2012). My research philosophy stated below includes reasoned arguments for its adoption.

Whilst external entities exist in the world, we are not capable of accessing them objectively because of a priori subjective conditions in the human mind, i.e., biases, prejudices and values that filter our experience of the world. In other words, we only know the world around us through interpreting our empirical experiences (Gill and Johnson, 2010; Johnson and Duberley, 2000). Consequently, research should involve a reflexive engagement with the researched, as this allows researchers to consider their own biases, as well as to form interpretations that emerge from understanding life itself (McAuley, 2004). Therefore, rather than testing a hypothesis for falsification through deductivism, a more useful research praxis would be to investigate the meanings participants attach to their every day life and to allow the inductive emergence of theories through reflection (Hirschheim, 1985; McAuley, Duberley and Johnson, 2013; Stacey, 2010). Not only does an inductive approach hold greater scope for generating theories that fit the data than a deductive one (Gill and Johnson, 2010), but also fits the exploratory nature of my research.

My research interest therefore seeks to develop a hermeneutic-interpretative understanding of participants' motivations, emotional experiences and actions within their cultural convention and history (Gabriel, 1999; Hirschheim, 1985; McAuley, 2004). Accordingly, a hermeneutic perspective negates the need to dominate the social world through the discovery of generalisable laws of cause and effect, because it holds a humane interest in meaning and understanding, along with how values, ideologies and identities are developed (Hirschheim, 1985; McAuley, 2004; McAuley, Duberley and Johnson, 2013). Furthermore, since a hermeneutic interest has the consequence of 'improving communication and self-understanding in an essentially ameliorative way' (McAuley, 2004, p.194), it holds an ethical position highly conducive to the research purpose of exploring the adoption of EALIM – an ethical QI model.

My research interest also holds an ontological commitment to examining non-empirical (non-observable) entities, i.e., ‘generative mechanisms’ (Bhaskar, 2008, p.3), such as power relations, social structures, feedback loops, defensive mechanisms, unconscious assumptions, intra-psychic conflicts, etc. (Gabriel, 1999; Hunt, 1989, Schein, 2010). Since patterns of local human activity are bound by the tolerance of generative mechanisms (Johnson and Duberley, 2000), exploring them through a process of change would provide meaningful insights into what enables and constrains organisational practices. Not only does this meta-physical reality put practical limits to the success or failure of interventions in my research praxis, but also obfuscates any certainty of explanations and theorising, since contextual causal mechanisms may be unrecognised, or may occur as constant conjunctions (Johnson and Duberley, 2000). It follows that knowledge is neither absolute nor relative, but tentative (McNiff and Whitehead, 2011).

4.3 The Nature of Qualitative Research

Although qualitative research is generally described as an interpretivist form of inquiry that excludes the use of numbers (Bryman and Bell, 2011), Gill and Johnson (2010) argue that trying to describe qualitative research along these terms can miss an important philosophical point of explaining human behaviour through an entirely different view of what science should be – ‘verstehen’ (p.155). This view of science denotes a qualitative strategy of understanding the internal logic of human action by explaining participants’ experiences, interpretations, motives, attitudes and beliefs, as we meet them in their lives (Gill and Johnson, 2010; Hirschheim, 1985; McAuley, 2004). Furthermore, verstehen is central to the idea of hermeneutic interpretation that involves a rule of relating the particular with the general – the individual with the social (McAuley, 2004). McAuley explains the iterative process of alternating between the part and the whole as the ‘hermeneutic circle’ (p.194), allowing researchers to develop a deeper understanding of the research subject. It therefore seems entirely appropriate to adopt a qualitative strategy that allows me to develop a hermeneutic understanding of participants’ experience and cultural convention.

4.4 Action Research – My Chosen Methodology

In this subchapter, I describe and explain action research and provide warranted reasons for its selection.

4.4.1 What is action research?

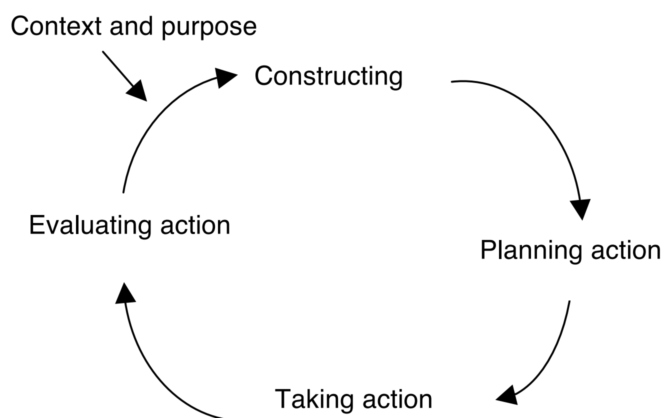
Action research (AR) has been around since the 1930s and can be traced back to the work of John Collier, an American Commissioner for Indian Affairs and John Dewey, an Amercian philosopher and social reformer (McNiff and Whitehead, 2011). However, scholars largely attribute the conceptualisation of AR to the work of Kurt Lewin (1890-1947), a German American psychologist, who was the first to use the term and saw it 'as a means of contributing to the betterment of society by enabling the resolution of social problems' (Gill and Johnson, 2010, p.95). AR has always been associated with social change and Dr. Martin Luther King made reference to it in a talk he gave in 1961 at the Conference on Social Change and the Role of Behavioural Scientists (McNiff and Whitehead, 2011; Noffke, 1997). Lewin thought if all members of a workforce were collaboratively involved in taking action and evaluating ideas, they would not only be more motivated, but an organisation would improve more sustainably (Coghlan and Brannick, 2010; Gill and Johnson, 2010; McNiff and Whitehead, 2011). AR is therefore not about doing research on people, but rather doing research with people for the purpose of improving organisational arrangements (Gill and Johnson, 2010; Heron and Reason, 2001).

According to McNiff and Whitehead (2011), AR not only emanated from critical theory (a core philosophical commitment of EALIM), but also seeks to go beyond it by attempting to change power imbalances through democratically just practices. Whilst AR has many definitions, the following definition seems to accord more closely with Lewin's conceptualisation: 'It seeks to bring together action and reflection, theory and practice, in participation with others, in pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities' (Reason and Bradbury, 2006, p.1). This definition not only denotes the scope of AR, but also its social

intent, which is ‘the flourishing of individual persons and their communities’ (p.1). As such, as well as exploring and explaining the world, action researchers also seek to change the world. However, the people who decide on the desired change and those that benefit are critical issues and undescore the importance of a democratic process (Coghlan and Brannick, 2010).

AR methodology has been the subject of much debate in regard to its rigour and viability, largely due to the wide diversity of its approaches and methods (Cox, 2012; Gill and Johnson, 2010). Toward ameliorating this predicament, Reason and Bradbury (2006) explain AR as a methodology that embraces a family of related methods from which the researcher can select, to produce practical outcomes by working with people in their every day lives. Their view is based on a Lewinian approach, most action researchers tend to follow, especially in their use of an iterative cycle (Cox, 2012; Gill and Johnson, 2010). The diagram in figure 6 depicts an iterative AR cycle that initially begins with a pre-understanding of the research context and purpose, followed by four core activities.

Figure 6: The AR cycle (reproduced with permission from the authors)



Source: Coghlan and Brannick (2010, p.8)

Each of the activities of an AR cycle can be described as follows (Coghlan and Brannick, 2010):

- Constructing – discussing, identifying and diagnosing ongoing problems, along with constructing a desired future state.
- Planning action – formulating action strategies and deciding how improvement is to be assessed.
- Taking action – typifies the transition and tension between a present and future state, which involves gaining commitment and dealing with conflicts.
- Evaluating action – reflecting on experience, reviewing the enabling and constraining forces of change and linking theory with data.

The empirical process of studying the effects of change within an AR cycle was regarded by Lewin as essential to understanding social phenomena and is a rigorous method for inductively linking theory with data (Gill and Johnson, 2010). Once the intended and unintended effects of change have been evaluated, informed decisions can be made as to what is fed into the next cycle of constructing, planning and acting, forming successive AR cycles over time (Coghlan and Brannick, 2010).

4.4.2 Why action research?

There are a number of reasons why I chose to adopt AR as my form of methodological inquiry. The main three reasons are that,

- As an action researcher, I am working collaboratively toward a desired state of change (Coghlan and Brannick, 2010; McNiff and Whitehead, 2011), which is a position entirely congruent with my role in the adoption of EALIM. Lewin believed that one could only understand a social entity when one tried to change it (Coghlan and Brannick, 2010; Schein, 2010). Therefore, as an insider change agent, my social intent is to create just practices by challenging irrational and anxiety driven organisational norms, particularly in regard to hierarchies of power, then make sense of participants' response to that change (Coghlan and Brannick, 2010).

- AR is congruent with my research philosophy of pragmatic critical realism and hermeneutic-interpretivism. For example, Coghlan and Brannick (2010) assert that AR is closely aligned with critical realism and holds a subjectivist epistemology similar to the hermeneutic tradition. As such, my research philosophy fits with AR's underpinning assumptions, some of which include that research is value laden and morally committed; organisations are socially constructed with multiple meanings; interpretation is socially, culturally and historically context dependent; there is no single truth to be identified; and knowledge is tentative (Coghlan and Brannick 2010; McNiff and Whitehead 2011; Reason and Bradbury, 2006).
- AR has a high degree of congruence with EALIM in that they both hold a participatory and heuristic approach toward learning where all can take responsibility for improving their own practice (McNiff and Whitehead, 2011).

4.5 Methodologies Not Selected

Since ethnomethodology and ethnography are considered to be the two main traditions within qualitative research (Bryman and Bell, 2011), these were the only other two methodologies I considered. Ethnomethodology is based on a sociological interpretivist position from which the researcher seeks to examine how social order is created in every day life by uncovering participants' taken for granted assumptions in talk, text and interaction (Bryman and Bell, 2011; McAuley, Duberley and Johnson, 2013). Ethnography typically involves a combination of observation and social interaction over a longitudinal period of time, allowing researchers to understand the culture of a social group as an insider. (Bryman and Bell, 2011; Gill and Johnson, 2010). While they both have some relevance to my research – in that they both engage in the every day life world of participants, my reasons for rejecting them are stated below.

4.5.1 Ethnomethodology

Ethnomethodology's sociological position omits the deep significance of intra-psychic conflicts and emotional transferences that mediate everyday life (Hunt, 1989). Studying the emotional experience of organisational life is particularly

important to my research as this could explain how organisational members facing uncertainty and anxiety create psychological defences ‘through projections and introjections that distort organisational rationality’ (Gabriel, 1999, p.223). Furthermore, ethnomethodology is commonly associated with conversational analysis, a fine grained method that has been criticised for limiting interpretations to talk alone, which excludes hermeneutic understanding of an organisation’s culture and history (Bryman and Bell, 2011).

4.5.2 Ethnography

Although ethnography supports fieldwork methods allowing the observable and hidden aspects of culture (Yanow, Ybema and Hulst, 2012), its methodology does not usually encompass an attempt to obtrusively change the culture of a social group (Coghlan and Brannick, 2010). Since my research purpose involves the implementation of EALIM and answering research questions in regard to participants’ responses to interventions, a traditional ethnographic methodology would not be congruent with my research.

4.6 Research Methods

The qualitative methods I selected for this research involve a combination of participant observation, qualitative interviews, focus groups and the use of a reflexive diary. In the following subsections, I give a short description of each method, discuss the main methodological concerns from the literature and provide justification for my selections.

4.6.1 Participant observation

Participant observation is a research method involving relatively prolonged periods of social interaction between the researcher and the researched. The idea is to study participants’ everyday experiences, thinking and actions, which may include talking to them about their feelings and interpretations (Waddington, 2004). Although this method can be a source of interference in the natural setting, I posit that reactivity from participants is inevitable, even during covert forms of observation (Bryman and Bell, 2011). One can look at the Hawthorne experiments

as a typical example of how research subjects altered their behaviour simply out of an awareness they were being observed (Bryman and Bell, 2011).

Participant observation was appropriate for my research because it would enable me to infiltrate and examine the essence of organisational culture in participants' everyday habitats, consequently allowing me to gain powerful insights as to why things happen in a particular way, why specific problems reoccur and why power struggles exist (Schein, 2010). Furthermore, participant observation would allow me to gain first hand experience of the interventions taking place through the adoption of EALIM, as well to generate meaningful information for explaining participants' acceptance of and resistance to EALIM, including my intervention as a researcher (Argyris, 2010; Coghlan and Brannick, 2010; Gabriel, 1999).

4.6.2 Qualitative interviews

The purpose of qualitative interviews is to interpret descriptions of participants' life worlds and to understand how and why they hold particular perspectives (Bryman and Bell, 2011). They are generally informal, include a low degree of structure, adopt open questions and are flexible enough so the researcher can depart from the initial area of interest to allow participants the liberty to talk about what is important to them (Alvesson, 2011; King, 2004).

Qualitative interviews are often criticised by opponents who prefer a more rigorous, structured and standardised method of interviewing, which they claim can minimise researcher influence and bias (Alvesson, 2011). Such criticisms usually suggest positivist or neo-positivist assumptions that regard the interview as a formal instrument capable of collecting undistorted and transparent facts, presumably to mirror an external reality (Alvesson, 2011). However, since my research is an interpretive inquiry, positivist notions and empirical facts have been abandoned (Nadin and Cassell, 2006) because the view taken here is that interview accounts are socially constructed through the interplay of interviewer, participant and local context (Alvesson, 2011).

Qualitative interviews would be particular useful for my research, as they create a context allowing individual participants to convey their perspectives, emotions and experiences around the a priori and emergent themes I wish to explore (Bryman and Bell, 2011; King, 2004). Qualitative interviews would therefore allow me to explore participants' perceptions, beliefs and values, motivations, decision-making, power relations and conflicts, as well as participants' successes and failures (Alvesson and Ashcraft, 2012).

4.6.3 Focus groups

A focus group is a qualitative method typically involving communicative interaction among a group of individuals around a topic of interest and is usually distinguished from a group interview where discussions tend to range more widely (Bryman and Bell, 2011).

Although the use of focus groups within research has increased over the last twenty years, some researchers have challenged their relevance due to their use by politicians in shaping their policies or public image (Kandola, 2012). Nevertheless, focus groups are still used in research to gain insights into the divergent views of participants on areas of research interest (Kandola, 2012). Unlike one-to-one interviews where participants' views are rarely challenged, focus groups allow participants to probe and challenge each other's perspectives and modify their views to one they would otherwise not have thought of (Bryman and Bell, 2011).

Used in a loosely structured way, focus groups would enable me to gain meaningful insights into how participants respond to each other around particular points of interest and to examine shared understandings, while still allowing individual differences to be heard (King, 2004). Furthermore, with focus groups, I could generate inter-subjective understandings of complex business problems, formulate action for EALIM's adoption and co-evaluate EALIM's impact on organisational culture and improvement. It follows that the collaborative and dynamic interaction within focus groups would not only generate novel action

strategies for the implementation of EALIM, but also enable me to gather information to answer my research questions (Bryman and Bell, 2011; Kandola, 2012).

4.6.4 Reflexive diary

Although different forms of reflexivity exist in management research, the two main types are methodological reflexivity, by which researchers think about the impact of their methods on the research setting, along with epistemic reflexivity, by which researchers 'think about their own thinking' (Johnson and Duberley, 2000, p.178). The argument for reflexivity stems from the notion that perceptual, cultural and theoretical assumptions in the human mind shape our interpretations of empirical material and by opening our assumptions up to self-critique, we can account for the way our research and thinking mutually affect each other, consequently leading to better research praxis (Alvesson, 2011; Cunliffe, 2011; Haynes, 2012; Johnson and Duberley, 2003; Nadin and Cassell 2006).

However, reflexivity in social research is not without its criticisms, which include positioning the voice of the author over the voice of participants, it could become more central than empirical content and be used to promote a theoretical or methodological advantage (Haynes, 2012). While these arguments appear convincing, Cunliffe (2011) argues that because underpinning assumptions constitute all forms of knowledge, no one can remain theory neutral and value free. In other words, we cannot put ourselves outside of the research and the consequence of being non-reflexive far outweighs the tensions of being reflexive (Cunliffe, 2011). Accordingly, adopting a reflexive approach would allow me to be more transparent in regard to my own knowledge-constituting assumptions and to examine the impact my methods had on the research setting.

An effective method for adopting reflexivity in practice is a reflexive diary, which can be used to note my experience of research encounters, as well as my thinking on the factors influencing the interpretations I produced (Nadin and Cassell, 2006). I therefore argue that adopting a reflexive diary would provide complimentary

empirical evidence, allow me to examine the methodological efficacy of my chosen research methods and create a record of my thinking and how it changed over time (Nadin and Cassell, 2006).

4.6.5 Reasons for combining qualitative methods

The process of using more than one method to study a social phenomenon is called triangulation and proponents argue it can generate greater credibility of research findings (Bryman and Bell, 2011). Although Silverman (2011) warns that using too many methods could complicate the research process, Johnson and Duberley (2000) suggest empirical evidence produced from divergent methods could illuminate different facets of phenomena. For example, interpretations from combined methods could be used to construct common themes, as well as examine inconsistencies, all of which could create broad qualitative insight (Layder, 1993). However, my argument for triangulation is not to validate findings among accounts in pursuit of ostensible objective truth, or to obtain a valid representation of reality, since these approaches connote positivist assumptions. Instead, my argument for using triangulation is to combine the accounts derived from each locally situated method to make better sense of social phenomena, generate contextual understanding and add 'rigour, breadth, complexity, richness and depth' to the inquiry (Silverman, 2011, p.371).

4.6.6 Reasons why mixed methods were not selected

Mixed methods research generally denotes a strategy of adopting both quantitative and qualitative methods (Bryman and Bell, 2011). Proponents of mixed methods (i.e., pluralists) argue that because qualitative and quantitative strategies do not have fixed epistemological and ontological assumptions, they can be combined to study the same phenomenon (Bryman and Bell, 2011). However, Gill and Johnson (2010) contend such pluralism in qualitative research is not tenable, because quantitative methods are based on assumptions that do not allow the possibility of verstehen. Gill and Johnson also suggest most pluralists agree qualitative methods are appropriate for exploring the construction of shared meanings and argue that beliefs in mixed methods are founded on positivist assumptions.

Although AR has a wide family of research methods, Johnson and Duberley (2000) argue these are typically qualitative, supporting the assertion from Heller (2004) that qualitative research should be aligned with AR. Since my research philosophy postulates that knowledge is socially constructed, it is difficult to see how any quantitative method could produce a rich understanding of the inter-subjective and multiple meanings individuals produce in their everyday interaction (Gill and Johnson, 2010; Stacey, 2010).

Various authors (e.g., Argyris, 1993; Argyris and Schon, 1978; Schein, 2010; Stacey, 1995) now accept, behaviour in organisations is largely driven by unconscious underlying assumptions, which can differ from participant's explicit beliefs and values. Consequently, applying a quantitative method like a cross-sectional survey instrument to test various hypotheses is unlikely to elucidate participants' tacit mental models and unconscious assumptions, since this method relies on what participants make explicit (Stacey, 1995). As such, data derived from questionnaires could be misleading as surveys may only produce espoused theory data (Argyris, 2010; Stacey, 1995). I therefore posit that qualitative methods located in local interaction over a longitudinal period would allow me to develop insights into tacit and explicit dimensions of organisational life, generate a wider degree of variability in findings and explore changes in participant behaviour over time (Argyris, 2010; Gabriel, 1999; Schein, 2010).

4.7 The Target Organisation – Bettercare

For reasons of confidentiality, I have replaced the name of the target organisation with the name Bettercare. My two brothers and I founded the organisation in 2008 along with four non-family members, all of whom were shareholders. The organisation was a private care provider offering specialist residential and hospital care services to adults with a primary diagnosis of Learning Disability (LD) and a secondary diagnosis that could include Personality Disorder (PD), Autistic Spectrum Disorder (ASD) or Challenging Behaviour (CB). Care services were tailored to meet the needs of each patient group within specialist units ranging from five to nine beds and two self-contained flats. Bettercare's residential and

hospital units were mostly based in the London, with its head office located in a nearby home county.

Although the organisation began trading in 2008 with a small daycare centre and three hospital units totaling 22 beds, it experienced rapid organic growth over the proceeding four years to 2012. For example, at the time I commenced my fieldwork in July 2011, Bettercare employed 150 employees and provided 59 beds comprised of eight units (one step-down residential care home and seven low secure hospitals). However, by the time I completed my field research in January 2013, the organisation had grown to 270 employees by opening two additional step-down residential care homes, with an aggregate total of 74 beds in 10 units. Placements within residential homes and hospitals were funded by over 30 customers composed largely of NHS purchasing authorities followed by social service authorities across London and the home counties. Most patients were admitted through back to borough schemes, i.e., patients moving back to London from settings further afield. Other admissions involved patients requiring a low secure environment, therapeutic rehabilitation, or an emergency admission under mental health legislation.

The top management structure included a chairman, seven directors and two senior managers. The chairman was responsible for leading board meetings and quality assurance processes, as well as chairing clinical governance and audit meetings. The Chief Executive Officer (CEO), my brother, was the managing shareholder with oversight over the whole organisation and had leadership over the strategic growth of the organisation. The Chief Operating Officer (COO) held responsibility for all care operations and reported to the CEO. The other five directors, who held individual responsibilities for care services, finance, marketing, facilities management and operations, mostly reported to the CEO. The two senior managers were the operations manager and compliance manager, both of whom were my nephews. However, due to restructuring in May 2012, the chairman was dismissed and replaced by the CEO, who empowered the COO with autonomy for line managing all other directors. Due to the organisation's rapid growth, three

additional senior managers were appointed with responsibility for line managing all middle managers.

The middle management structure consisted of seven hospital and care home managers, responsible for the day-to-day management of their respective units. The line management structure within each unit consisted of an assistant manager, a team of staff nurses (for hospitals) and a team of senior care workers (for residential homes), all of whom had responsibility over care workers for the provision of direct care to local patients. In addition, a dedicated multi-disciplinary team of psychiatrists, psychologists, occupational health and speech and language professionals provided clinical services to patient groups. An organogram of Bettercare can be found in appendix 1.

4.8 My Role as a Consultant and Insider-Researcher

In this section I describe my roles as both consultant and researcher within my own organisation and reflexively discuss the political issues these roles entailed.

4.8.1 My role as consultant

As a former HR Director for ten years with a previous healthcare organisation, my role at Bettercare was to provide business consultation services on a self-employed basis. This typically involved offering advice and guidance to directors on matters relating to strategic growth, problem solving and human resource management. However, from 2010 my focus changed to improving organisational sustainability and service quality, which has a high congruence with the implementation of EALIM. While the nature of my consultant role precluded me from any line management, it provided me with an almost unfettered access to organisational members.

Furthermore, my role as a consultant not only gave me a pre-understanding of organisational issues and context, but also formal and informal access to social domains that perhaps would have remained hidden to an ‘outsider-researcher’ (Coghlan and Brannick, 2010, p.114). Tietze (2012) suggests having an

accessible network such as this provides depth and colour to a research project, supporting the suggestion from Coghlan and Brannick (2010) that an insider researcher role provides access to a wide range of organisational members, which can produce divergent accounts of mean-making.

Although my relationships with organisational members were mostly situated at head office, I had not worked with or met many others, particularly in frontline services. I would therefore be familiar with some but not others, which raises an important reflexive issue about taking account of my own pre-conceptions of both types of participants – the strange and the familiar (Tietze, 2012). While I cannot avoid bringing my own pre-understandings into the research scene, being reflexive allowed me to render them to critical examination, so as to make explicit what I may have taken for granted. According to Tzietze, this involves a balancing act between 'strangeness' and 'familiarity' (Tietze, 2012, p.60) – that is to say, asking questions which makes familiarity more strange and render what is strange more familiar.

4.8.2 My role as an insider-researcher

According to Coghlan and Brannick (2010), doing insider research within one's own organisation holds the following advantages:

- My researcher role could to be taken for granted, meaning I could freely participate or observe without creating suspicion or bringing attention to myself as a researcher.
- I could use use my pre-understanding of the organisation's power structures and socio-historical context to see beyond organisational objectives that are mere 'window dressing' (p.115).
- I could turn familiar situations and unintended consequences into objects of social inquiry, e.g., a poor CQC audit, or the unexpected discharge of a patient.

Tietze (2012) asserts the background and experience of an insider-researcher forms a research foundation that shapes themes and questions and the

completion of empirical work. In other words, insider-researchers cannot remove themselves from the social milieu of their own organisations. However, there are caveats with being too familiar, some of which include being biased toward certain peers and relatives, not being open to disconfirming evidence, assuming too much and being pulled or pushed by others with a vested interest in the research (Coghlan and Brannick, 2010). However, these disadvantages could be addressed through a constant reflexive examination of the relationship between the researcher and the researched (Tietze, 2012). During this research I therefore adopted a reflexive approach involving asking myself questions concerning my own personal interests, personal relationships and presuppositions, along with how the duality of my role as both a consultant and researcher influenced the research process including participants' responses (Coghlan and Brannick, 2010; Tietze, 2012).

4.8.3 Political issues

In my particular research context, some participants may have seen the adoption of EALIM as a subversive process that threatened their power, taken for granted assumptions, or established organisational norms. I therefore needed to be attentive to internal politics and form alliances with key protagonists who could play a vital role in moving change forward. Forming political alliances accords with the ideas of Coghlan and Brannick (2010) who argue doing AR in one's own organisation is a political process because it rarely affects all stakeholders in the same way. For example, some participants may have identified me as an empathic confidant, a welcome change agent who held the promise of a better future, while others may have seen me as an informer to be treated with suspicion. Conversely, others may have perceived me as a saboteur of organisational rituals and norms – a threat to their common sense ordering of the world (Goffman, 1990). Therefore, adopting a repertoire of political strategies that aid tactful engagement without compromising ethics of democracy and fairness, are critical to surviving as an AR change agent (Buchanan and Badham, 2008).

I was also conscious that holding a desire for the successful adoption of EALIM could potentially influence my interpretation of participants' responses and the production of research findings. I therefore took the following steps to ameliorate this potential bias:

- I modified my research questions so the object of my inquiry was not to prove whether EALIM worked, but to explore participants' responses to its implementation, including the analysis of defensive mechanisms.
- I took an honest view about my pre-understandings and was open to disconfirming evidence by seeking it out in observations and interviews.
- I combined the empirical accounts derived from each situated method, so as to generate hermeneutic-understanding of research findings.

I was also aware that my role as a shareholder could pose a political influence over participant's views, especially in regard to their perceived acceptance of EALIM. Although my identity as a shareholder was unlikely to be widely known, participants who were aware may have perceived me as a powerful figure and therefore censored (consciously or unconsciously) specific attitudes, experiences, or misgivings about EALIM and the organisation. Conversely, the opposite could occur, where participants attempt to seize opportunities to discuss their work-related qualms in the hope of exploiting my perceived political power for their own interests. Although it is not possible to eliminate such biases, I took the following reflexive steps throughout the research process, to reduce the potential of political biases distorting the authenticity of my research:

- I was open to listening to grievances and to search for any relationship these had with accounts from other participants.
- I was mindful of any defensive behaviours of my own if criticisms were levied against EALIM or the organisation, since any defensive behaviour could be counter-productive in constructing a context for open discussion without power distortions.
- I consciously searched for clues, innuendoes or implicit suggestions of political assuagement from participants, including re-examining empirical material.

- In all research encounters, I emphasised my role as a researcher and encouraged participants to explicitly share concerns about EALIM and the organisation, explaining why their feedback was crucial for improvement.

Nevertheless, despite the political milieu I found myself in, I could not separate myself from the triadic roles of consultant, researcher and shareholder. In other words, I was who I was in this research process and as 'the research instrument par excellence,' I could not remove myself from my own inquiry (Tietze, 2012, p.54). However, by adopting a reflexive AR inquiry, I was able to mitigate my own potential biases, be attentive to political dynamics and take account of the influence my perceived role had on the researched.

4.9 Ethical Considerations

Before I commenced any fieldwork with research participants, I obtained ethical approval from the Ethics Committee at the University of Hertfordshire and followed its ethical guidelines. A copy of the consent letter from Bettercare duly authorising me to carry out my research, can be found in appendix 2. Although I had permission from Bettercare to include patients in my research, I deemed that generating data directly from patients was inappropriate because it was doubtful they held the mental capacity to provide informed consent. Moreover, the copious amount of information gathered from management and staff was sufficient to answer my research questions. Whilst for the most part, ethical considerations are addressed within the general discourse of this thesis, the ethics I adopted throughout my research inquiry were based on four main principles: 1) safeguarding participants from harm, 2) gaining informed consent, 3) maintaining privacy and confidentiality and 4) upholding honesty and transparency (Bryman and Bell, 2011).

4.9.1 Safeguarding participants from harm

I was attentive of the need to safeguard participants from physical, emotional and psychological harm. This process involved checking that interview rooms were secure from interruptions from volatile patients, treating participants with dignity

and being empathic to their emotional and psychological needs. During observations, I satisfied myself as much as reasonably practicable that frontline workers were not distracted from carrying out needful duties toward patients. I was also mindful not to say or do anything that could jeopardise participants' career prospects with the organisation, during or after research encounters.

4.9.2 Gaining informed consent

I always explicitly obtained informed and voluntary consent from participants, along with permission to take notes before the start of each interview. I also sought consent when a voice recorder was deployed. For the most part, I used a voice recorder for focus groups and meetings involving multiple persons. On two occasions when participants were not comfortable with the voice recorder, I reverted to writing notes. During naturally occurring observations, sometimes my role as both consultant and researcher became blurred, especially during informal chats, luncheons and corridor conversations (Tietze, 2012). Therefore, in cases where discussions were too impromptu to gain prior consent, I requested permission from participants to write up research notes after conversations ceased.

4.9.3 Maintaining privacy and confidentiality

During research encounters, I reassured participants that their identities would remain confidential in all my written reports. In cases where a possibility existed of a reader identifying participants in my final report, I carefully explained this to participants and gained their verbal consent to proceed. In cases where participants disclosed matters that caused me an immediate concern for their safety, I reported these matters to the relevant director, but only after gaining consent from the respective participants.

4.9.4 Upholding honesty and transparency

An explanation of the research was always given prior to the start of each interview and where practicable, before observations. This explanation typically involved informing participants of my role and the purpose of the research.

However, with regard to focus groups, I only maintained this approach for the first few meetings, as thereafter, my research purpose seemed to be commonly understood and accepted. However, in cases where a new focus group participant joined, I reiterated the purpose of both the focus group and my research intent.

4.10 Concepts and a Priori Themes

A concept is a category the researcher is interested to explore and an a priori theme is a pre-defined indicator relating to a particular concept, used to connect fragments of information together (Bryman and Bell, 2011; King 2012). Although the development of concepts is not a significant consideration for most qualitative researchers because their use can restrict aspects of the phenomenon being explored, I chose to use a set of concepts because they provided me with a general sense of structure and guidance (Bryman and Bell, 2011).

Given the object of my AR inquiry related to the adoption of EALIM, its four concepts (ethics, adaptability, learning and improvement) were taken as categories for operationalisation. Adopting them provided me with a structure to analyse; changes to EALIM's conceptual framework (research question 3a) and participants' acceptance and resistance to EALIM's concepts (research question 3b). I then created an additional three concepts to explore participants' perceptive value of the organisation, power relations and motivation. Perceptive value of the organisation was selected so I could explore what impact EALIM's adoption had on participants' perceptions of Bettercare and organisational ideal; power relations was chosen to examine EALIM's impact on collaboration and workplace democracy; and motivation was included since I was interested to explore any changes to participants' motivations toward the good of the organisation (Porter, 2008; Stacey, 2010). These seven concepts (perceptive value of the organisation, power relations, motivation, ethics, adaptability, learning and improvement) were then used as a conceptual framework to analyse organisational culture (research question 3c) and organisational improvement (research question 3d).

After closely examining all seven key concepts, I developed several a priori themes relating to each concept, which allowed me to construct some loosely structured interview questions to elicit data that would inform those themes. A full list of interview themes and their associated questions can be found in appendix 3. For example, a priori themes on ethics included participants' espoused values, perceived conflict between Bettercare's values and those of participants' and how Bettercare valued its staff. In regard to learning, themes included participants' learning methods, individual and organisational knowledge sharing methods and the extent reflexivity was used.

Although questions were prepared in advance of interviews, they were only used as a guide, as questions often differed from person to person due to variations in participants' understanding, language and cognitive abilities. The important aim in the interview process was not to systematically repeat the same questions, but to generate meaningful information to inform the concepts and themes I was exploring. Some themes overlap slightly and in a few interviews, I could not gather information on all the a priori themes due to time constraints. If answers from participants did not fit within any of the a priori themes, I would allow the discussion to take its course, as this could emerge as an area of genuine interest (Cassell, 2004). Instead of generating a uniform collection of data, similar to a detective, I was interested in pursuing exceptions, clues and anything out of place that could present value in the search for rich qualitative meaning (Gabriel, 1999). This loosely structured approach allowed me to explore a priori (top-down) themes and emergent (bottom up) themes that could be useful in informing both theory and practice (King, 2012).

Unlike interviews, my observations had less structure as these were context led, allowing the examination of everyday activities and behaviours in their natural context (Bryman and Bell, 2011). As such, observations were mainly used as a method to explore emergent themes as well as any inconsistencies between the theories participants espoused in interviews and theories they used in practice (Argyris, 2010). Focus groups tended to follow a more focused inquiry like a

problem to be solved, an EALIM action strategy, or the exploration of multiple meanings (Bryman and Bell, 2011; Coghlan and Brannick, 2010; Kandola, 2012).

4.11 Choosing Research Participants

Generating information from the whole population of Bettercare would have been highly impracticable because of resource and time constraints. As a consequence, it was only practicable to gather and analyse information from a sample of research participants. Probability sampling methods were not selected because they are largely driven by a positivist epistemology and quantitative research strategy, where statistical representation is important for enhancing external validity (Bryman and Bell, 2011). Furthermore, probability sampling is almost never used in participatory research because in-depth analysis is far more important than being able to generalise research findings to larger populations or apply them to other contexts. Therefore, a range of non-probability sampling techniques were deployed, because these were more suited to qualitative research where the focus is on generating new insights in which rich theoretical inferences can be made (Bryman and Bell, 2011; Saunders, 2012).

4.11.1 Qualitative interviews

Quota sampling was not selected as this technique is commonly used for surveys (Saunders, Lewis and Thornhill, 2012) and would have been problematic due to the unpredictability of changing shift patterns of staff. Although my selection of interview participants was not a proportional reflection of the population, it nevertheless produced an illustrative profile that included a diversity of participants from management and non-management positions of differing rank, discipline, location, gender, age, ethnicity and length of service. The non-probability sample largely involved using my judgment to select participants using purposive sampling techniques that would generate:

- Critical cases of participants who were important to the research aims and who could provide critical information.

- Heterogeneous cases of participants across different sites, disciplines and varying levels in the hierarchy, to generate the maximum variation of information and to inform key themes.
  (Saunders, 2012; Saunders, Lewis and Thornhill, 2012)

Interviews involving management and head office staff were scheduled in advance by email or telephone. However, advance scheduling was too problematic for frontline staff because of their changing shift patterns and workloads. When I attended interviews in hospitals and care homes, I would typically request to see a heterogeneous mixture of frontline staff but the choice of participants was sometimes constrained by local managers or charge nurses, who used their judgement to select the staff available at the time I was present. I also recruited a small number of snowball cases in which participants identified a colleague whom they invited while I was on-site. In total, I interviewed 45 participants from a population of 270 employees and the total interviews held during my entire fieldwork reached 60 as I interviewed some participants twice, i.e., cycles one and three. Each participant's position, team, gender, ethnicity, approximate age, location and the AR cycle in which I interviewed them, are given in table 10 (in the order they were first interviewed.

Table 10: Composition of interview participants

No.	Position	Team/Department	Characteristics	Location	Cycle
1	Marketing Director	Top Management	Female, white, 45	Head Office	1 & 3
2	CEO	Top Management	Male, white, 49	Head Office	1 & 3
3	HR Administrator	Administration	Male, white, 29	Head Office	1 & 3
4	Payroll Administrator	Administration	Female, white, 52	Head Office	1 & 3
5	Facilities Director	Top Management	Female, white, 38	Head Office	1 & 3
6	Project Coordinator	Administration	Female, white, 25	Head Office	1 & 3
7	Medical Secretary	Administration	Female, white, 22	Head Office	1 & 3
8	Care Home Manager	Middle Management	Female, African, 51	Home W	1 & 3
9	Day Care Manager	Frontline services	Male, white, 32	Day Centre	1
10	Assistant Manager	Frontline Services	Female, Asian, 42	Day Centre	1
11	Hospital Manager	Middle Management	Male, Asian, 35	Hospital F	1
12	Hospital Manager	Middle Management	Female, white, 45	Hospital B	1
13	Care Director	Top Management	Male, Asian, 53	Head office	1 & 3
14	Operations Director	Top Management	Female, white, 38	Head Office	1 & 3
15	COO	Top Management	Male, white, 50	Head Office	1 & 3
16	Staff Nurse	Frontline Services	Male, African, 47	Hospital O	1
17	Hospital Manager	Middle Management	Male, Caribbean, 45	Hospital C	1 & 3
18	Staff Nurse	Frontline Services	Female, African, 32	Hospital C	1 & 3
19	Compliance Manager	Top Management	Male, white, 24	Head Office	1 & 3
20	Operations Manager	Top Management	Male, white, 26	Head Office	1 & 3
21	Care Worker	Frontline Services	Female, African, 48	Hospital C	1
22	Care Worker	Frontline Services	Female, Caribbean, 51	Home W	1
23	Care Worker	Frontline Services	Female, white, 23	Hospital O	1
24	Staff Nurse	Frontline Services	Female, white, 26	Hospital F	1
25	Care Worker	Frontline Services	Male, African, 26	Hospital F	1
26	Care Worker	Frontline Services	Female, African, 24	Hospital F	1
27	Care Home Manager	Middle Management	Female, white, 28	Home B	3
28	Snr Care Worker	Frontline Services	Female, African, 42	Home B	3
29	Snr Care Worker	Frontline Services	Female, white, 35	Home B	3
30	Care Worker	Frontline Services	Female, African, 42	Home B	3
31	Care Worker	Frontline Services	Female, white, 23	Hospital B	3
32	Care Worker	Frontline Services	Female, white, 24	Hospital B	3
33	Care Worker	Frontline Services	Female, white, 22	Hospital B	3
34	Staff Nurse	Frontline Services	Female, Caribbean, 32	Hospital F	3
35	Staff Nurse	Frontline Services	Female, African, 36	Hospital F	3
36	Care Worker	Frontline Services	Male, African, 24	Hospital F	3
37	Snr Care Worker	Frontline Services	Female, Asian, 26	Hospital C	3
38	Care Worker	Frontline Services	Female, white, 23	Hospital C	3
39	Care Worker	Frontline Services	Female, African, 26	Hospital C	3
40	Hospital Manager	Middle Management	Female, Caribbean, 45	Hospital O	3
41	Care Worker	Frontline Services	Female, Asian, 23	Hospital O	3
42	Care Worker	Frontline Services	Female, white, 25	Hospital O	3
43	Care Worker	Frontline Services	Female, African, 28	Hospital O	3
44	Snr Care Worker	Frontline Services	Female, African, 32	Home W	3
45	Care Worker	Frontline Services	Female, white, 51	Home W	3

4.11.2 Participant observations

As an insider-researcher, I had access to observe a wide scope of activities. However, to avoid gathering an excessive amount of information that would preclude any meaningful in-depth analysis, I purposefully selected observations based on their importance to informing my research questions and key concepts (Bryman and Bell, 2011; Silverman, 2011). Nevertheless, my observations spanned a diversity of participants, whom I selected using the following purposive sampling techniques:

- Critical cases that yielded essential information on participants' perceptions, behaviours, feelings and use of discourse.
- Heterogeneous cases that could describe and explain key concepts and to provide maximum variation.
- Theoretical cases that yielded relevant information to evolving narratives and emerging theories.

  (Bryman and Bell, 2011; Saunders, 2012; Saunders, Lewis and Thornhill, 2012)

The cases I selected involved a range of informal and formal discussions, meetings and EALIM seminars. The total number of observational cases I selected from my fieldwork notes and transcripts amounted to 37 entries. Details of the observed activities, their location, my level of participation, the position of participants and in which AR cycle I observed them, are given in table 11 (in date order). My level of participation has been classified in accordance with three participant observer roles (Bryman and Bell, 2011): 1) 'Total participant' – completely involved in activities, 2) 'Researcher-participant' – semi-involvement, i.e., asking occasional questions and 3) 'Total researcher' – full observation without participation in the flow of events (p.438).

Table 11: Activities and participants observed

Entry No.	Activity and Location	My Participation	No of	Participants	Cycle
1	Board Meeting at Head Office	Total Researcher	7	Chairman, CEO, COO, Care Director, Financial Controller, Facilities Director, Marketing Director	1
2	Informal discussion over lunch at a cafe	Total Participant	1	Chief Executive Officer	1
3	Board Meeting at Head Office	Researcher/ Participant	6	Chairman, CEO, COO, Care director, Facilities director, Marketing Director	1
4	EALIM Seminar at Head Office	Total Participant	7	Chairman, CEO, COO, Care Director, Facilities Director, Operations Manager, Compliance Manager	1
5	EALIM Seminar at Head Office	Total Participant	3	Financial Controller, Operations Director, Marketing Director	1
6	Informal Discussion at Head Office	Total Participant	1	Operations Manager	1
7	Informal Discussion at Head Office	Total Participant	1	Marketing Director	1
8	Formal Discussion at Head Office	Total Participant	1	Marketing Director	1
9	Formal Discussion at Head Office	Total Participant	1	Operations Director	1
10	Formal Discussion at Head Office	Total Participant	1	CEO	1
11	EALIM Seminar at the Training Suite	Total Participant	5	2 Hospital Managers, 2 Assistant Managers, 1 Staff Nurse	2
12	Informal Discussion in a Taxi	Total Participant	1	Care Director	2
13	Informal Discussion at the CEO's home	Total Participant	1	CEO	2
14	Board Meeting at the CEO's home	Total Participant	6	COO, Financial Controller, Care, Facilities, Marketing Director, Operations Manager	2
15	Formal Discussion at Head Office	Total Participant	1	CEO	2
16	Formal Discussion at Head Office	Total Participant	1	Facilities Director	2
17	Formal Discussion at Head Office	Total Participant	1	Operations Manager	2
18	Field Trip to India, Indore	Researcher/ Participant	7	Operations and Compliance Manager, 2 Administrators, Project Coordinator, 2 Care Workers	2
19	EALIM Seminar at the Training Suite	Total Participant	4	1 Hospital Manager, Day Care Manager, 1 Assistant Manager, HR Administrator	2
20	EALIM Seminar at the Training Suite	Total Participant	4	1 Hospital Manager, 1 Care Home Manager, 2 Assistant Managers	2

Entry No.	Activity and Location	My Participation	No of	Participants	Cycle
21	Formal Discussion at Head Office	Total Participant	1	Marketing Director	2
22	Informal Discussion in builders home	Total Participant	1	Operations Manager	2
23	Evaluation Meeting at Head Office	Total Participant	7	COO, Care Director, Operations Manager, Compliance Manager, 3 senior Managers	2
24	Evaluation Meeting at Head Office	Total Participant	2	Operations Director. Marketing Director	2
25	Evaluation Meeting at Head Office	Total Participant	1	CEO	2
26	Informal Discussion with the CEO at Head Office	Total Participant	1	CEO	2
27	Informal Discussion in a Cafe	Total Participant	1	Operations Manager	2
28	EALIM mini-seminar at Care Home B	Total Participant	4	1 Snr Care Worker, 3 Care Workers	2
29	EALIM mini-seminar at Hospital O	Total Participant	4	1 Staff Nurse, 3 Care Workers	2
30	EALIM mini-seminar at Care Home W	Total Participant	6	2 Snr Care Workers, 4 Care Workers	2
31	EALIM mini-seminar at Hospital F	Total Participant	4	1 Staff Nurse, 3 Care Workers	2
32	EALIM mini-seminar at Hospital B	Total Participant	7	1 Assistant Manager, 2 Staff Nurses, 4 Care Workers	2
33	Board Meeting at Head Office	Total Researcher	6	CEO, COO, Financial Controller, Operations Manager, Care Director, Operations Director	2
34	Training Seminar at Head Office	Total Participant	6	CEO, COO, Financial Controller, Operations Manager, Care Director, Operations Director	2
35	EALIM mini-seminar at Hospital C	Total Participant	4	1 Staff Nurse, 3 Care Workers	2
36	EALIM mini-seminar at Care Home P	Total Participant	5	2 Snr Care Workers, 3 Care Workers	2
37	Evaluation Meeting At Head Office	Total Participant	9	COO, Care Director, Operations Director, Operations Manager, Compliance Manager, Interview Consultant, 3 senior managers	3

4.11.3 Focus groups

The non-probability sampling techniques I used for selecting focus group members involved a purposive critical case of participants who I deemed essential in taking part in the group, along with a volunteer group of snowball participants who expressed an interest in EALIM's adoption. I attempted to generate a heterogeneous sample of participants from different disciplines and positions,

because I deemed this would allow me to examine both shared and divergent understandings and experiences. Participants were invited by email and some verbal invitations were given during my visits across different locations. Top and middle managers were invited with the intention of forming a strong political alliance that could garner support toward the adoption of EALIM. Coghlan and Brannick (2010) assert AR is a political inquiry, since it involves changing organisational norms that could be seen as subversive to those who have control in the hierarchy. Therefore, involving key members from top and middle management was critical in reducing any perceived threat to their power. I also invited staff nurses and care workers who expressed the most interest in EALIM during interviews and seminars. A total of eight focus groups were held in Bettercare's training suite in North London. The numbers of participants' that attended each focus group, their position, gender, ethnicity, approximate age and in which AR cycle they were held, are given in table 12 below.

Table 12: Focus group participants

Month	No of	Participants	Characteristics	Cycle
Oct 11	7	COO, Care Director, Operations Manager, Compliance Manager, Day Care Manager, 1 Staff Nurse and 1 Care Worker	2 females, 4 males, 1 Asian, 6 white, Age range: 23 – 53.	1
Dec 11	4	COO, Care Director, 1 Staff Nurse and 1 Care Worker	2 females, 2 males, 1 Asian, 3 white, Age range: 23 – 53.	2
Jan 12	5	COO, Care Director, Compliance Manager, 1 Staff Nurse and 1 Care Worker	2 females, 3 males, 1 Asian, 1 African, 3 white, Age range: 26 – 53.	2
Feb 12	6	COO, Care Director, Day Care Manager, 1 Clinical Therapist, 1 Staff Nurse and 1 Care Worker	3 females, 3 males, 1 Asian, 5 white, Age range: 23 – 53.	2
Apr 12	3	COO, Care Director and 1 Care Worker	1 female, 2 males, 1 Asian, 2 white, Age range: 23 – 53.	2
July 12	2	COO and Care Director	2 males, 1 Asian, 1 white, Age range: 50 – 53.	2
Aug 12	6	Care Director, Compliance Manager, Clinical Therapist, Occupational Therapist, Psychologist and 1 Care Worker	3 females, 3 males, 2 Asian, 5 white, Age range: 25 – 53.	2
Dec 12	6	COO, Care Director, Operations Manager, Compliance Manager, Clinical Therapist and Interview Consultant	1 female, 5 males, 1 Asian, 5 white, Age range: 24 – 53.	3

4.12 Chronicle of Action Research cycles

My entire AR fieldwork spanned an eighteen-month period, from July 2011 to January 2013 and consisted of 60 qualitative interviews, 37 participant observations and 8 focus groups. This longitudinal period is divided into three AR cycles: pre-implementation of EALIM, implementation of EALIM and post-implementation of EALIM. Although a more detailed reflective narrative of how I went about gathering data (including reflexive outcomes) is given in the method sections of cycle chapters five, six and seven, a synopsis of each cycle is chronicled in the following three subsections.

4.12.1 Cycle one – pre-implementation of EALIM

The first AR cycle involved gathering data prior to the implementation of EALIM, from July 2011 to November 2011. During this period, I carried out 26 qualitative interviews from a population of 150 employees, 10 participant observations and one focus group, as depicted in table 13 below.

Table 13: Cycle one timeline

AR activity / Month	July11	Aug11	Sep11	Oct11	Nov11
Board Meetings	1	1			
EALIM Seminar		1	1		
Qualitative Interviews		7	8	6	5
Informal Discussions	1			2	
Formal Discussions				3	
Focus Groups				1	

My first research encounter involved attending a board meeting in July 2011, as I was interested in observing the discourse of board members, their power relations and dominant interests. This activity was followed by an informal luncheon with the CEO, to gain agreement in holding an EALIM seminar with top managers at the end of the next board meeting. After attending Augusts' board meeting, I delivered my first EALIM seminar with top managers, which was useful in galvanising top management's commitment toward EALIM's adoption, as well as generating information from participants' responses. However, because 3 directors were absent, I held a second seminar in September for them. My seminar slides can be found in appendix 4.

Qualitative interviews began in August with four head office workers and three top managers and continued into September during which I interviewed three top managers, four middle managers and one assistant manager. These interviews allowed me to generate insights into both top and middle management culture and to gather data on the a priori themes I wished to explore. In October, I noted two informal conversations with the operations manager and marketing director with reference to a damning CQC inspection in Hospital B because it seemed to act as a critical event that fortuitously supported the adoption of EALIM. See appendix 5 for excerpts of various observational notes. In the same month, I also noted three formal discussions with the Chief Operating Officer (COO), marketing director and operations director, with reference to a proposed change to EALIM's moral anchor, denoting the reflexive nature of my research inquiry (Haynes, 2012). During the lull periods between fieldwork encounters, I often examined my notes, formed initial interpretations and reflected on where the research was taking me.

Toward the end of October, I sent email invitations to 12 participants, of whom seven attended, to collaboratively plan the implementation of EALIM. The focus group not only garnered a coalition that could support EALIM's adoption, but also allowed me to understand the complex business problems participants wanted to solve – a process typifying the participatory approach of action research (Reason and Bradbury, 2006). During October and November, 11 further qualitative interviews were carried out from a heterogeneous sample of two top managers, one middle manager, three staff nurses and five care workers. These interviews generated divergent perspectives and accounts of organisational life. However, I ceased interviewing toward the end of November because I deemed enough data had been generated to saturate the key concepts and themes I was exploring (Bryman and Bell, 2011).

Information gathered from this cycle generated a rich cultural understanding of the organisation, allowing me to generate key findings of participants' conceptualisations and their patterns of interaction within the natural flow of everyday life. Furthermore, empirical accounts derived from the divergent methods

I deployed enabled me to identify inconsistencies between theories espoused and theories in use (Argyris, 2010). Findings from all these accounts were used to devise a baseline assessment (presented in chapter five), which shaped the construction of collaborative action plan with top management in the next AR cycle.

4.12.2 Cycle two – implementation of EALIM

The second AR cycle involved the implementation of EALIM over a twelve-month period from November 2011 to October 2012. During this period, I held six further focus groups and 26 participant observations, as illustrated in table 14.

Table 14: Cycle two timeline

AR activity / Month	Nov11	Dec11	Jan12	Feb12	Mar12	Apr12
EALIM Seminars	1		1	1		
Informal discussions	2					1
Board Meetings		1				
Formal Discussions		3		1		
Focus Groups		1	1	1		1
Field Trip to India			1			
Evaluation Meetings						
EALIM mini-seminars						
EALIM Articles			1	1	1	1
AR activity / Month	**May12**	**Jun12**	**July12**	**Aug12**	**Sep12**	**Oct12**
EALIM Seminars				1		
Informal discussions			1			
Board Meetings				1		
Formal Discussions						
Focus Groups			1	1		
Field Trip to India						
Evaluation Meetings	3					
EALIM mini-seminars			3	3		1
EALIM Articles	1		1	1	1	1

I began this cycle by delivering an EALIM seminar to five participants in November 2011. The slides I presented can be found in appendix 4. The seminar was repeated in January and February 2012 to eight more participants. Those attending were predominantly middle managers and their assistants, as I sought to galvanise a mass of leaders that would create a tipping point for organisational change (Kim and Mauborgne, 2003). In November, I also noted two informal discussions – one was with the care director who shared how EALIM enabled

changes in the delivery of company training and the other was with the CEO with reference to making board meetings more informal. I then attended the next board meeting in December to observe any differences these changes had on participants' interactions and after the meeting, I held formal discussions with three directors where I obtained their feedback on those changes.

Between December 2011 and August 2012, six focus groups were held. These focus groups facilitated mini AR cycles – that is, where members reflected on what was happening, constructed what the issues were and collectively planned actions to be taken (Coghlan and Brannick, 2010). However, after reflecting on the action strategies deployed for EALIM's adoption, I reasoned most employees were unaware of EALIM, with the exception of those attending seminars and focus groups. Therefore, commencing from January 2012, I began distributing monthly EALIM articles to all employees by post. See appendix 6 to view a selection of articles. Although the codification of theories may only superficially transfer knowledge (Hislop, 2009), I deemed the articles would provide a focal point for discussions among staff. In January, I also attended a 3-day field trip to India with seven organisational members to open a school and orphanage funded by Bettercare's shareholders. This trip gave me first hand experience of the impact corporate philanthropy had on the participants attending. In February, I met with the marketing director to review the impact the India project had on external stakeholders' perceptions of Bettercare and in April, I noted an informal discussion with the operations manager where he shared important information concerning the adoption of EALIM's methods at local sites.

After completing my analysis of data from cycle one, I held three evaluation meetings in May where I presented my findings to 10 top managers. These meetings allowed participants the opportunity to respond to my findings and engage reflexively with their organisational world. Reason and Bradbury (2006) argue that allowing organisational members to reflexively engage with their work is a criterion for the quality of action research. Toward the end of both meetings, action plans were discussed and agreed upon for the remaining period of EALIM's

implementation.

In May, I had an informal discussion with the CEO who informed me the chairman had been dismissed from the organisation and in July, I noted another informal conversation with the operations manager who shared how he presented my findings to other organisational members in an effort to cooperatively redress organisational issues identified in my baseline assessment. Between July and October 2012, I presented seven EALIM mini-seminars to a total of 34 participants consisting of one assistant manager, five staff nurses, five senior care workers and 23 care workers. The slides I presented can be found in appendix 7. These mini-seminars not only further facilitated the diffusion of EALIM's concepts and methods to frontline staff, but also allowed me to gather information on their acceptance and resistance to the model. In August, I attended my final board meeting, with a particular focus on how members' interactions had changed from the first board meetings I observed the previous year. After the meeting, I held a session with six top managers to experiment with the idea of adopting Quaker space – an approach for generating space for intuitive learning and creative thought. My presentation slides on Quaker space can be found in appendix 8.

The empirical accounts gathered from all participant observations and focus groups enabled broad qualitative insights into the study of EALIM's implementation. After these accounts were analysed, findings were produced (presented in chapter six) with reference to; changes to EALIM's conceptual framework, participants' acceptance and resistance of EALIM's adoption and the impact of its interventions upon organisational improvement.

4.12.3 Cycle three – post-implementation of EALIM

In the third cycle, during the three-month period between November 2012 and January 2013, data were gathered for the purpose of evaluating EALIM's overall impact on the research setting. During this cycle, 34 qualitative interviews were carried out from a total population of 270 employees, along with one focus group and one evaluation meeting, as portrayed in table 15.

Table 15: Cycle three timeline

AR activity / Month	Nov12	Dec12	Jan13
Focus Groups		1	
Qualitative Interviews	25	10	
EALIM Articles		1	
Evaluation Meeting			1

In November, I began the process of reinterviewing participants from the first cycle. However, I only interviewed 15 from the 26 participants I interviewed in the first cycle, as some had either left the organisation, or were unavailable for interview due to work absence. In addition, I interviewed 19 participants, as I deemed it necessary to increase my interview sample since the organisation had increased by 120 employees from when I first commenced fieldwork in July 2011. Over a 2-month period, I managed to interview a total of eight top managers, four middle managers, four head office workers, three staff nurses, four senior care workers and 11 care workers.

In December 2012, six participants attended the final focus group, consisting of four top managers, a clinical therapist and interview consultant. Discussions in the group involved reflecting on what had happened during the period of EALIM's adoption and the impact the model had on the organisation. After analysing the information I gathered from this cycle, I presented my findings to nine top managers at an evaluation meeting in January 2013 to gather their feedback. The meeting proved useful in allowing top managers the opportunity to validate, critique or offer alternative interpretations to my analysis (see McNiff and Whitehead, 2011).

Findings from this third cycle are discussed and comparatively analysed against the baseline assessment from the first cycle (presented in chapter seven), to identify EALIM's overall impact on organisational culture and improvement.

4.13 Methods of Analysis

The way researchers move toward developing an understanding of the information gathered from research encounters depends on the analytical methods they employ (King, 2012). The following repertoire of methods was selected and combined to form an integrated analytical framework due to their fit with the context of my AR inquiry, research philosophy and their suitability in answering the research questions.

4.13.1 Critical discourse analysis

Although there are different descriptions of Critical Discourse Analysis (CDA), it is generally regarded as a qualitative method concerned with the social practice of constructing ideologies and identities through language, with a particular focus on its discursive use as an instrument of power and dominance (Fairclough, 2003; Luke, 1997; Oswick, 2012; Van Dijk, 1993). Whilst CDA includes discourse analysis, it also connects language to non-discursive elements such as, social structure, culture and hegemony, therefore mediating the connection between language and socio-historic context (Grant, Iedema and Oswick, 2009).

CDA is particularly relevant to my research, since it provides a method for hermeneutic interpretation (Wodak and Meyer, 2009), is based on critical realist ontology and is of value to research within a context of organisational change (Fairclough, 2003). Furthermore, CDA has been used by organisational researchers to address issues of CSR and business ethics (Oswick, 2012), which are themes principally germane to the adoption of EALIM. The following three discernable levels were used as a method for the analysis of discourse (Boje, Oswick and Ford, 2004, p.557):

- The ‘micro’ level – analysing talk and text, i.e., syntaxes and metaphors.
- The ‘meso’ level – identifying patterns of communicative interaction, along with how power relations and dominance are enacted through discourse.
- The ‘macro’ level – interpreting meta-discourse, i.e., context, culture and wider social implications of discourse.

Using this method allowed me to understand the complexity of organising, explore differences in meanings, expose how power relations and dominance are mediated through discourse and produce knowledge leading to emancipatory change (Boje, Oswick and Ford, 2004; Fairclough, 2003; Grant, Iedema and Oswick, 2009).

4.13.2 Psychoanalysis (depth psychology)

Originating from the work of Sigmund Freud (1856-1939), psychoanalysis is a theory of intra-psychic conflict that postulates the human psyche as a tripartite system composed of the 'id', 'ego' and the 'super-ego' (Hunt, 1989, p.25). According to Gabriel (1999), these three layers of the mind are described as follows:

- The id is the unconscious mind that holds innate human instincts derived from birth. The id is has no sense of reason and acts in accordance with the 'pleasure principle' (p.15), which seeks the immediate gratification of impulses.
- The ego is the conscious mind that holds a sense of self, others and human reasoning. The ego acts in accordance with the 'reality principle' (p.16), which seeks to realistically function in the social world by meditating the desires of the id, the needs of others and the dictates of the super-ego.
- The super-ego is the psychic agency that holds human conscience or the 'ego-ideal' (p.20). This reflects a conceptualisation of the idealised self, derived from internalised morals and cultural roles. The super-ego acts in conflict to the id and controls our sense of right and wrong by punishing misbehaviour with feelings of guilt.

I chose psychoanalysis because it is an interpretative discipline that provides powerful insights of human motivation, action and emotional experiences (Gabriel, 1999). The notion that psychoanalysis is interpretative is also supported by Hunt (1989), who asserts psychoanalytic research is an inter-subjective process that mediates the interpretations of both researcher and researched. Since psychoanalysis allows understanding of unconscious forces and defensive

mechanisms (Gabriel, 1999; McAuley, Duberley and Johnson, 2013), adopting its concepts enabled me to conceptualise why EALIM was accepted or resisted and explore defensive routines and psychological transferences that might inhibit organisational improvement.

Although there is much debate in the literature as to whether psychoanalysis can be adopted as a method in the social sciences (Flick, Von Kardoff and Steinke 2004), according to McAuley, Duberley and Johnson (2013), a psychoanalytic approach is often overlooked in the organisational literature and could answer deep questions about the nature of organisations, management and leadership. Furthermore, to the best of my knowledge, this research inquiry presents a first step toward adopting psychoanalysis in the research of TQM. While I am not a professional psychoanalytic practitioner, I argue that a researcher does not need to be, in order to generate psychoanalytic insights from a research setting. This argument is congruent with the view by McAuley (2004) who purports psychoanalysis as one of a number of approaches that could be used within hermeneutic research to explore the 'restoration of meaning' (p.196) – that is to say, understand distorted communication, i.e., transference and counter-transference.

4.13.3 Template analysis

Template Analysis (TA) is a flexible style of thematic analysis, allowing researchers to develop a set of codes (template) 'representing the themes identified in their textual data' that are 'modified and added to as the researcher reads and interprets the texts' (King, 2004, p.256). Although some of the themes are a priori, these are flexible to allow the adoption of descriptive and interpretive themes to emerge within an evolving template (King, 2004).

Although TA is a technique researchers have mainly applied to qualitative interviews, it could certainly be applied to information derived from focus groups and observations (King, 2012). My main reason for adopting TA is that the textual information I gathered from empirical accounts was so voluminous, I needed a

method to enable me to select and organise the many descriptive and interpretive themes generated from my use of CDA and psychoanalysis.

My use of TA involved comparing textual accounts from each cycle in search of descriptive and interpretive themes occurring across several accounts, important phenomena occurring several times in one account, or a phenomenon from one account that significantly related to my research questions (King, 2012). This process involved moving from descriptive themes resembling empirical accounts, to selecting interpretive themes from my analysis until I was able to develop a dominant set of themes (King, 2012). For the purpose of rigour, I maintained an approach of reading my analytical accounts and empirical material several times, whilst relating them to my perception of the cultural context of the organisation. This approach is congruent with hermeneutic analysis, where the idea is to find common themes located within a specific cultural and socio-historic context (McAuley, 2004). As such, my adoption of TA allowed my analysis to progress 'through an iterative process of applying, modifying and re-applying' my template (King, 2012, p.430), until I was satisfied it captured the dominant themes across empirical accounts. An example of one of my final templates from cycle one can be seen in appendix 9.

4.14 Evaluating Quality in Qualitative Action Research

Adopting criteria for evaluation is a significant decision because it provides a set of appropriate indicators researchers and interested others can use to judge the quality and efficacy of the research process (Johnson et al., 2006; Reason and Bradbury, 2006). Although a number of indicators can be used to evaluate the quality of one's research, according to Bryman and Bell (2011) the most common indicators involve internal validity (i.e., the accuracy of findings specifying a causal relationship), external validity (i.e., the extent research findings can be generalised across other contexts) and reliability (i.e., whether the findings of a study are replicable). However, since measurement is not a concern for qualitative research (unlike quantitative research), issues of validity and reliability have less bearing on

its evaluation (Bryman and Bell, 2011). My specific reasons as to why criteria of validity and reliability should be excluded from this research are as follows:

- From a critical realist perspective, the possibility of a meta-physical reality obfuscates any certainty of theorising causal connections because there may be causal mechanisms that are unknown (Johnson and Duberley, 2000).
- From an interpretivist perspective, the generalisability of findings is rendered inapplicable because research is locally, culturally and contextually dependent (Coghlan and Brannick, 2010; Johnson et al., 2006).
- Since qualitative research emerges through the process of verstehen, fieldwork cannot remain stable and neutrally accessible for the purpose of replication (Johnson et al., 2006).

However, the question still remains of how the quality and efficacy of qualitative research can be evaluated. Due to the heterogeneity of qualitative research, a diversity of evaluative criteria exist, which Johnson et al. (2006) claim are outcomes of competing philosophical commitments. Therefore, to avoid the confusion of fitting the qualities of this AR study into a set of criteria that may be incommensurable, I developed a contingent criteriology based on the AR commitment of doing research with and for people, rather than on people (Reason and Bradbury (2006). Johnson et al. (2006) advocate a contingent approach, arguing that researchers should reflect upon their own particular philosophical commitments then match them to a contingent criteriology for evaluation. Reason and Bradbury (2006) assert that because no AR study can address all issues with equal value, action researchers must make specific choices in relation to what they believe is of value to their research. The criteriology I developed is described in Table 16, which I devised and adapted from a selection of AR choice-points by Reason and Bradbury (2006, pp.346-349):

Table 16: My AR evaluative criteria

AR Choice-Points	Description of criterion
Quality as a relational praxis	- To what extent was the inquiry participative? - What opportunities existed that allowed participants, especially those less powerful, to be fully involved? - Did the research enable members to better understand the perspectives of other members?
Quality as a reflexive-practical outcome	- How much of the knowledge generated was of relevance and pragmatic benefit to people? - Was the research validated by participants' new ways of acting in light of the work? - To what extent did new theories allow us to re-see the world or see taken for granted assumptions that are no longer helpful?
Quality as engaging in significant work	- Did the inquiry enable us to ask about the values we hold and the value of the work we engage with? - How did the inquiry addresses questions of fundamental importance? - Did the research enable an impetus for members to engage in action to change their work?
Emerging inquiry towards enduring consequence	- What was the transformative potential of the inquiry? - Did the research addresses human social needs and promote social change? - What was the potential of the inquiry to merge a community of practice between scholars and practitioners at a macro-level?

My selection of the above choice points is congruent with both the philosophy and context of this research, in that they allow evaluation of the collaborative involvement of research participants (i.e., quality as a relational praxis), how well the research ameliorates communication and understanding of self and others (i.e., quality as a reflexive-practical outcome), solutions addressing issues of pressing concern (i.e., quality as engaging in significant work) and the promotion of positive organisational change and improvement (i.e., emerging inquiry towards enduring consequence).

Essentially, these choice points shift the emphasis from validity and reliability to a concern for 'engagement, dialogue, pragmatic outcomes and an emergent, reflexive sense of what is important' (Reason and Bradbury, p.343). These choice-points also support the suggestion from Coghlan and Brannick (2010) that AR studies should be judged on the criteria of participation, the process of

constructing joint meaning, a concern for real life problems and generating sustainable outcomes. I therefore posit that the above choice points provide suitable evaluative criteria to allow me and interested others to judge the quality, efficacy and authenticity of this research.

4.15 Summary and Conclusion

In this chapter, I discussed and identified an appropriate research methodology for studying the adoption of EALIM, a QI model I devised for use in a private healthcare context. A reflexive engagement with my own knowledge constituting assumptions culminated in the adoption of a research philosophy combining hermeneutic interpretation with pragmatic critical realism. This philosophy was deemed suitable for my research because it allows interpretations of participants' values and ideologies within their socio-historic milieu and the study of hidden empirical entities that constrain organisational practices. A qualitative strategy of gathering data was discussed and deemed appropriate for this inquiry, because it enables understanding of contextual factors and the internal logic of human action in response to interventions.

Although other qualitative methodologies were considered, an AR inquiry was selected since it possesses features germane to the participatory context of adopting EALIM within my own organisation. Qualitative interviews, participant observations and focus groups were discussed and found to be appropriate methods for this research, as their combined use would illuminate different facets of social phenomena, provide triangulation and add both rigour and depth to the inquiry. However, in the context of insider-research, engaging reflexively with the researched was particularly important, because this approach allowed me to consider the influence my perceived role had upon the research process and to take account of biases that may potentially distort the authenticity of research findings. The ethical considerations discussed in this chapter shed light on the need to maintain ethical principles to safeguard participants from harm and to prevent deceptive research practices.

Although the use of a priori concepts and themes could restrict aspects of the phenomenon being explored, adopting them in a loosely structured way allowed the flexibility needed to explore emergent themes of interest. Selecting participants from a range of non-probability sampling techniques was considered appropriate, as these yield flexibility in selecting participants who are important to the research aims and generate a heterogeneous case of participants allowing maximum variation of information.

The three core iterative AR cycles used in this methodology were critical in producing information that yielded answers to the research questions. Information from cycle one generated a baseline assessment of the organisation prior to EALIM's adoption and played a vital role in shaping the construction of a collaborative action plan with top managers in the second cycle. Information from the second cycle produced qualitative insights of participants' responses to EALIM's concepts and methods and the use of focus groups facilitated a spiral of mini AR cycles, allowing participants to collaboratively generate and evaluate action strategies for EALIM's adoption. In the third and final cycle, the information gathered was critical in developing an understanding of EALIM's impact over the entire research process, findings of which were fed back to top managers for their evaluation.

The analytical methods selected to theorise and organise findings were discussed and found to be congruent with the philosophy and context of this AR inquiry. Having adopted the methodology outlined in this chapter, I present findings from each of the three cycles in chapters five, six and seven respectively.

Chapter Five: Cycle One – pre-implementation of EALIM

5.1 Introduction

This chapter provides details of the first AR cycle prior to the implementation of EALIM. This cycle involved gathering information from my fieldwork encounters at Bettercare for the period July 2011 to November 2011. My fieldwork included ten participant observations (two board meetings, six discussions and two seminars), 26 qualitative interviews and one focus group.

This chapter was written using a reflective narrative style and has been structured in accordance with the chronology of my empirical accounts, as this seemed the most appropriate way of communicating the sequence of practice and reflection as an action researcher (Bryman and Bell, 2011). Each empirical account begins with a description and explanation of the deployed research method, followed by the findings I generated from my analysis of textual information. However, findings from some participant observations, including qualitative interviews, have been grouped together because the methods used and the concepts I explored were consistent. At the end of each empirical account, I note some reflexive outcomes taken from my reflexive diary, which allows the integration of reflexive practice into the research process and creates a record of how my thinking changed over time (Nadin and Cassell, 2006). Toward the end of this chapter, I provide a baseline assessment of Bettercare. This process involved template analysis, which I used to select and organise the main descriptive and interpretive themes from my findings. The similarities and differences of these themes are discussed and linked to theories from the literature to answer my research questions. Finally, I end this chapter with a conclusion of my baseline assessment.

5.2 Monthly Board Meetings

I observed a one-hour monthly board meeting in July 2011, followed by a second one-hour board meeting in August 2011. I thought my attendance at these meetings would be useful as they could provide information on directors' discourse, power relations and dominant interests. At July's meeting, there were

seven directors present: the chairman, chief executive officer (CEO), chief operating officer (COO), care director, financial controller, facilities director and marketing director. At the August board meeting, there were six directors present, due to the financial controller's absence. While my attendance at board meetings was not uncommon, I had not attended one for three years and therefore thought I should ease myself in as a 'total researcher' (Bryman and Bell, 2011, p.438), by observing proceedings without participating in the flow of events. At the August board meeting, I attended as a 'researcher-participant' (Bryman and Bell, 2011, p.438), where I observed with some superficial interaction, i.e., I asked the occasional question to clarify the issues discussed.

5.2.1 Findings

Findings from the textual information I generated during my observations of both board meetings are given below and have been organised in accordance with the themes that emerged from my analysis.

5.2.1.1 The Chairman's dominance

Throughout both board meetings, the chairman's communicative interaction with others emerged as a particular theme of interest. For example, I frequently perceived him controlling the agenda (i.e., prompted others to adhere to the agenda), controlling turn allocation (i.e., controlled who was allowed to speak) and on two occasions he stopped board members from discussing emergent issues and requested they continue 'outside of the board meeting.' My interpretation of the chairman's interaction is that he used his dominance as an authority figure to frequently control who was included and excluded from discussions, which produced the consequence of inhibiting collaborative learning and creativity, since board members did not have the autonomy to freely share knowledge during the meeting.

5.2.1.2 Bureaucratic management

On two occasions I perceived the chairman relying on bureaucratic forms of management. In July's meeting, when the COO began discussing a new bonus

scheme he had in mind, I perceived the chairman to hastily respond with a request for a 'procedure to be written for use across the organisation.' The second occasion occurred in the August meeting where the chairman requested a 'company policy and procedure' to be drawn up around the CEO's idea of adopting a 'zero tolerance approach' toward regulatory breaches by staff. The chairman's discourse during both observations conveyed a managerialist strategy, since he relied on the use of policies and procedures, standardisation and codified knowledge sharing.

5.2.1.3 Risk minimisation

In response to the CEO's idea of a 'zero tolerance approach,' several other board members explicitly agreed and recommended that future regulatory breaches involving incident reporting be met with 'disciplinary action' as a 'deterrent' to others. However, at no point during or after these discussions did I observe any director explore why staff were not reporting some incidents. My interpretation of this omission is that top management relied on improvement strategies, which focused on minimising risks to the organisation without identifying possible root causes. A preoccupation with risk minimisation appeared to be a general theme among top managers, since large parts of both board meetings involved discussions on classifying incidents into 'green,' 'amber,' or 'red'; what incidents were 'reportable to the CQC'; staff efficiency in reporting a SOVA (Safeguarding Of Vulnerable Adult) incident; and managing 'high risk patients'. It follows that the 'zero tolerance' approach agreed on by board members and their pre-occupation with risk minimisation, connoted anxiety about falling foul of the CQC and an underlying assumption that risk threatens the survival of the organisation.

5.2.1.4 Cost minimisation

In the July board meeting, the financial controller brought attention to a monthly underspend of 'five hundred staffing hours' in one particular hospital, which I perceived was a significant amount. Upon hearing about the underspend, the CEO praised the respective manager for 'saving the company money' and proposed to reward staff with 'a bonus.' However, the care director objected to the CEO's

proposal because of a reported ‘SOVA incident’ in the same hospital. I interpreted the CEO’s proposal to signify an underlying tacit commitment to profit maximisation and an action strategy of cost minimisation, since he intended to reward staff for the underspend. Furthermore, the care director’s objection implied he valued work performance more than he valued staff.

5.2.1.5 Single loop learning

At the end of the July board meeting, the chairman shared a narrative of how he learned to chair meetings years ago when he ‘worked as a civil servant in a local authority’ and asserted, ‘meetings must be kept within an hour.’ His narrative suggested he was confined to single loop learning (Argyris, 2010), because he did not implicitly or explicitly question his own chairing methods, or the usefulness of restricting meetings to an hour.

5.2.2 Summary of key findings from board meetings

Both board meetings appeared dominated by the chairman’s frequent control of discussions, which inhibited collaborative learning and creativity. The chairman’s use of codified procedures and standardisation typified a bureaucratic management strategy that other board members implicitly complied with, while the CEO signified the use of cost minimisation. Most directors appeared to share the tacit assumption that risk threatens the survival of the organisation and must therefore be minimised, while the care director implicitly alluded, performance was valued above staff.

5.2.3 Reflexive outcomes

During both board meetings, I felt the chairman should have afforded board members more time and autonomy to address complex issues at length. There were occasions during both meetings when I felt frustrated by the chairman’s behaviour and wanted to verbally interject, but chose not to do so because I deemed it important to observe organisational life prior to the implementation of EALIM.

5.3 A Critical Luncheon

This next research encounter involved an informal discussion over lunch with the CEO at a café during the month of August 2011. During the luncheon, I acted as a 'total participant' – that is, I was completely involved in the activity (Bryman and Bell, 2011, p.438). I invited the CEO out to lunch because I deemed the meeting would provide an interval, uninterrupted by the lively environment of head office, to gain his commitment on two proposals I had in mind. These were, 1) hold a two-hour EALIM seminar with top managers to galvanise their commitment toward EALIM's adoption and 2) share information with staff on the construction of a school and orphanage Bettercare shareholders were funding in India, as I considered this would allow me to analyse its impact on staff perceptions of Bettercare.

5.3.1 Findings

The CEO explicitly rejected my proposal of a two-hour EALIM seminar and stated 'Two hours is too long…why don't you provide notes or handouts?' His response suggested he was reliant on using codified knowledge sharing. However, after I explained the limitations of using written handouts and prompted him to question his own assumptions about their use, he eventually agreed to the two-hour time frame. In regard to my second proposal, the CEO seemed to strongly object and remarked, 'I don't want to be seen blowing my own trumpet,' which I perceived to mean his charitable deeds were a personal matter that should not be exploited for corporate gain. After what I perceived was a long debate involving my encouraging him to question the reasoning behind his objection, the CEO finally gave his explicit consent.

5.3.2 Reflexive outcomes

My experience of gaining the CEO's consent was more arduous than I had expected, perhaps because I envisaged less resistance from him since he is my brother. Even though he initially resisted, I persisted in my efforts because I was aware that a lack of top management commitment is cited as one of the main

failures of quality improvement initiatives in the healthcare sector (Mosadeghrad, 2013).

5.4 Presenting EALIM to Top Management

After gaining the CEO's consent, I sent an email to all nine top managers inviting them to attend an EALIM seminar at the end of the August board meeting. Please see appendix 10 for a copy of my email. With the exception of the financial controller, marketing director and operations director, all top managers attended, which meant I had to schedule a second seminar in September 2011 for them. The August seminar was attended by the chairman, CEO, COO, care director, facilities director, operations manager and compliance manager. The room was spacious and had a wide screen, which I used to project my PowerPoint slides. The slides contained pictures, diagrams and text, as I thought this might convey greater meaning of EALIM's concepts. See appendix 4 for a copy of the slides I presented. Although both seminars were scheduled for a two-hour duration, I could not finish my presentation of EALIM's improvement methods as I overran my time limit. During each seminar, my aims were to 1) describe and explain EALIM, 2) communicate its potential for quality improvement and 3) gather information on participants' responses. At the start of each seminar, I distributed handouts for participants to make notes and use for future reference.

5.4.1 Findings

The following findings from both seminars are grouped together and categorised in accordance with participants' responses to each EALIM concept I presented.

5.4.1.1 Responses to EALIM's ethical concepts

As I presented EALIM's ethics, most participants appeared to nod in agreement and made explicit comments such as 'Sounds good,' 'Yes' and 'I agree.' In response to EALIM's Kantian ethic, the operations director commented, 'This works well with the new CQC framework and what was expected from us in terms of patient led care.' Her discourse indicated a Kantian ethic had a good ethical fit with her perception of CQC requirements. As I presented EALIM's CSR methods,

several directors explicitly supported the idea of 'recycling' and becoming 'greener,' which suggested they valued environmental sustainability.

Although most top managers in both seminars explicitly agreed with corporate philanthropy, in response to my idea of widely communicating Bettercare's philanthropy in India, the chairman asserted 'we would be taking a risk' because 'purchasers could become critical of the way the organisation uses its public funding.' I interpreted the chairman's assertion to denote a strong resistance to the idea of sharing information of Bettercare's philanthropy. For several minutes, the chairman and I seemed to be locked into a verbal skirmish as I counter-argued each one of his concerns. However, this skirmish ended after the CEO interposed by giving his explicit support to publicise the India project, which suggested my efforts to enlist the CEO's support during our luncheon in July had been useful. The CEO also proposed producing a 'newsletter' and to 'invite staff for the opening' of the orphanage and school in January 2012, indicating a genuine commitment to involve staff in the project.

5.4.1.2 Responses to EALIM's adaptive concepts

As I presented my slides on EALIM's adaptive concept, several top managers made comments such as 'Adapting to change is important,' '…we should be flexible' and '…we have to change to survive.' However, after I suggested that being adaptable meant using fewer procedures and questioned why the organisation had so many, the chairman responded, 'We need policies and procedures because of CQC requirements.' My interpretation of the chairman's response is that my suggestion challenged his sensemaking of using managerial control to create a predictable environment. After I described the concept of chaos theory, the COO responded, 'I would be concerned if we presented chaos theory to nurses and managers, as they don't like the idea of chaos. Their jobs are to create stable environments for patients.' The COO's response not only indicated a tacit assumption of creating stability and predictability, but also seemed to attribute his own feelings about the unacceptability of chaos to others (i.e., nurses and managers). When I explained the butterfly effect, i.e., how tiny changes can

produce large non-linear effects (Stacey, 2010), the marketing director responded, ‘But the company has already experienced a lot of change in the market.’ I interpreted her response to mean she had taken the future stability of the company for granted and the idea of more market instability made her feel anxious.

5.4.1.3 Responses to EALIM’s learning concepts

Top managers indicated implicit or explicit support for EALIM’s learning concepts and methods. For instance, the care director gave a narrative of how nurse training first began, which involved working in practice with experienced nurses and the COO stated ‘Externally there is a group of people I have discussions with who are considered experts in the field.’ I perceived their responses to mean they positively identified with practice-based learning methods and communities of practice. Furthermore, while I presented triple loop learning, the operations director gave a story of how she ‘worked with a staff nurse to develop reflexive skills as part of her practice and claimed, ‘It made a tremendous difference to her approach to patients and staff.’ Her narrative suggested she valued the role of reflexive learning in healthcare improvement.

5.4.2 Summary of key findings from presenting EALIM to top managers

Both seminars appeared valuable as a method for garnering commitment for EALIM’s adoption, with the exception of the chairman who appeared to show the least commitment. Most top managers implicitly or explicitly agreed with EALIM’s ethical and learning concepts, particularly in regard to Kantian ethics, environmental sustainability, corporate philanthropy, practice-based learning, sharing best practice and triple loop learning. Conversely, I perceived EALIM’s adaptive concept did not invoke the same level of support, but generated anxiety among the chairman, COO and marketing director, probably because adaptive concepts challenged their taken for granted assumptions about creating a stable and predictable environment.

5.4.3 Reflexive outcomes

After much introspection, I felt I had been overly defensive toward the chairman in relation to his objection of communicating Bettercare's philanthropy to purchasers. My reaction appeared driven by an underlying assumption that the seminar was a win or lose situation. See appendix 11 for more detailed reflexive notes. Thereafter, I made a conscious decision to focus a great deal more on exploring why participants appeared resistant, rather than attempting to counter their arguments.

5.5 Interviews

Qualitative interviews were used to allow participants to convey their individual perspectives, emotions and experiences around the seven concepts I wished to explore; namely, perceptive value of the organisation, power relations, motivation, ethics, adaptability, learning and improvement. The interview guide I used can be found in appendix 3.

During the month of August 2011, I held interviews with four head office workers (the HR administrator, payroll administrator, project coordinator and a medical secretary) and three directors (the CEO, marketing director and facilities director). I selected the four head office workers because I deemed they could provide useful information on their experience of working with top managers and the three directors were chosen due to their prominent roles in the organisation. During September and October 2011, I interviewed fourteen more participants from a diversity of positions and disciplines because I wanted to generate the maximum variation of information. These participants included five top managers (the COO, care director, operations director, compliance manager and operations manager), five middle managers, one assistant manager, two staff nurses and one care worker. Although I had planned to interview more frontline staff, their availability during my site visits was limited because of staffing shortages. Therefore, during the month of November 2011, I set out to hold further interviews with frontline staff. Although interview appointments were arranged in advance, I sometimes waited up to thirty minutes before care staff became available and interviews were

occasionally interrupted because of pressing patient needs. Despite these difficulties, I managed to interview five frontline staff: one staff nurse and four care workers.

My itinerary sometimes involved interviewing up to four people per day and interviews typically lasted sixty minutes. I took notes using my iPad and my questions usually began around participants' work roles and histories, as I deemed these were areas they would feel comfortable in answering. This approach appeared to work as it opened the flow of communication. I generally asked open-ended questions with a few closed-ended questions to obtain clarification. I normally followed participants' answers with probing questions until I was satisfied I had sufficient answers to the concepts and themes I was exploring. To elucidate meaning I encouraged the use of narratives by asking participants to recall examples and situations, which Gabriel (1999) argues can illuminate understanding of ethics, politics, leadership and culture. After November 2011, I perceived further interviews would be unnecessary, as felt I reached a theoretical saturation point where enough information was gathered to inform the concepts I was exploring (Bryman and Bell, 2011).

5.5.1 Findings

Findings below are categorised in accordance with the seven concepts identified in section 4.10: perceptive value of the organisation, power relations, motivation, ethics, adaptability, learning and improvement. These concepts relate to my research questions and at the same time, provide a sense of structure that could be repeated for interviews in the third and final cycle – the post-implementation of EALIM. To allow interview responses to be distinguished between groups, where appropriate, I include in parantheses the number assigned to each participant from table 10.

5.5.1.1 Perceptive value of the organisation

Most participants indicated a common perception that Bettercare provided quality patient care. Responses supporting this finding include 'The company provides a

quality service' [2], '…the services are high quality' [8], 'It [Bettercare] provides quality care' [16] and '[Bettercare] is delivering a high standard of care' [21]. Those whom I perceived had the highest perceptive value of the organisation were top managers, whose remarks include 'We are a market leader,' 'I'm proud of the organisation,' 'I can't think of anything negative when I think of [Bettercare]' and 'The brand is the beast [sic].' Conversely, responses from middle managers and care workers include 'We do a lot for our patients but what about staff?' [11], 'The name [Bettercare] speaks for itself. Care should not be just for patients but staff' [17], 'It [Bettercare] needs to do what's important for staff' [21] and 'I think service quality is good…staff are not rewarded well enough' [25]. My interpretation of these responses was that middle managers and care workers had a lower perceptive value of the organisation compared to top managers, which seemed driven by a governing belief that Bettercare valued patients more than staff.

In regard to what would make Bettercare an ideal organisation, two head office workers and three top managers respectively proposed Bettercare could be 'greener' and more 'environmentally friendly,' indicating socially responsible business practices was a critical ideal, while most middle managers and frontline staff (i.e., staff nurses and care workers) commonly proposed 'higher pay' or a 'pay rise' for care workers.

5.5.1.2 Power relations

On the theme of decision-making processes and interactions between managers and staff, comments from top managers include '…staff needs are sometimes ignored,' 'Staff are not always listened to' and 'Staff do not get enough space and facilities to use in the unit.' What I perceived top managers meant is they were aware of overlooking the explicit needs of frontline staff. The care director gave a narrative about a request he made to the CEO for more staffroom facilities during the design stage of construction, claiming his request was 'was never acted on' by the CEO. I perceived the care director to mean the CEO worked in ways that undermined collaboration.

When I probed head office workers for descriptions of their everyday interactions with top managers, the HR administrator responded ‘I’m told to carry out ideas,’ and the payroll administrator stated, ‘I’m usually told how the company should run.’ Their descriptions suggested top managers use managerial control, a theme consistent with comments from middle managers. For instance, one middle manager said, ‘Most of my care team was recruited from head office without my involvement,’ while another said, ‘We are excluded from decisions that affect us.’ I perceived these middle managers to mean they lacked autonomy, which created tension between them and top managers.

Other comments from middle managers such as ‘I don’t have the confidence to suggest changing the system’ and ‘There isn’t the freedom to speak of real company issues,’ suggested they survived organisational life by repressing their opinions to conform to formal systems and top management diktats. Conversely, descriptions middle managers gave of their own leadership appeared more benign. These include ‘I balance informality with being formal,’ ‘I empower staff with specific responsibilities’ and ‘I get feedback from my staff.’ These descriptions alluded to a humane leadership approach, a theme supported by the experiences of care workers, who described middle managers as ‘supportive,’ ‘accommodating’ and ‘friendly.’ However, care workers descriptions of top managers appeared less positive and include ‘They [top managers] should have frequent meetings with staff instead of just staying at head office,’ ‘They [top managers] don’t spend time with us’ and ‘…they [top managers] only visit when there is an incident.’ These comments not only correlate with the theme that top managers overlooked the needs of frontline staff, but also implied care workers valued social interaction and appreciation – the lack of which seemed to generate a ‘them’ and ‘us’ perspective of top managers.

In terms of participants’ experiences of everyday shifts, descriptions from care workers implied that staff nurses lacked engagement with staff and patients, a finding corroborated by staff nurses who commented, ‘I spend more time in the office’ and ‘I have a bias toward paperwork.’ These comments also suggested staff

nurses placed greater focus on administration than hands on care. Other descriptions from staff nurses indicated low commitment to collaboration and propensity toward task-centered leadership. For instance, one nurse referred to herself as 'the coordinator,' stating her role was to 'oversee certain tasks so care workers do things in a certain way.' She made this point twice, which I perceived to mean she thought of herself as the thinker and care workers as the doers, indicating her use of managerial control and a tacit assumption that she knew more than care workers. In relation to staff nurses' use of managerial control, other descriptions from care workers include '…nurses will make decisions a lot of the time, they will make decisions we as healthcare workers disagree with,' 'Some nurses put your name down for an activity and tell you what you are doing' and 'Nurses blame us for mistakes.' These comments indicated defensive behaviour from staff nurses and power struggles between them and care workers.

5.5.1.3 Motivation

With regards to my questions around participants' motivation and commitment, responses from head office workers such as 'My job motivates me,' 'I love my job' and '…doing my work effectively,' signified they had a tacit motivation toward the nature of their work. Responses from top managers include '…maintaining a high level of care,' 'Getting our services right,' '…our service provision' and '…the quality of our services.' What I perceived top managers to mean is they were driven toward providing a quality service. Conversely, responses from middle managers such as 'I value people,' '…making clients happy,' 'Creating a safe environment for patients and staff' and 'Empowering others,' signified they had a higher tacit commitment toward patients and staff than to the organisation.

During interviews, most staff nurses often referred to their nursing identities and to the need to develop their 'profession' or 'nursing practice,' with few references to patients. Comments like 'I'm a nurse' or 'I'm here because I'm a nurse,' typified the language they used. As a result, I perceived staff nurses' discourse to mean they held greater commitment to their profession, than to the organisation and patients. In contrast, responses from care workers include 'I like caring for people,' 'I'm

inspired by the patients' and 'I'm here to help clients.' Furthermore, some care workers told stories of how they developed an interest in care work whilst caring for relatives at home, which led me to perceive they had a high tacit commitment to patients and were driven by intrinsic values of altruism and compassion. However, other comments from care workers implied they felt a low commitment to the organisation and their low pay was a de-motivating factor. For example, one care worker said, 'If I should think of my pay at the end of the month, I wouldn't be working here,' while another remarked, 'The pay is ridiculously low.'

5.5.1.4 Ethics

On the theme of espoused values, most participants from each group implicitly espoused patient care (e.g., 'Looking after patients,' 'Caring for patients' and 'Patient-centered care'), social responsibility (e.g., 'Being green,' 'Environmentally friendly' and 'Supporting charities') and intrinsic human values (e.g., 'Honesty,' 'Respect' and 'Compassion.' These types of responses indicated patient care, social responsibility and intrinsic human values were a common set of espoused ethics among all groups. In addition, several top and middle managers implicitly espoused the value of collaboration, since they typically used descriptions such as 'Teamwork,' 'Working together' and 'Working with people.' Also, most middle managers and frontline staff explicitly espoused the need for 'Staffroom' space and 'Higher pay' for care workers, while several care workers made reference to 'Appreciation.'

When I explored the theme of ethical conflicts, two middle managers remarked, 'What facilities do staff have?' and 'The staffroom is like a small box,' inferring the lack of staffroom facilities was both unacceptable and unethical. Two middle managers also described how their staffrooms had been converted into patient bedrooms and one of them stated, '…every bit of space is used to generate income without regard for the needs of staff,' a view supported by one care worker who said, 'I understand the company needs to make money, but not having a staff room reflects how much the company cares for us.' These comments indicate a perception that top management valued profit above staff. Their perception

seemed justified since the CEO confirmed some staffrooms had been converted into bedrooms to 'boost turnover.'

The issue of low care worker pay appeared to provoke strong feelings from some middle managers. For example, one middle manager said she was 'willing to forgo employing a deputy manager to fund a pay increase,' while another remarked, 'I would rather have less staff earning fifty pence more than more staff earning fifty pence less.' These responses conveyed middle managers' solidarity with care workers and a sense of compassion toward them. One staff nurse informed me in confidence that some care workers had two jobs and asked, 'What would you do when you have a mortgage to pay?' He then described how some care workers cancelled shifts at short notice when they were offered higher paid work from temping agencies. This predicament indicated an organisational trap, whereby the low pay of care workers was fuelling an iterative cycle of shift cancellations and staffing shortages.

In response to my question of whether there were any ethical concerns, one particular middle manager made several references to a lack of 'social contact' between top managers and frontline staff, indicating she had perceived this as an ethical issue. She remarked, 'There should be more face to face meetings with directors and staff have mentioned the same.' What I perceived she meant is social interaction and appreciation was valued by staff but not by top management, suggesting top managers were detached from frontline staff. This particular theme was supported by the marketing director's response. When I asked the marketing director if she was aware of any conflicts, she replied, 'Everybody shares the same vision.' However, when I asked what she meant by 'everybody,' she answered, 'Management.' I understood her exclusion of frontline staff from the use of the pronoun 'everybody,' to mean she had an unconscious disconnected view of frontline staff.

When I asked two top managers whether they were aware of conflicts between their own values and those of the company, the operations director replied, 'I've

contributed to the values [Bettercare] stands for, so it's a bit difficult answering that.' Her reply was similar to a comment made by operations manager who stated, 'We invent the company ethics, therefore it's difficult to separate my ethics with the company'. My interpretation of their responses is that because they strongly identified Bettercare's espoused ethics with their own ego ideals, they could not bring themselves to consciously criticise company ethics, as this would have threatened their identities of self. It follows that these top managers' inability to critically reflect on Bettercare's ethics, signified their use of defensive reasoning.

5.5.1.5 Adaptability

In response to my questions around how participants adapt to change, narratives from the operations and care service directors suggested a good level of external adaptation – matching business goals to the dynamic requirements of external stakeholders (Schein, 2010). For example, they each gave a narrative describing how they were able to quickly adapt company mission statements and policies to changing CQC and purchaser requirements. However, the CEO admitted staff was '…struggling to adapt to increased aggression from new patients.' His account was confirmed by middle managers and frontline staff who described difficulties with managing 'aggressive' or 'challenging' patients, which some explicitly attributed to 'staffing shortages.' These accounts suggested problems with internal integration (Schein, 2010), meaning there were organisational difficulties in managing human resources and working methods to meet the dynamic needs of the service. In the face of these difficulties, responses from care workers such as 'We console each other and discuss things,' 'We work together' and 'Teamwork is good between us,' suggested they used collaboration, shared commitment and support, as adaptive psychological strategies to cope with everyday challenges.

With regards to how participants deal with unpredictability, the payroll administrator answered, 'When the Panorama programme (on the Winterbourne View scandal) was broadcast, people said it wouldn't happen here because of safeguarding policies in place and the abuse prevention and C&R (Control and Restraint) training staff have.' However, when I asked what she meant by 'people'

she answered, 'Directors.' I interpreted her response to mean top managers relied on using training programmes and company policies as a defense against instability. This finding was supported by other top managers who stated, 'When the Winterbourne thing happened, we bolstered safeguarding procedures,' 'If we have eleven different things going on in eleven different units, there are more opportunities for error' and '…it's correct to do things in a standard manner.' These responses also conveyed the idea that standardisation was a strategy for reducing variability in the service. However, comments from middle managers such as '…unnecessary form filling limits me from doing my job' and 'Policies are restrictive' indicated that standardisation inhibited middle managers adapting to the specific needs of their local service. Furthermore, one staff nurse commented, 'All these rules and policies make you scared to be flexible or make a decision,' while another remarked, 'Policies limit me as a nurse as I can't explore my knowledge.' The meaning I understood from these staff nurses is that copious company policies limited the spontaneous use of their professional judgment and generated anxiety about being flexible.

5.5.1.6 Learning

On the theme of participants' learning methods, most head office workers and frontline staff referred to reading written material like 'websites,' 'emails,' 'journals' and 'company documents,' along with attending 'training courses' and 'supervisions.' Their responses indicated dependence on codified and explicit learning methods, which differed from top and middle managers whose responses implied the use of practice-based methods like 'observations,' learning 'through experience' and 'working together.'

On the theme of how participants share knowledge, middle managers' responses include 'I coach people by training them through practice,' 'I allow staff to lead,' '…being on the shop floor' and 'I teach them [staff] to make a decision.' These knowledge-sharing methods were consistent with practice-based learning and signified an underlying assumption that sharing knowledge empowers others. Descriptions of how frontline staff shared knowledge include 'staff meetings,'

‘handover meetings’ and the ‘communication book,’ which indicated reliance on codified and explicit knowledge sharing and the use of formal systems. However, descriptions from staff nurses mostly involved sharing knowledge with other nurses, which was consistent with comments from two top managers who claimed, ‘Nurses don’t share knowledge with care workers because this devalues their authority’ and ‘Some nurse are reserved in others knowing what they know because of self-preservation.’ While these accounts suggested a community of practice among staff nurses, they also implied staff nurses had a tacit assumption that clinical knowledge was privileged and sharing too much with care workers threatened their nursing identities.

With regards to organisational learning strategies, top managers’ descriptions mostly involved employees reading ‘policies’ and ‘procedures,’ as well as attending centralised ‘training programmes’ and formal ‘meetings.’ These strategies connoted the use of codified and explicit knowledge sharing and at the same time, conveyed a governing belief the organisation was a bureaucracy that should be managed with formal rationality – that is to say, the organisation is a hierarchy requiring management through technical means. This interpretation is supported by the discourse of several top managers. For example, the operations manager commented, ‘If you look at head office as the federal agency and the units as the states, we write the procedure, we review the provisions and that’s it,’ while the operations director said, ‘I am very clear about how they [middle managers] should operate so their work is done effectively.’ The operations director’s comments not only signified the use of formal rationality, but also of managerial control, since she implied imposing her knowledge on others.

However, the compliance manager appeared critical of top managers’ use of managerial control when he remarked, ‘People at head office think they know better but there would be no harm in listening to the opinions of staff.’ I interpreted his discourse to mean top managers were not open to emergent ideas from staff because they assumed they knew better. This interpretation was supported by a comment from the facilities director, who said, ‘People sometimes go to meetings

with ideas but nine out of ten ideas put forward are normally useless.' When I asked who decides which ideas are useful, she replied, 'Decisions are based on authority or sanctioned through clinical governance meetings.' Her response was similar to the CEO who commented, 'Any ideas above five hundred pounds must be authorised by me personally' and '…proposed changes are put through clinical governance.' Comments from both the facilities director and CEO signified low confidence in staff and the use of managerial control inhibited creativity. Furthermore, their descriptions of how clinical governance meetings were used to sanction emergent ideas from staff inferred, bureaucracy was stifling experimentation and innovation.

On the theme of using reflexivity, I only perceived five participants from the twenty-six I interviewed to provide descriptions supporting the use of reflexivity. These were one care worker, two middle managers, the COO and care director. Their descriptions include 'I ask myself, "What would I do if I were in their [employees] shoes?" I look at how the person felt and what they were going through' [13], '…sometimes I sit back and ask what else can I learn? Can I do it differently?' [15], 'I ask myself why I do things a certain way' [17] and 'I ask myself, how can I do it? How can I make it better? Am I doing it right?' [22]. Their responses indicated the use of reflexivity because they either implied thinking about their own thinking, or considering alternative ways of thinking and doing.

5.5.1.7 Improvement

On the theme of how participants improve their own practice, most responses from head office workers, middle managers and frontline staff include references to 'appraisals,' 'supervisions' and 'advice' from line managers. Based on these responses, I interpreted employees' improvement methods were largely predicated on performance management systems and guidance from their managers. The participants whom I perceived had the greatest reliance on others were care workers, whose responses include 'I talk to senior staff,' 'My manager normally tells me where to improve' and '…direction from nurses,' which I interpreted to

mean they had a tacit dependence on leaders to show them where and how to improve. However, responses from most top managers appeared to differ from employees, since they often made reference to their own 'experience' or 'knowledge,' indicating they were self-reliant for improving their own practice.

In terms of quality improvement strategies, the most common descriptions top and middle managers gave include the use of 'monthly inspections' to detect errors, 'clinical governance' and 'audit meetings,' indicating the use of classical quality control. However, in regard to clinical governance and audit meetings, middle managers commented, 'There isn't much discussion on different ideas to solve problems,' 'There's no freedom to speak' and 'The clinical governance structure is restrictive and doesn't always allow people to learn together, where things can be explored.' I interpreted these comments to mean quality improvement strategies lacked collaborative improvement and group problem solving.

When I asked the CEO for his thoughts on how the organisation was improving, he commented 'There are high variances across the organisation…we sacked nearly all the nurses at hospital O, because they did not respond to the expectations required of them and recruited new ones.' The meaning I perceived from the CEO's comments is that he blamed staff nurses for high service variations, which indicated his use of defensive reasoning. However, responses from other participants suggested inhibitors to improvement lay elsewhere. Responses such as '…there isn't time to improve' [3], 'I am overloaded with paperwork…Bureaucracy within the running of my unit limits me from doing my job' [11] and 'What limits me from improving is having other tasks added to my workload' [17], suggested the administrative overload generated by bureaucratic processes was inhibiting service quality. This finding links to responses from care workers who stated, 'The policies say you have to go this way, but practically, it doesn't succeed' and 'We are always getting new policies but sometimes it's not helpful.' What I perceived these participants to mean is that copious company policies were counter-productive to improvement.

Comments from other care workers such as 'If we don't have the staff, we can't take clients out to do things we should be doing' and 'When you are short of staff, you are not able to do a lot with patients,' implied staffing shortages created a lack of meaningful interaction with patients that hindered patient care. In relation to staff turnover, two middle managers commented, 'Having a turnover of new staff limits the team from improving because you get to the point where the team progresses together and suddenly someone joins who isn't at that level, which hinders the group' and 'We struggle with staff turnover and the patients suffer too in terms of more incidents.' Their comments strongly suggested staff turnover had a negative impact on service quality and patient safety. When the HR administrator informed me most of his time was spent recruiting care workers, I asked him their main reason for leaving. He replied, 'It boils down to pay…recruiting is an ongoing process.' His response implied the existence of another organisational trap in which the low remuneration of care workers fuelled a constant cycle of staff turnover and recruitment.

5.5.2 Summary of key findings from interviews

The common perception among participants was that Bettercare provided quality patient care. Although top managers held a high perceptive value of the organisation, middle managers and care workers held a lower perceptive value, which seemed influenced by a governing belief that Bettercare valued patients and profit more than staff. In terms of creating an organisational ideal, most participants proposed greater socially responsible business practices and higher pay for care workers.

With regards to power relations, top managers overlooked the needs of frontline staff, which seemed to generate a 'them and 'us' perspective from care workers. The use of managerial control appeared to create power struggles among top and middle managers, and among staff nurses and care workers. While middle managers' leadership styles were more humane than top managers and staff nurses, they survived organisational life by conforming to formal systems and top management diktats.

With reference to motivation, top managers seemed highly committed to the organisation and were driven to provide a quality service. Conversely, middle managers showed higher tacit commitment toward patients and staff than to the organisation. Although care workers signified a low commitment to the organisation, they indicated a high tacit commitment to patients and co-workers, which seemed driven by values of altruism and compassion. However, staff nurses signified greater commitment to their profession than to the organisation and patients, as well as low commitment to collaboration.

In terms of ethics, participants commonly espoused patient care, social responsibility and intrinsic human values. Top and middle managers also espoused collaboration as a value, while middle managers and frontline staff referred to staff room space and higher pay for care workers. In addition, care workers implicitly espoused the value of social interaction and appreciation. The issue of low care worker pay was perceived as an ethical conflict among most middle managers and frontline staff. Furthermore, this ethical issue attracted strong feelings from some middle managers, which symbolised their solidarity with care workers. The lack of social interaction between top managers and frontline staff was also seen as an ethical issue, along with the lack of staff room space, which reinforced staff's perception that Bettercare valued profit above staff. Two top managers indicated their use of defensive reasoning, since they could not critically reflect on Bettercare's ethics.

Responses to adaptability suggested top managers were good at external adaptation, although internal integration was problematic. Whilst managing aggressive patients was difficult, care workers appeared to face these challenges by adopting adaptive strategies of collaboration, shared commitment and support. In contrast, top managers used training programmes and standardised policies to reduce service variability and to defend against instability. However, top management's strategy of using copious policies resulted in preventing middle managers from adapting to the needs of their local service and at the same time, limited staff nurses from the spontaneous use of their professional judgments.

In terms of learning, responses indicated organisational learning strategies were based on codified and explicit knowledge sharing, which differed from top and middle managers use of practice-based learning methods. Although middle managers sought to empower others by sharing knowledge, staff nurses shared a minimal amount of knowledge with care workers, because doing so threatened their identities as nurses. Top managers' use of managerial control inhibited creativity, and bureaucratic management practices stifled experimentation and innovation. The CEO indicated the use of defensive reasoning and most participants did not indicate the use of reflexive learning.

Most methods used by employees to improve their practice were based on performance management systems and guidance from managers. However, care workers showed the greatest dependence on their leaders for improvement. Top management's use of classical quality control methods resulted in a lack of collaborative improvement and group problem solving, along with a focus on risk minimisation rather than detecting root causes. Although the CEO appeared to blame staff nurses for high variances across the organisation, other participants referred to bureaucratic processes, copious policies, staffing shortages and staff turnover – as factors that inhibited service quality.

5.5.3 Reflexive outcomes

Before I began interviewing, I expected to identify a single perspective of culture at Bettercare, probably because I expected to find manifestations of culture with consistent themes across groups (Hatch, 2013). However, after interviewing participants from different levels of the organisational hierarchy and disciplines, my perspective changed to a differentiated organisational culture (Martin, 2002), since I interpreted four dominant conflicting subcultures: top managers, middle managers, staff nurses and care workers.

5.6 A Damning CQC Inspection

During October 2011, I noted two informal conversations at head office – one with the marketing director and another with the operations manager. The information they shared emerged from informal conversations, which could have been missed had I not been an insider researcher. This experience corresponds with writings of Coghlan and Brannick (2010) who purport insider action research can generate spontaneous information from informal interactions with participants.

5.6.1 Findings

After I approached the marketing director to have an informal chat, she shared information about a recent CQC inspection at hospital B. She described the inspection as 'damning' and stated the CQC 'voiced critical concerns about how little staff knew on safeguarding procedures,' which nearly resulted in an 'enforcement notice.' She claimed this outcome had 'unsettled directors' and caused 'stress and disappointment' for the CEO. Her account suggested the threat of CQC action created much anxiety among directors. She also remarked, 'EALIM is really needed at this time…the CQC exposed the wholly inadequate way staff are learning' Her remarks indicated the CQC inspection disconfirmed her assumptions about the stability of the organisation and the effectiveness of company training methods and at the same time, acted as a catalyst toward adopting EALIM.

In the course of another informal conversation the same afternoon, the operations manager made reference to the same CQC inspection at Hospital B and remarked it 'did not go as intended.' During an operations meeting that followed after the inspection, he said there was 'a lot of tension' between him and middle managers, who 'blamed' the shortfall of staff knowledge on 'ineffective company training.' He also acknowledged 'arguing' with middle managers to 'make better use of resources and take the lead on teaching their own staff.' I interpreted his account to mean each party attributed blame to the other for shortfalls in staff knowledge, which created an organisational trap, i.e., an impasse. The operations manager then remarked '…the learning concepts of EALIM are much needed right now.' His

comment signified the unintended CQC inspection outcome made him question existing company training methods and at the same time, motivated him to adopt EALIM's learning methods. I responded to him by spending a few minutes explaining EALIM's practice-based learning concept.

5.6.2 Summary of key findings from informal conversations with the marketing director and operations manager

Accounts from both the marketing director and operations manager indicated the unexpected outcome of the CQC inspection made them question their assumptions about the effectiveness of company training methods and motivated them to adopt EALIM. Having said that, the account from the operations manager suggested both he and middle managers used defensive strategies to protect themselves from taking responsibility for the shortfalls in staff knowledge identified in the CQC inspection.

5.6.3 Reflexive outcomes

I perceived the timing of this 'damning' CQC inspection to be a serendipitous circumstance, which I was prepared to use as an opportunity for change. Taking advantage of this fortuitous situation accords with the work of Coughlan and Brannick (2010), who purport unforeseen events in an organisation can create crisis that action researchers can use for action learning and change.

5.7 An Emergent Change in EALIM

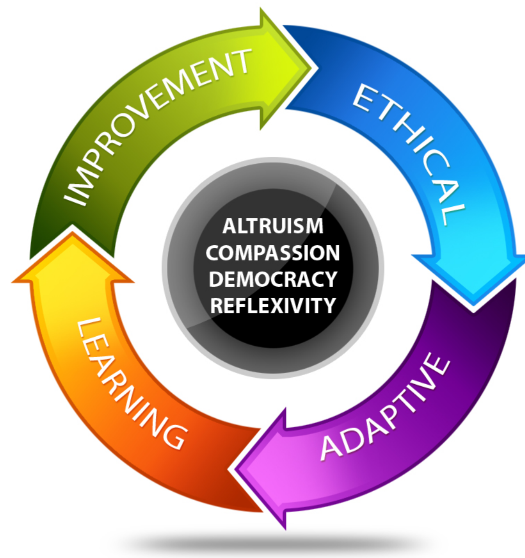
Although I was satisfied with EALIM's conceptual framework, I sensed the model required a construct that would make it even more germane to a healthcare context. Following this line of thought, I attended a generic training session at the University of Hertfordshire in October 2011, where I heard a PhD student describe her thesis on 'compassionate care,' which deeply resonated with me. After a week of reading various healthcare articles on the subject of compassionate care, I sensed the virtue of compassion could be included within EALIM's moral anchor as an affective construct. I reasoned, whilst a Kantian ethic (Kant, 1788) provides a rational moral construct that elucidates our ethical duty, compassion was an

affective construct that would help focus the emotions of healthcare professionals toward virtuous care (Armstrong, 2006; Van Der Cingel, 2009). Although Holland (2010) asserts the applicability of virtue ethics are questionable to a professional nursing context, Armstrong (2006) argues a virtue-based approach to nursing is critical, since it guides practitioners to exercise excellent character traits like honesty, patience and compassion, which sustain high quality care. Furthermore, during my literature search, I also discovered compassion is commonly associated with the caring profession, enshrined in the NHS constitution and is included in value statements of health professions like the Nursing and Midwifery Council (Cornwell and Goodrich, 2009; Sellman, 2010). For these reasons, I deemed the integration of compassion within the heart of EALIM could enable the model to become more germane to a healthcare context.

5.7.1 Findings

Before making any changes to EALIM, I formally consulted the operations director, marketing director and COO, to elicit their views on the idea of integrating compassion within EALIM. After I explained my reasoning, all three directors explicitly agreed to the idea. The operations director stated 'Compassion matches the values of Florence Nightingale,' while the marketing director stated, 'It's very relevant…the CQC will like this' and explicitly committed to include compassion within a 'new service specification' she was writing for the opening of a new unit. Moreover, the COO stated compassion was a 'nursing value,' claiming it related to 'empathy.' I perceived their responses to mean they regarded compassion as a valued construct that matched their perception of the quality care they wished to provide. A revised EALIM cycle that includes compassion is found in figure 7.

Figure 7: Revised EALIM cycle



5.7.2 Reflexive outcomes

The change to EALIM's core values demonstrates how my thinking evolved during this research. Consulting with three top managers on my proposal to integrate compassion within EALIM enlightened me as to their meanings of compassion and its relevance to the kind of patient care they wanted to deliver.

5.8 My First Focus Group

I emailed all top and middle managers inviting them to attend a focus group in October 2011, to plan the implementation of EALIM. Four top managers and two middle managers responded with a commitment to attend. I also invited three frontline staff I met during interviews because I sought to create collaboration from across disciplines and ranks. My choice of participants involved those I perceived had similar values and beliefs to EALIM, as I hoped to form a coalition of participants with a shared vision of the future (Beer, Eisenstat and Spector, 1990). Since I was unsure whether their shift patterns would permit their attendance, I also encouraged some snowballing by asking various participants to invite colleagues they thought could make useful contributions.

On the day of the focus group, seven participants attended: the COO, care director, operations manager, compliance manager, one middle manager, one staff nurse and one care worker. Although I chaired the focus group, I adopted an approach that would guide conversations rather than control them, because I wanted to encourage democracy and collaboration in accordance with EALIM's tenets. Before we began our discussions, I briefed participants on the purpose of the meeting, which was to discuss the organisational changes important to them and contribute ideas on how EALIM could be implemented to enable those changes. After I explained my role as a researcher, I asked permission to use my voice recorder and no one explicitly objected, nor did I perceive the recording to inhibit the forty-five minute conversation that followed.

5.8.1 Findings

For the first ten minutes, participants appeared to criticise the company's use of policies and procedures. For example, the COO remarked, 'The company's stumbling block is having policies that are thirty to forty pages long and expect staff to internalise that and be able to reflect on it and use it appropriately.' The care worker stated 'I don't necessarily understand a procedure by reading it' and the staff nurse remarked 'Care workers don't even read the most important policies…they are not really accessible to them.' The meaning I understood from their comments is that reading copious amounts of written material was not an effective knowledge sharing method. The COO also mentioned there were 'two hundred and twenty-five policies' and in relation to reading them he said, '…you just want to set fire to yourself after a while.' A conversation then ensued about why some staff did not read company policies. The reasons participants put forward suggested staff were disengaged from company policies because of the volume of written material they were expected to learn. After I shared my interpretation that top management were focused on imposing policies to generate compliance, the COO said, 'We have nurses and managers who just don't do any nursing, they're just compliance managers.' The compliance manager then commented, 'The big culture is about compliance…and this EALIM thing is about working in a different way.' These responses signified that Bettercare's prevailing

culture of bureaucracy and compliance, removed middle managers and nurses from patient care.

I then took a few minutes to share the importance of practice-based learning and tacit knowledge sharing. After hearing this, the care service director described his nurse training as one that was largely spent in 'practice' and not 'sitting in a classroom.' Furthermore, narratives shared by the care worker and staff nurse implied that while they found company-training courses informative, most of their learning was generated by working with 'experienced' staff who gave them frequent 'feedback.' What I perceived they meant is they found practice-based learning and personalised knowledge sharing more effective than explicit classroom training. After I prompted participants to think about how organisational learning could improve, they proposed ideas such as reducing company policies and procedures down 'to the essential few,' local practice-based training, i.e., 'microteaching' in practice, 'more knowledge sharing from nurses,' as well as frequent 'feedback' from shift leaders. The meeting ended with my suggestion of presenting their ideas to the board for approval.

5.8.2 Summary of key findings from the focus group

Participants signified knowledge sharing through the use of copious codified policies and procedures was counter-productive to learning and at the same time, generated a culture of bureaucracy and compliance that removed nurses and managers from frontline care. Conversely, the experiences participants shared indicated tacit knowledge sharing and practice-based learning was more meaningful and effective. The ideas they suggested as to how organisational learning could improve largely involved decreasing bureaucracy and increasing personalised knowledge sharing from leaders.

5.8.3 Reflexive outcomes

After the focus group ended, I was disappointed with myself for suggesting participants' ideas should be presented to the board for approval, because I realised I had unconsciously subjected EALIM's implementation to the stricture of

managerial control. See appendix 11 for more detailed reflexive notes. Consequently, I contacted participants the following day to apologise for my error and encourage them to spread the ideas from the group into everyday discussions. I also proposed to top managers who attended, that they begin implementing these ideas. I perceived a positive response from all participants and top managers explicitly welcomed my proposal.

5.9 Discussion

In this discussion, I relate key findings from previous sections of this chapter to theories from the literature. This process involves examining differences and similarities between key findings, their implications and how they illuminate my research questions (Bryman and Bell, 2011). In order to relate key findings to my research questions, this discussion is structured in accordance with the following four subsections: changes to EALIM's conceptual framework, acceptance and resistance to EALIM's adoption, assessment of organisational culture and assessment of the seven concepts. Key findings relating to my assessment of organisational culture and the seven concepts were so numerous, I have included illustrative tables to present the main descriptive and interpretive themes from previous sections of this chapter. These tables facilitate a clear and succinct thematic discussion and are based on templates I constructed using template analysis (King, 2012). The templates can be found in appendices 9 and 12. In regard to organisational culture, findings were organised into Schein's (2010) three layers of, a) underlying assumptions, b) espoused beliefs and values and c) artefacts. However, because of conflicts between theories espoused and theories in use (Argyris, 2010), the title of the artefacts layer was changed to action strategies to capture this disparity. The underlying assumptions layer includes assumptions, tacit commitments and governing values, which I placed at the head of my cultural table because I perceived them to be the 'master programme' in participants' heads that produced their action strategies (Argyris, 1993, p.21).

5.9.1 Changes to EALIM's conceptual framework

The only change to the model during this cycle involved integrating the virtue of compassion within EALIM's moral anchor. This change proved useful since most staff nurses and care workers explicitly espoused compassion as a value and three directors implicitly regarded compassion as a construct of quality care. This finding reinforces the assertion from Sellman (2010) that compassion is a morally admired construct commonly associated with the caring profession. Although Holland (2010) argues that virtue ethics have no relevance to a professional role like nursing, this finding indicates otherwise; that compassion was a construct valued by nursing practitioners at Bettercare. Furthermore, the operations director's remark 'compassion matches the values of Florence Nightingale,' supports the view from Rassin (2008) that nursing pioneers like Florence Nightingale espoused ethical virtues. Although not all participants explicitly espoused compassion during interviews, nearly all participants espoused intrinsic human values like 'honesty' and 'respect', which according to MacIntyre (2007, p.190) are virtues that sustain healthcare practice. Therefore, adopting the virtue of compassion within the heart of EALIM appeared consistent with participants' intrinsic human values and at the same time, allowed the model to become even more germane to a healthcare context.

My approach of consulting top managers on my proposed change to EALIM typified the democratic and co-operative nature of my inquiry – that is to say, doing research 'with' people rather than 'on' people (Heron and Reason, 2001, p.144). This approach allowed top managers to exert their support and influence over research decisions, which according to Coghlan and Brannick (2010) builds the shared commitment necessary for changing organisational practices.

5.9.2 Acceptance and resistance to EALIM's adoption

Although EALIM's implementation had not fully begun, participants' responses during discussions and seminars provided useful insights in relation to their acceptance and resistance of EALIM's concepts, as well to the process of change required for its adoption. During my luncheon with the CEO, I perceived his initial

rejection of my proposed two-hour EALIM seminar was based on reliance on codified knowledge sharing, which according to Hislop (2009) is predicated on the assumption, knowledge is a discrete object that can be transmitted from sender to receiver. However, from a knowledge-as-practice perspective, codified methods only impart superficial knowledge and cannot explicate tacit kinds of knowledge (Collins, 2013; Newell at al., 2009). Although EALIIM seminars involved the use of written material, the argument I put to the CEO was this material would only be used to stimulate mutual discussion and narratives of how concepts relate to practice, which according to Newell at al. (2009) can lead to mean-making and tacit understanding. The CEO's eventual acceptance of my proposal appeared influenced by my encouraging him to question his assumptions about the use of written material, supporting the notion from Argyris (1993) that enabling others to question their assumptions can stimulate double loop learning, leading to alternative action strategies.

Another occasion where double loop learning appeared to encourage change was when a damning CQC inspection appeared to 'unfreeze' (Schein, 2010, p.381) the marketing director and operations managers' reliance on existing company training methods. The CQC inspection seemed to generate what Schein (2010, p.301) describes as a 'survival anxiety,' which made them question their assumptions and at the same time, acted as a stimulus to adopt EALIM. This situation supports the view from Argyris (1977) that crisis or potential crises can trigger double loop learning. However, double loop learning is not a straightforward process since it requires critical reflection of one's own thinking, which can trigger defenses that block learning (Arygris, 1991). These defenses seemed triggered during the August EALIM seminar when I questioned why the organisation had so many procedures, prompting the chairman to respond with a defensive answer that reinforced his reliance on them; i.e., 'we need policies and procedures because of CQC requirements.' According to Kegan and Lahey (2001), people block change when they perceive a reality that threatens their sensemaking of the world. My exegesis as to why the chairman resisted using fewer procedures, is this idea challenged his sensemaking of using managerial control to create a predictable

environment, which corresponds with Schein's (2010) argument that the human minds needs cognitive stability and any threat to this stability can release anxiety and defensiveness.

Another occasion in which the chairman exhibited defensive behaviour was when he resisted the idea of sharing information of Bettercare's philanthropy with purchasers, claiming they 'could become critical of the way the organisation uses its public funding.' According to psychoanalytic theory (Gabriel, 1999, p.17), individuals use a number of maladaptive defensive mechanisms, some of which include 'denial' (refusal to acknowledge an external reality), 'splitting' (separating objects into polar extremes of good or bad with no middle ground), 'projection' (falsely attributing one's own feelings or thoughts to another) and 'rationalisation' (providing rational arguments to conceal or repress a feeling of anxiety). My analysis is that the chairman tended to use the psychological defense of rationalisation, since he frequently used rational reasons to defend himself against the anxiety that instability or risk taking provoked. Whilst the chairman appeared to pose the greatest resistance toward EALIM, on one occasion the COO exhibited defensive behaviour when he claimed nurses and managers 'don't like the idea of chaos.' His response indicated the use of projection because he attributed his own unacceptable feelings about chaos into others. According to Bovey and Hede (2001), projection can also result in placing blame and responsibility on others as opposed to acknowledging the cause of anxiety is located in one's self, which is what the operations manager displayed when he attributed responsibility for shortfalls of staff knowledge to middle managers after the damning CQC inspection.

Although EALIM's adaptive concept seemed to invoke maladaptive defensiveness from some top managers, in contrast they explicitly agreed with EALIM's Kantian ethic, which according to the operations director had a good ethical fit with CQC expectations of patient-led care. Her perspective supports the argument from Sellman (2010) that a Kantian ethic can ground the requirement of healthcare practitioners to be patient-centered. This finding and the comments of the three

directors who regarded compassion as a construct of quality care, suggest top management accepted EALIM's core ethical values. Although Carney (2006, p.112) asserts 'not a single moral model' exists in healthcare management, this finding may indicate otherwise.

With regard to the focus group, the participation and ideas that emerged from those who attended, symbolised a coalition committed to change organisational practices. Their commitment is an important development since Coghlan and Brannick (2010) argue that forming alliances with key protagonists is vital for moving change forward. Furthermore, at the focus group, four top managers appeared to adopt double loop learning because they critically questioned organisational practices. Argyris (2010) argues double loop learning is crucial for engaging with model II productive reasoning, which he claims allows individuals to become truthful, open and trusting. Without these ingredients, the group could have succumbed to the perils of defensive reasoning, which hinders learning and organisational change (Argyris, 2010).

5.9.3 Assessment of organisational culture

The main descriptive and interpretive findings from previous sections of this chapter have been organised into table 17 using Schein's (2010) three layers of culture. The full template I used to construct this table is located in appendix 9.

Table 17: Cycle one – Organisational culture

CYCLE ONE - ORGANISATIONAL CULTURE AND CONFLICTS	
TOP MANAGEMENT	
Underlying assumptions	
T1: Risk threatens survival	T5: We know better than staff
T2: The organisation is a bureaucracy	T6: Work performance is valued above staff
T3: Create stability and predictability	T7: Commitment to profit maximisation
T4: Low confidence in staff	
Espoused beliefs and values	
T8: Intrinsic human values	T10: Social responsibility
T9: Patient care	T11: Collaboration
Action strategies used	
T12: Bureaucratic management	T15: Risk minimisation
T13: Managerial control	T16: Cost minimisation
T14: Classical quality control methods	T17: Codified and explicit knowledge sharing
MIDDLE MANAGEMENT	
Underlying assumptions	
M1: Higher commitment toward patients & staff than to the organisation	M3: Sharing knowledge empowers others
M2: Bettercare values patients and profit more than staff	M4: Survive organisational life by conforming
Espoused beliefs and values	
M5: Intrinsic human values	M8: Staffroom space
M6: Patient care	M9: Higher pay for care workers
M7: Social responsibility	M10: Collaboration
Action strategies used	
M11: Conform to formal systems	M14: Solidarity with care workers
M12: Humane leadership approach	M15: Practice-based learning & knowledge sharing
M13: Classical quality control methods	M18: Rely on top management for improvement
STAFF NURSES	
Underlying assumptions	
S1: Greater commitment to profession than to the organisation & patients	S3: We know more than care workers
S2: Sharing knowledge with care workers threatens our identity	S4: Low commitment to collaboration
Espoused beliefs and values	
S5: Instrinsic human values	S8: Staffroom space
S6: Patient care	S9: Higher pay for care workers
S7: Social responsibility	
Action strategies used	
S10: Minimal knowledge sharing with care workers	S13: Rely on management for improvement
S11: Managerial control	S14: Focus on administration than hands on care
S12: Task centered leadership	S15: Community of practice
CARE WORKERS	
Underlying assumptions	
C1: Leaders show me where and how to improve	C3: Low commitment to the organisation
C2: High commitment to patients and co-workers	C4: The company values profit more than staff
Espoused beliefs and values	
C5: Intrinsic human values	C8: Social interaction and appreciation
C6: Patient care	C9: Staffroom space
C7: Social responsibility	C10: Higher pay
Action strategies used	
C11: Cancel shifts to work with agencies for higher pay	C14: Shared commitment and support
C12: Use of explicit and codifed knowledge sharing	C15: Rely on leaders for improvement
C13: Reliant on formal systems	C16: Collaboration

My assessment identified four dominant conflicting cultures with divergent assumptions, values and norms. This accords with Martin's (2002) differentiated perspective of culture, since there were multiple subcultures with inconsistent manifestations – an area of theory I had not previously examined. These

differentiated subcultures not only typified a hierarchical structure, but also silos of discipline composed of individuals who often blamed others. For example, the CEO blamed staff nurses for not meeting expectations required of them, middle managers blamed shortfalls of staff knowledge on ineffective company training courses and staff nurses blamed care workers for mistakes. This kind of blaming culture signifies a defensive organisation plagued by tribalism, consistent with research by McGee-Cooper (2005) who found that tribalism tends to manifest in misunderstandings, a lack of trust and backbiting between groups. From a psychoanalytic perspective, the blame that one subculture attributed to the other could be explained as pathological 'splitting,' a situation in which individuals split the organisation into good and bad parts (Gabriel, 1999, p.17). According to Armstrong (2005), splitting allows individuals to avoid injury to their egos by identifying with the good parts of the organisation and separating themselves from the bad parts. While this process allows individuals to preserve their self-esteem, it often results in damaging consequences, such as scapegoating, fragmented relations and impaired team working (Gabriel, 1999), which were evident at Bettercare.

Disparities in espoused beliefs and values like the need for staffroom space and higher care worker pay, were advocated by middle management and frontline staff but not by top management. These differences correspond with the assertion from Jefferson (2002), that healthcare environments are often complicated by stakeholders with different expectations and conflicting interests. Although top managers espoused valuing staff and collaboration, their statements were inconsistent with their action strategies of managerial control, bureaucracy and cost minimisation. These inconsistencies correspond with the theory from Argyris (2010) that people tend to unconsciously act in ways, which undercut the very values they espouse. Having said that, top managers' underlying assumptions were consistent with their action strategies. For instance, commitment to profit maximisation corresponds with cost minimisation; we know better than staff relates to managerial control; risk threatens survival links to risk minimisation; and the organisation is a bureaucracy accords with bureaucratic management.

Similar linkages existed between the underlying assumptions and action strategies of other cultural groups. This finding suggests behavioural norms were fuelled by deeper unconscious psychological constructs that framed how participants ordered their work, supporting the view from various other authors (e.g., Argyris, 1993; Argyris and Schon, 1978; Schein, 2010; Stacey, 1995) – that behaviour in organisations is largely driven by tacit assumptions held below consciousness, which can differ from explicit beliefs and values. However, according to Argyris, (2010), individuals who espouse one thing and do another, tend to deny these discrepancies because they are too embarrassing or upsetting to acknowledge, an area of interest I could be explore in the next cycle.

What is also apparent from table 17 is the differentiated underlying assumptions between top and middle managers. For example, top management's assumptions of 'performance is valued above staff' and 'we know better than staff,' signified a mental model steeped in instrumental rationality. However, the problem with instrumental rationality, is it represents a cybernetic way of thinking that implicitly treats human beings as a resource to be controlled and overlooks the value of social interaction that can inspire compelling motivations for employees to act toward the good of the organisation (Stacey, 2010). In contrast, middle management's assumptions of 'sharing knowledge empowers others' and 'commitment to patients and staff,' signified a more substantive rationality and humane mental paradigm.

These kinds of paradigmatic conflicts resonate with Parkin's (2009) argument that healthcare settings are marked by differences in the way individuals and disciplinary groups think and act. At Bettercare, these differences manifested in tensions between top and middle managers, particularly in regard to top managers' uses of managerial control and bureaucratic management. According to McAuley, Duberley and Johnson (2013), bureaucratic management creates implications such as distorted communications and the oppression of workers, which can be a source of stress and anxiety for employees. Comments from employees such as 'All these policies make you scared' and 'There isn't freedom

to speak of real company issues,' indicate these implications were evident at Bettercare. Conversely, care workers descriptions of middle managers implied a humane leadership approach and resonate with servant leadership in which one adopts a style not simply for utilitarian gain, but to empower the flourishing of others and facilitate their development (Sendjaya and Pekerti, 2010). Even so, middle managers' efforts seemed severely undermined by staff nurses' actions of managerial control, task-centered leadership and minimal knowledge sharing, typifying a lack of consensus on roles and responsibilities, which Parkin (2009, p.57) describes as the 'hub and the rub' of health service management.

A lack of consensus between middle managers and staff nurses may be attributed to conflicting underlying assumptions. For instance, middle management's assumptions of 'sharing knowledge empowers others' and 'high commitment toward patients and staff,' conflicted with staff nurses' assumptions of 'sharing knowledge with care workers threatens our identities' and holding 'greater commitment to our profession than to patients.' It follows that staff nurses had a defensive mindset that served their narcissism, meaning they implicitly focused more on the evolution of self and on the instrumental values of their profession, than on the practice of caring for others (Gabriel, 1999). This finding supports a study from Rassin (2008), who found the nursing value of altruism was eclipsed by narcissism and instrumental values of social recognition and self-esteem. According to Schwartz (1999), narcissism creates implications such as the destruction of inter-dependence and team working, which seemed evident at Bettercare since care workers signified power struggles with nurses who blamed them for mistakes. Furthermore, staff nurses' low commitment to collaboration appeared to obstruct care workers' input and ideas, resulting in their marginalisation. McGee-Cooper's (2005, p.14) description aptly describes this type of obstruction, 'The pride of prejudice, "we are better than you," shows its ugly head as the tribe closes ranks to defend against new ideas and cultural differences.' This kind of marginalisation could be viewed as a complex patterning process of inclusion-exclusion – a power dynamic that reflects individual and collective ideologies and identities (Stacey, 2007). From this perspective, staff

nurses' assumptions of 'we know more than care workers' and 'sharing knowledge threatens our identity' was expressive of their collective ideology and identity, which sustained and was sustained by the process of inclusion-exclusion. Care workers were marginalised in other ways, such as their low pay, lack of social interaction and lack of appreciation from top managers. Although, their low pay seemed to fuel low commitment to the organisation, care workers held high commitment to patients and were the most altruistic and compassionate.

5.9.4 Assessment of the seven concepts

Key thematic findings from previous sections of this chapter relating to the seven concepts are categorised in table 18. The full template is located in appendix 12.

Table 18: Cycle one – Concepts and key themes

CYCLE ONE - CONCEPTS AND KEY THEMES	
PERCEPTIVE VALUE OF BETTERCARE	
1.1: Bettercare provides quality patient care	1.4: Bettercare values patients & profit more than staff
1.2: Top managers hold a high perceptive value	1.5: Bettercare should be more socially responsible
1.3: Middle managers and care workers hold a low perceptive value	1.6: Bettercare should increase pay for care workers
POWER RELATIONS	
2.1: Chairman's dominance	2.5: Power struggles
2.2: Top managers overlook the needs of front line staff	2.6: Humane leadership from middle managers
2.3: Top managers and staff nurses use managerial control	2.7: A 'them' and 'us' perspective
2.4: Middle managers survive organisational life by conforming	2.8: Blame culture
MOTIVATION	
3.1: Top managers are driven to provide a quality service	3.4: Care workers hold low commitment to Bettercare
3.2: Middle managers hold high commitment to patients & staff	3.5: Low pay is a demotivating factor for care workers
3.3: Care workers hold high commitment to patients & co-workers	3.6: Nurses hold high commitment to their profession
ETHICS	
4.1: All groups espoused patient care, social responsibility	4.4: Lack of staffroom space for taking breaks
and intrinsic human values	4.5: Low pay for care workers
4.2: Lack of social interaction between top managers & staff	4.6: Defensive reasoning by top managers
4.3: Top management value performance & cost efficiency above staff	
ADAPTABILITY	
5.1: Good external adaptation	5.5: Problems with internal integration
5.2: Standardisation inhibits adaptation to the local needs of services	5.6: Top managers seek stability and predictability
5.3: Care workers use adaptive strategies to cope with challenges	5.7: Copious policies inhibits flexibility and spontaneity
5.4: Training and policies are used as a defence against instability	
LEARNING	
6.1: Learning is mostly based on codified & explcit knowledge sharing	6.4: Managerial control inhibits learning and creativity
6.2: Middle managers empower others by knowledge sharing	6.5: Bureaucracy stifles experimentation & innovation
6.3: Staff nurses shared minimal knowledge with care workers	6.6: Lack of reflexive learning
IMPROVEMENT	
7.1: Reliance on management for improvement	7.5: High variance in service quality
7.2: Reliance on classical quality control	7.6: Bureuacratic processes inhibit service quality
7.3: Lack of collaborative improvement & problem solving	7.7: Copious policies are counter-productive
7.4: Nurses place greater focus on administration than hands on care	7.8: Staff shortages & turnover inhibit service quality

5.9.4.1 Perceptive value of Bettercare

While most participants perceived Bettercare as a quality care provider, their perception that Bettercare should adopt more socially responsible business practices (i.e., being greener) supports Kotler and Lee's (2005) suggestion that environmental sustainability has become a mainstream view among employees. However, of all the cultural groups, only top managers held a high perceptive value of the organisation, which could be linked to them identifying Bettercare with their own ego ideals – that is, they identified Bettercare as an organisational ideal. A severe problem with such identification is it can make people blind to amoral organisational policies and practices, where the organisation becomes symbolic of 'the all-good mother of fantasy' (Gabriel, 1999, p.197). Schwartz (1987) warns such internalisation could result in overly defensive behaviour, since any threat to the organisation is seen as a threat against one's self. In contrast, most other participants had a lower perceptive value of the organisation, predicated on the view that Bettercare valued patients and profit more than staff.

5.9.4.2 Power relations

Top management's utilitarian rationality of valuing profit and performance above staff resulted in overlooking the needs of workers and contributed to a 'them' and 'us' mentality, which according to McGee-Cooper (2005), is underpinned by a perspective that sees an organisation as a bureaucracy. According to Grey (2013), bureaucracy tends to weaken social relations, generate distrust and create gaps between leaders and followers, which were most evident in the relations between top managers and care workers. The negative perspective care workers expressed toward top managers suggested they were disinclined toward leaders with masculine traits (i.e., impersonal, rational), which Hatch (2013) argues is embedded in bureaucratic forms of organisation. According to Hatch, care workers' prefer leaders with feminine and relational traits, which could explain why care workers at Bettercare valued middle management's humane leadership. In contrast, the leadership approach from top managers and staff nurses was predicated on managerial control – an ideology that created a power balance tilted in their favour (Stacey, 2007). Although power is an inevitable aspect of human

relating (Stacey, 2010), at Bettercare this power imbalance was unproductive because it created power struggles between top and middle managers, as well as between nurses and care workers. These powers struggles resonate with Parkin's (2009) description of healthcare environments in which conflict and paradox are generated concerning what takes priority and who gains the most. Another implication of managerial control is that it strikes at the heart of organisational ethics because it excludes employee discretion from work processes, treating them akin to machine parts (Grey, 2013).

Among top managers, perhaps the most controlling was the chairman, who restricted board meetings to one hour and whose control of discussions created the dynamic of inclusion-exclusion (Stacey, 2010), which inhibited collaborative learning and creativity. My perception of the chairman fits with the psychological traits of an 'anal character,' which according to (Schwartz, 1999, p.60), is a compulsive economiser of time and effort and an individual who seeks 'orderly relations which they feel they can control.' While middle managers survived top management diktats by repressing their opinions and conforming to formal systems, according to Schwartz (1999) conformity places a premium on flexibility and imagination, until eventually organisational members lose sense of their individual worth. Conformity therefore poses serious questions in relation to the morality of managerialism, since those adopting it treat people as objects rather than subjects (Grey, 2013).

5.9.4.3 Motivation

Top management's utilitarian treatment of the workforce seemed linked to their drive toward quality service provision, which manifested in their paying more attention to inspection audits and procedures than to the intrinsic motivational needs of workers such as social interaction and appreciation. This finding is consistent with Armstrong's (2005) argument that an externally driven preoccupation with tasks and quality assurance squeezes out relational aspects of organisational life. In addition, top management's preoccupation with cost minimisation created a situation where care worker pay was given short shrift, a

factor that demotivated care workers and contributed to their low commitment to Bettercare. Although middle managers and care workers showed high commitment to patients and staff, nurses indicated higher commitment to their profession. This finding is consistent with research from Kanji and Moura e Sá (2003) who found clinicians tend to show greater commitment to their professions than to a strategy of empowerment and collaboration.

5.9.4.4 Ethics

Despite differences in commitment between cultural groups, participants from all four groups commonly espoused values that resonated with EALIM's. These were intrinsic human values, patient care and social responsibility. This is an important finding as Mosadeghrad (2013) suggests that if a common set of values could be found within a healthcare setting, they could be used to diffuse differences and guide human behaviour. Having said that, top management's utilitarian rationality seemed to generate ethical conflicts with care staff such as converting staffrooms into bedrooms to maximise profit and maintaining low care worker pay to minimise costs, which generated a low perceptive value of Bettercare among care staff. These ethical conflicts suggest a mismatch between care staffs' organisational ideal and their experience at Bettercare, supporting Gabriel's (1999) theory that employees tend to demonise their employer when their experiences do not measure up to their organisational fantasies.

5.9.4.5 Adaptability

Low care worker pay also seemed correlated with staffing shortages, which generated problems in dealing with aggressive patients. For instance, care workers who cancelled shifts or left the organisation, created staffing shortages that had a negative impact on the teams' abilities to cope with challenges to the service. This problem supports findings from Potter, Morgan and Thompson (1994), whose action research study in three NHS hospitals showed financial stringency was a major constraint to organisational improvement. Another constraint was the 'two hundred and twenty five policies' in Bettercare's quality manuals, symbolising what Nwabueze (2004, p.11) describes as the 'belt and

braces of control.' Although Parkin (2009) maintains standards and procedures are required for highly regularised healthcare environments, Nwabueze (2004) asserts too many rules could produce a culture of managerialism that undermines creativity and improvement. At Bettercare, copious policies and procedures served more to relieve top management's anxiety about instability than to improve service quality, typifying work as a ritual of compliance instead of a creative interplay of activity between individuals. I therefore identify with Schwartz (1999) when he alleges executives do not value work as output, but as displays of loyalty and conformance. Although top managers at Bettercare seemed skilled at external adaptation (i.e., adapting goals and policies to meet external stakeholder requirements), their use of standardised policies inhibited internal integration (i.e., adapting working methods to meet dynamic patient needs) and stifled experimentation and innovation.

5.9.4.6 Learning

Most participants' learning was dependent on codified and explicit knowledge sharing (i.e., reading policies and procedures and attending classroom style company training), the limitations of which were wholly exposed by a damning CQC inspection that found shortfalls in staff knowledge. This outcome strongly suggests a link between the use of codified and explicit knowledge sharing, with shortfalls in staff knowledge. This link corresponds with Alvesson and Spicer's (2011) assertion that explicit and codified instructions limit learning, because those receiving them do not always understand why they are given or how to implement them. The finding that managerial control inhibited learning and creativity was evidently displayed by the chairman's control of discussions and by middle managements lack of 'freedom to speak' in clinical governance meetings – supporting Nwabueze's (2004) argument that managerialism disempowers creativity and learning of root causes to problems. In regard to reflexive learning, the finding that very few participants signified its use, accords with research from Argyris (2010) who found organisational members tend to hold governing values that prohibit double loop learning.

5.9.4.7 Improvement

Most middle managers and frontline staff relied on their managers for improvement, which was indicative of the dependency generated from managerial control and centralised authority. However, according to Newell et al. (2009), a command and control culture is damaging to improvement because it inhibits workers from using their experience and knowledge to autonomously solve problems confronting them. With regards to quality improvement, top management strategies (i.e., monthly inspections, clinical governance and audit meetings) were more symbolic of classical quality control methods of error detection, than of strategies focused on error prevention. Furthermore, the lack of involvement of frontline staff in clinical governance and audit meetings suggested a lack of collaborative problem solving – a finding consistent with research from Mosadeghrad (2013) who found a lack of employee involvement was typical among healthcare organisations. Even when top and middle managers did attend such meetings, the focus was on reducing risks, not learning root causes of problems.

In terms of barriers to improvement, the administration overload generated by bureaucratic processes precluded organisational members from focusing on service quality. This issue was particularly evident among head office workers and managers who espoused lack of 'time' and excessive 'paperwork' as inhibitors to improvement. Although this finding has some resonance with research from McGilloway et al. (1999) who found a lack of time was the most frequently reported quality improvement barrier, this was only reported by a few participants at Bettercare. However, one commonly reported barrier to improvement was staffing shortages. This supports the research of Mosadeghrad (2013) who found employee shortage is a major barrier to improvement in healthcare firms. At Bettercare, these employee shortages were fuelled by low care worker pay, reinforced by top management's strategy of cost minimisation, signifying another organisational trap. I therefore identify with Argyris (2010, p.3) who claims resolving organisational traps 'represent the next big challenge to raising the level of performance of organisations.'

5.10 Summary and Conclusion

The multiple and conflicting subcultures at Bettercare typified a defensive organisation plagued by tribalism and power struggles between groups who exercised pathological splitting and scapegoating that damaged internal relations and team working. The behavioural norms of each cultural group were driven by deep psychological constructs that often conflicted with their espoused values, confirming research findings from other authors.

While all cultural groups perceived Bettercare as a provider of quality care, top management's utilitarian preoccupation with profit maximisation appeared to engender a low perceptive value among care staff that Bettercare valued patients and profit more than its staff. This perception was most apparent in the conversion of staffrooms into bedrooms and the short shrift given to care worker pay. Top management's psychological structure of bureaucracy symbolised their anxiety about instability, which manifested in strategies of managerial control and copious standardised policies that acted as barriers to adaptation, innovation and service quality. While top managers allocated responsibility, their use of bureaucratic management and control squeezed out the space for staff autonomy and professional judgment, creating a state of dependency where followers relied on their leaders for improvement. Consequently, instead of work being a creative interplay between interdependent individuals and groups, work at Bettercare symbolised a place of compliance, generating oppression and stress among workers.

Conversely, middle management leadership appeared more humane than top managers', typifying a supportive approach disposed to sharing knowledge and empowering others. However, their efforts seemed significantly undermined by staff nurses who displayed narcissistic traits and showed more commitment to their profession, than to a strategy of knowledge sharing and collaboration with care workers. Staff nurses' marginalisation of care workers typified a complex pattern of inclusion-exclusion that reflected their ideologies and identities as professional nurses. Despite their alienation, care workers held high commitment

to patients and appeared the most altruistic and compassionate of the four cultural groups, although some cancelled shifts to work with temping agencies for higher pay, resulting in staffing shortages. Whilst this consequence seemed unintended, staffing shortages had a negative impact on service quality, confirming findings from other quality improvement studies.

Although cultural groups were differentiated by divergent assumptions, values and behavioural norms, they commonly espoused intrinsic human values, patient care and social responsibility – values congruent with EALIM. It follows that these commonly espoused values could be used to diffuse differences and guide the behaviour of healthcare practitioners. While behavioural norms seemed driven by deep psychological constructs, a damning CQC inspection that disconfirmed the underlying assumptions of two top managers appeared to trigger double loop learning and stimulate their thinking toward adopting EALIM. The four top managers who attended the focus group also appeared to use double loop learning and showed commitment toward the next phase of this research – the implementation of EALIM.

Chapter Six: Cycle Two – implementation of EALIM

6.1 Introduction

This chapter provides details of the second AR cycle relating to the implementation of EALIM at Bettercare. I begin this chapter by outlining the timeline of adoption strategies and research methods I deployed, followed by narrated accounts of the processes used for both the implementation of EALIM and the gathering of information. Coghlan and Brannick (2010) purport the dual process of implementation and inquiry distinguishes AR from other research studies, which serves to reduce the gap between theory and practice.

Since a large volume of information was gathered during this cycle, it was not practicable to follow the same structure of the first cycle chapter, in which I detailed each empirical account in sequence. Consequently, in this chapter empirical findings are structured into themes and arranged to answer my research questions: changes to EALIM's conceptual framework, acceptance and resistance to EALIM's adoption, as well as EALIM's impact on organisational improvement. The full template I used to construct these themes is located in appendix 13.

Key findings are then discussed in light of the literature to illuminate how they fit with the existing body of knowledge, as well as to identify their implications and significance (Bryman and Bell, 2011). At the end of this chapter, conclusions relating to the outcomes and limitations of EALIM's adoption during this cycle are presented.

6.2 Adoption Strategies and Research Methods

The implementation of EALIM spanned from November 2011 to October 2012. During this period, I held six focus groups and 26 participant observations, as illustrated in the timeline of table 14 below.

Table 14: Cycle two timeline

AR activity / Month	Nov11	Dec11	Jan12	Feb12	Mar12	Apr12
EALIM Seminars	1		1	1		
Informal discussions	2					1
Board Meetings		1				
Formal Discussions		3		1		
Focus Groups		1	1	1		1
Field Trip to India			1			
Evaluation Meetings						
EALIM mini-seminars						
EALIM Articles			1	1	1	1
AR activity / Month	**May12**	**Jun12**	**July12**	**Aug12**	**Sep12**	**Oct12**
EALIM Seminars				1		
Informal discussions			1			
Board Meetings				1		
Formal Discussions						
Focus Groups			1	1		
Field Trip to India						
Evaluation Meetings	3					
EALIM mini-seminars			3	3		1
EALIM Articles	1		1	1	1	1

6.2.1 An epidemiological approach toward change

After the focus group in October 2011, I deemed more momentum was needed to garner commitment to EALIM. I reasoned that if I could inspire the values and beliefs of a critical mass of leaders, a tipping point might emerge so EALIM's concepts and methods could spread like an epidemic. This approach is in keeping with Kim and Mauborgne's (2003) epidemiological approach involving mobilising the commitment of key players to act as change agents, by spreading new ideas across an entire organisation. I therefore rolled out three EALIM seminars for all middle managers and their assistants between November 2011 and February 2012, as I regarded them to be key stakeholders in the organisation. From the twelve email invitations I sent, eleven participants attended along with one staff nurse and HR administrator who had heard about the seminars and had requested to attend. A copy of my email invitation is located in appendix 14. Each seminar

was held at the company's training suite and lasted for approximately three hours. However, to generate organisation wide commitment to EALIM, from May to October 2012, I also delivered seven EALIM mini-seminars to a total of thirty-four front line staff at local sites. These mini-seminars lasted for approximately thirty minutes each. The slides I presented can be found in appendix 7.

I began each EALIM seminar and mini-seminar by listing various healthcare scandals over the last ten years to construct a sense of crisis or urgency that could motivate participants toward change (Kotter, 1995). I used my voice recorder to capture conversations and I explicitly invited participants to share their thoughts, concerns and criticisms of the model.

6.2.2 Focus Groups

From December 2011 to August 2012, I held six focus groups, attended by a diversity of participants from different disciplines, positions and locations across the organisation. Please refer to table 12 for details of those that attended each group. I sent email reminders to group members two weeks in advance and between two to seven persons attended each focus group. I perceived the COO and care director to be the most committed protagonists of EALIM, since they consistently attended focus groups and were actively involved in implementing agreed action plans. Their commitment is an important point, as a study by Sirkin, Keenan and Jackson (2005) found the success of change programmes in 225 companies was correlated to the commitment of key executives and frequent project reviews. Discussions in each focus group involved evaluating actions from the previous meeting, constructing a list of issues and forming new action plans. This process closely followed the sequential steps of acting, reflecting and planning – critical hallmarks of action research (McNiff and Whitehead, 2011). Without breaching confidentiality, I often shared information from my research encounters and invited group members to confirm, disconfirm or add new perspectives. According to Heron and Reason (2001), this particular approach can break down barriers between researchers and subjects, deepen the understanding of researchers and enhance the credibility of findings. Participants also collectively

produced new ideas in relation to EALIM's adoption, one of which involved the use of early morning community groups at local sites, so staff and patients could democratically discuss and agree daily action plans. Focus groups typically lasted for approximately one hour and my use of a voice recorder did not appear to hinder group discussions.

6.2.3 Monthly EALIM articles

With the exception of those attending seminars and focus groups, I reasoned most organisational members would be unaware of EALIM's concepts and methods. Consequently, I thought of producing and distributing monthly articles among employees to create greater awareness of EALIM and shared this idea in December's focus group. Focus group participants welcomed the idea, but suggested I should write the articles in exoteric prose to ensure care workers understood them, a suggestion to which I agreed. Since EALIM embodies many concepts and methods, we also agreed to phase each EALIM concept with each quarter of the year (i.e., Ethics – Jan to Mar; Adaptability – April to June; Learning – July to Sep; Improvement – Oct to Dec) would be practicable. Accordingly, with the help of a head office administrator, from January 2012 I began writing, copying and distributing each article to employees' home addresses on a monthly basis. A selection of articles can be viewed in appendix 6.

6.2.4 Discussions with participants

During this cycle, I noted eight discussions as a 'total participant' (Bryman and Bell, 2011, p.438), which yielded vital information in regard to EALIM's adoption. The first was an informal discussion in November 2011 during a taxi ride with the care director, who informed me EALIM's adoption influenced a change in company training, making it more practice-based and localised to each site. In the same month I had an informal discussion with the CEO during a social visit to his home, where I took the opportunity to share my interpretations of the previous two board meetings. I shared my interpretations in the hope they could provide him with insights into how counterproductive board meetings were and to suggest changing them to an informal style, allowing greater engagement among directors and time

for free-flowing conversation. This approach is consistent with EALIM's method of extra-ordinary management (Stacey, 1995) and the approach proposed by Lewis, Passmore and Cantore (2011) of using conversational and relational processes as a way of generating change. After the CEO gave his consent, I attended the next board meeting (in December 2011) to observe the outcomes from these changes. The board meeting lasted for approximately two hours and after the meeting, I held separate formal discussions with the facilities director, operations manager and CEO to note their feedback.

In February 2012, I met with the marketing director, who disclosed emails and comments she received from case managers and commissioners in relation to Bettercare's philanthropy in India. In April 2012, I noted an impromptu discussion with the operations manager during an informal social gathering, where he mentioned important information regarding the progress of community groups. In July 2012, I held another informal discussion with the operations manager who described how he had set up a community of practice among staff nurses, as well as a trans-disciplinary project group consisting of clinicians and non-clinicians to redress problems in the organisation.

6.2.5 Field Trip to India

In January 2012, I attended a three-day field trip to India with a group of seven participants to open a school and orphanage funded by Bettercare's shareholders. The trip was collaboratively organised with the CEO, the operations manager, a secretary and myself. The secretary sent letters to the entire workforce inviting staff to register their interest and selection decisions were made by the CEO and compliance manager based on employees' contributions to the organisation. My role involved liaising with the project team in India and organising the itinerary. The seven participants who attended the trip were the operations manager, compliance manager, project coordinator, two administrators and two care workers. The first day of the trip involved visiting a slum in Mumbai, which gave us a context of where some of the children in the orphanages had come from. This was followed by a two-day visit to Indore where we attended opening ceremonies and a dinner

banquet at the site of the school and orphanage. During the trip, I made observational notes and took videos and photographs of key moments. As participants gathered on the evening before our departure, I also used my voice recorder to capture discussions on what the whole experience meant to them.

After we returned from the India trip, I asked myself how the experience of the trip could be communicated to other employees' so they too could become aware of the social impact of Bettercare's philanthropy. After discussing this point during January's focus group, members agreed on a strategy of presenting photographs and a video of the trip in staff meetings across the organisation. This was implemented over the following month and a video of the India trip was uploaded on YouTube for employees and external stakeholders alike to freely access.

6.2.6 Evaluation meetings

After I completed my analysis of information from the first cycle (pre-implementation of EALIM), I scheduled a meeting with top managers in May 2012, to present my findings. I emailed all top managers several weeks in advance, stating the purpose was to collaboratively evaluate my findings, identify desirable states of change and plan actions for the rest of the year. A copy of my email invitation can be found in appendix 15. I reasoned this feedback process would provide top managers an opportunity to validate or critique my findings (McNiff and Whitehead, 2011) and at the same time, allow them to reflexively engage with their organisational world, which Reason and Bradbury (2006) argue is a criterion for the quality of action research.

The meeting was held at Bettercare's head office and seven participants attended: the COO, care director, operations manager, compliance manager and three senior managers who were recently promoted from middle management. However, because the CEO, marketing director and operations director were absent, I held two further evaluation meetings with them to repeat the process. During each evaluation, I presented my tables on organisational culture and the seven concepts (located on pages 176 and 180). Without breaching confidentiality,

I quoted participants' responses to support my findings and invited feedback from top managers. Each of the three meetings lasted for approximately two hours, during which I captured comments on my voice recorder.

6.2.7 Final board meeting

In August 2012, I attended my final board meeting to observe whether there had been a sustainable change to directors' communicative interactions, since the informal style was introduced back in December 2011. At the end of the meeting, I held a seminar with six top managers to experiment with the idea of adopting Quaker space as a learning method and to obtain their responses. According to McNiff and Whitehead (2011), experimenting with developmental ideas epitomises the inventiveness of action research in which new possibilities are explored. My presentation slides of Quaker space can be found in appendix 8.

6.3 Changes to EALIM's Conceptual Framework

There were two changes made to EALIM's conceptual framework during this cycle, typifying the evolving and reflexive nature of this AR inquiry. These were the use of Quaker space as a learning method and the adoption of an appreciative approach as a method for improvement. Each method is described and explained in the following subsections, which include warranted reasons for their adoption within EALIM's conceptual framework.

6.3.1 Adoption of Quaker Space

The first change to EALIM involved adopting Quaker space. Originally developed by the Quakers in the 17th Century, Quaker space was used as a way of giving people space to express their individuality and be accepted regardless of their spiritual traditions, beliefs and experiences (Dandelion, 2004). Since the Quakers believed there was no single version of the truth, they generated space to allow people to borrow ideas from different traditions to foster personal learning and growth, without any controlling or oppressive leader imposing judgment of what was acceptable (Dandelion, 2004). The concept of Quaker space involves respecting each person's individuality, creating a non-threatening environment

where people can admit their mistakes and affording people the space they need to connect to the teacher within (i.e., intuition), so they can explore creative thought (Dandelion, 2004; Hogan, 2007). According to Kets de Vries, Carlock and Florent-Treacy (2007), being part of an organisation that encourages this kind of space can promote more responsible learning and move people from a position of dependence, to a place of autonomy and interdependence. Kets de Vries, Carlock and Florent-Treacy suggest any environment that represses individuality tends to limit maturity, creativity and leadership.

Key thematic findings from the first cycle such as the use of managerial control, the presence of a blame culture, lack of reflexive learning and participants' reliance on management for improvement, suggested the adoption of Quaker space within EALIM was much needed at Bettercare. Furthermore, Quaker space is congruent with EALIM's core values of organisational democracy and reflexivity, and relates well to triple loop learning and extraordinary management methods (Flood and Romm, 1996; Stacey, 1995).

Whilst I was able to present Quaker space and gather responses from six top managers at a seminar in August 2012, I was unable to fully present it to other participants because nearly all mini-seminars and focus groups had been completed by that time. However, I did communicate its principles to employees through an EALIM article distributed in September 2012, which can be found in appendix 6. A revised table showing the inclusion of Quaker space within EALIM's KM methods is shown in table 19.

Table 19: Revised KM Methods

Method	Description and explanation	References
Triple loop learning	Single, double and triple loop learning that allows individuals and groups to engage in: - Improvement, by learning new ways of doing, - Reflection, by learning new ways of thinking, - Transformation, by learning new ways of learning.	Flood and Romm, 1996.
Communities of practice	Practitioner based (homogenous) groups for mutual support, knowledge sharing and learning of best practice.	Hislop, 2009; Newell et al., 2009.
Project teams	Intra-disciplinary (heterogeneous) teams for specific projects, problem solving, knowledge creation and building innovation.	Hislop, 2009; Newell et al., 2009.
Story telling and narratives	The use of story telling and narratives among organisational members for the purpose of creating identity, deep meaning and tacit knowledge sharing.	Gabriel, 1999; Newell et al., 2009; Senge, 2006.
Knowledge brokers / boundary spanning	Organisational members who act as sources and facilitators of knowledge, due to their interaction with different communities of knowledge and discipline.	Hislop, 2009; Newell et al., 2009.
Quaker space	Producing maturity, responsible learning and leadership by affording people space to express their individuality, intuition and creative ideas. Providing a safe environment for people to admit their mistakes without blame or criticism.	Dandelion, 2004; Kets de Vries, Carlock and Flordent-Treacy, 2007.

6.3.2 Adoption of an appreciative approach

The second change to EALIM was the inclusion of an appreciative approach as a method for organisational improvement. While analysing information from the first cycle, I was particularly struck by findings regarding care workers' espoused value of appreciation and the lack of appreciation they experienced, particularly from top management. Perhaps I noticed this because I too had experienced a lack of appreciation whilst working as a care worker many years before and therefore understood its value for personal growth and motivation. What further underscored the importance of including an appreciation approach within EALIM, were comments from care workers during EALIM mini-seminars such as 'We want to be

recognised and appreciated' and 'It is very important to us…to be appreciated.' These kinds of comments led me to explore the literature on Appreciative Inquiry (AI), which according to Lewis, Passmore and Cantore (2011) is a method of intervention utilising the power of appreciation to achieve growth and positive change.

AI begins with the 'unconditional positive question' of what sustains and gives life to organisations, so its potential can be realised (Ludema, Cooperrider and Barrett, 2001, p.156). In practical terms, AI involves asking questions such as, 'what are the values and behavioural norms we want to grow?' rather than 'what are the behaviours we want to prevent?' Those who hold an appreciative perspective see an organisation as a network of human beings and recognise the social, psychological and emotional needs of people working within them (Lewis, Passmore and Cantore, 2011). William James, an American psychologist claims 'The deepest principle of human nature is the craving to be appreciated' (James, 1981, p.313). When the human need for appreciation is overlooked, this can produce negative emotions that inhibit improvement despite the best problem solving efforts. Conversely, when people are appreciated for something they do, this can produce positive emotions, growing that area of their life because people seek experiences they find most rewarding (Lewis, Passmore and Cantore, 2011). In other words, an approach that makes people feel appreciated can generate sustainable change and improvement. Whilst there are a number of ways to show appreciation, Lewis, Passmore and Cantore (2011) suggest using positive conversations on areas we wish to grow, claiming such conversations affirm the value of people and create deeper relationships, shared understanding and new perspectives.

A criticism of using TQM problem solving methods such as the five whys, force field analysis and Pareto principle, is they are problem-based (Cooperrider and Whitney, 2001) and therefore tend to produce deficit-based questions and conversations that overlook what is right with people and the good work they already do (Ludema, Cooperrider and Barrett, 2001). Therefore, combining an

appreciate approach that borrows concepts from AI, can correct the imbalance of using problem solving techniques – to form an integrated and more sustainable approach to improvement. However, since the adoption of an appreciative approach occurred at a late stage in this action research, I was only able to communicate its principles through an EALIM article I distributed in December 2012, which can be found in appendix 6. As a consequence, I could not gather any information from participants on its use as an improvement method. A revised table illustrating my inclusion of an appreciative approach within EALIM's TQM methods is shown in table 20.

Table 20: Revised TQM Methods

Method	Description and explanation	References
VOC - Voice of the Customer	Continuous monitoring of dynamic customer requirements, so changes can be rapidly identified in order to avoid market drift.	Pande, Neuman and Cavanagh, 2000.
Five whys	A technique for finding root causes to problems, which supports sustainable troubleshooting.	Besterfield et al., 2003; Oakland, 1993.
Force field analysis	Identification of factors that support a problem (restraining forces) and factors that enable a change or solution (driving forces).	Besterfield et al., 2003; Oakland, 1993.
NGT - Nominal Group Technique	A democratic technique for acquiring group ideas for the detection and correction of errors.	Besterfield et al., 2003; Oakland, 1993.
AD - Affinity Diagram	Collaborative arrangment of a large number of ideas into groups for review and analysis, in order to stimulate a creative improvement.	Besterfield et al., 2003; Oakland, 1993.
Pareto principle	Data analysis of the 'vital few and the useful many,' which helps identify the biggest problems to solve.	Besterfield et al., 2003; Oakland, 1993.
Appreciative approach	Appreciating employees by focusing on the good work they already do and by engaging in positive conversations on areas that need growing, to produce sustainable improvement.	Lewis, Passmore and Cantore, 2011; Ludema, Cooperrider and Barrett, 2001.

6.4 Acceptance and Resistance to EALIM's Adoption

Findings in relation to participants' acceptance and resistance of EALIM and its adoption are organised in accordance with the following subsections, which represent the main themes that emerged during this cycle. These subsections include the adoption of practice-based training, staff nurses' resistance to collaboration and knowledge sharing, defensive reasoning from top managers, how evaluation meetings enabled commitment toward change and participants' responses during EALIM seminars.

6.4.1 Adoption of company wide practice-based training

During a taxi ride in November 2011, the care director implied the adoption of EALIM had influenced a change in company policy, which made training more practice-based and localised to each site. He described how the 'microteaching' initiative discussed in the EALIM focus group the previous month, had been 'implemented.' He explained, 'Instead of relying on classroom training sessions, the emphasis is on a question and answer approach in the units' on topics such as 'safeguarding,' 'incident reporting' and 'epilepsy.' He said these topics were 'now being taught in practice during the shift, maybe in a handover or by spending a few minutes on duty discussing the knowledge that needs to be understood.' His comments implied EALIM's adoption shifted the emphasis from explicit knowledge sharing through centralised training courses, to practice-based knowledge sharing at local sites. The adoption of 'microteaching' was also discussed at the focus group in July 2012, where the COO affirmed it had been implemented 'in all the units.'

6.4.1.1 Reflexive outcomes

Although I perceived EALIM's adoption was beginning to take root, I was under no misapprehension about the barriers laying ahead, particularly by those with vested interests in the status quo.

6.4.2 Staff nurse resistance to collaboration

In April 2012, during my informal discussion with the operations manager, he implied some staff nurses were resistant to the use of community groups (an initiative that emerged from January's focus group to support EALIM). He stated, 'Some nurses don't seem to like it [community groups].' After I asked for an example, he shared a narrative about one staff nurse whom he recently observed 'instructing others' to carry out tasks 'contrary to what was agreed in the community group' and described how he had to 'pull them to one side' to explain 'they can't do that because those decisions had already been made in the meeting.' His narrative suggested the staff nurse subverted the shared decisions made in the community group, which corroborated my cycle-one findings – staff nurses had low commitment to collaboration and were inclined toward task-centered leadership (see table 17, on page 176). The care worker who attended the April focus group also implied staff nurses were resistant to collaboration when she remarked, '…when they get to the community meetings…nurses say "well that's what they [patients] are going to do," but rather than nurses having an influence on the staff, staff are acknowledging what the patient wants to do, not what the staff nurse wants them to make the patients do.'

In July, during another informal discussion I had with the operations manager, he gave a narrative regarding a 'coup' involving staff nurses. He stated, 'At [hospital B], nurses had a meeting and pulled the manager in when she was really new and did a coup. They said, "Care workers should not be allowed to allocate duties." We made a lot of improvements when we introduced this… and they [staff nurses] sabotaged that process.' His narrative strongly indicated the presence of tribalism by members of the nursing team who felt threatened by the advancing role of care workers.

6.4.2.1 Reflexive outcomes

The operations manager's account made me aware of the political nature of action research and how the change process could be easily disrupted by those who stand to lose power (Coghlan and Brannick, 2010; Tripp, 2005). This awareness

made me feel that unless staff nurses recognised the importance of democratic ways of working, EALIM's adoption could be sabbotaged by them.

6.4.3 Staff nurse resistance to knowledge sharing

When I presented my findings on staff nurse culture during an evaluation meeting in May, the COO responded 'I was speaking to one nurse only a couple of weeks ago who said, if "I showed care workers everything, they might take my job." The COO's empirical observation was supported by the operations manager in July, when he described how he had presented my cycle-one findings to a group of staff nurses, in an effort to redress conflicts. He claimed '…they agreed their main allegiance is to their profession…they also discussed why they're reluctant to share knowledge.' When I asked him what reasons they gave, he replied 'A fear of losing their job because they see support workers becoming more predominant.' Empirical accounts from both the COO and operations manager suggested staff nurses' resistance to knowledge sharing with care workers was impelled by a fear of loss regarding position and power.

6.4.3.1 Reflexive outcomes

I remember feeling astonished when I heard that staff nurses agreed with my findings concerning their underlying assumptions, as I did not anticipate they would readily admit to them. On reflection, I thought this level of openness from staff nurses was perhaps a positive sign, indicating a step toward reframing their assumptions.

6.4.4 Defensive reasoning from three top managers

While sharing my findings of top management culture in evaluation meetings, the CEO, the operations director and the marketing director appeared defensive of top management routines, especially in regard to managerial control. Their respective comments include 'The way we are regulated has created some of this,' '…your point about we know better than the staff is because we're the people that liaise directly with the CQC and know exactly how it's to be done' and 'I think because we're governed so tightly by the CQC, we govern others so tightly.' Although their

responses indicated implicit agreement with my findings, they blamed the CQC for their use of managerial control, used rationalisations to justify their actions and did not seem to critically question their underlying assumptions.

Another case of defensive reasoning I perceived was when I addressed my finding that care workers value social interaction and appreciation. The marketing director and operations director respectively commented, ‘It is something that we don't do enough of, but there really aren’t enough hours in the day' and ‘That would be lovely but there's just no time to do that.' Their comments not only indicated resistance to EALIM’s servant leadership and appreciative approaches, but also signified greater commitment to managing processes and productivity, than to engaging and encouraging employees. In an effort to prompt both directors to think reflexively, I asked what would happen if we don't spend a few minutes to show staff we care? Their responses include 'Never mind staff getting any support from me...we have to rely on managers doing some of that because it's so time consuming' and '..,we know we need to.' Although my question was designed to prompt double loop learning, it did not appear to have the desired effect because both directors replied with the same reasoning they used to defend their theory in use (i.e., lack of social interaction with care workers). My exegesis for their defensive response is that my finding stimulated a sense of guilt, which they chose to repress by using rationalisations (i.e., lack of time) to justify their lack of social interaction with care workers. For example, their comments of ‘It is something that we don't do enough of’ and ‘…we know we need to,’ implied a sense of personal failure to achieve what they knew was a moral ideal (Gabriel, 1999).

Before I was able to present my findings on the seven concepts, both of these directors informed me they were 'tight for time' and within minutes, gathered their belongings and left the evaluation meeting. Their behaviour may have signified they felt awkward answering my questions or discussing aspects of my analysis and sought to avoid embarrassment by departing early.

6.4.4.1 Reflexive outcomes

The abrupt end to the evaluation meeting with the operations director and marketing director left me feeling frustrated. However, after much self-analysis, I became aware that the frustration I felt was perhaps more fuelled by my own unconscious heroic phantasy of making the world a better place, than by their perceived defensive behaviour. Thereafter, to limit the influence of negative emotions and biases upon my empirical interpretations, I sought to refocus my efforts to examine why participants resisted change efforts.

6.4.5 Evaluation meetings enabled commitment toward change

While there were mixed reactions from top managers in all three evaluation meetings, responses from the seven top managers (i.e., the COO, care director, operations manager, compliance manager and three senior managers) who participated in the first evaluation appeared the most positive. For example, while presenting my findings on top management culture, their responses include ‘Some of this is pretty anal stuff in terms of control,' 'Instead of anxiety…we need creativity transferring through the organisation' and 'A lot of this is not having confidence in staff...so it seems to me that a lot of the other problems may stem from that.' Responses from these top managers suggested they examined the assumptions influencing top management behaviours, recognised some of the unintended consequences of their action strategies and accepted the need for cultural change.

During our discussion of the culture of care workers, top managers from the first meeting also made the following comments: 'I think they feel very alone,' 'When I now reflect, it's a fact that the organisation looks at patients and neglects services for the staff,' '…there's a lack of space for staff to go and have lunch so now they're going into bedrooms and we're telling them off for doing that,’ '…the kitchen is always hot and they've raised the concern on numerous occasions' and ‘Like James was saying, it's the top management control or the authorisation.' These responses suggest my analysis allowed top managers to affectively re-interpret

their organisational world from a care workers perspective and to recognise their causal responsibilities toward the subjugation of care workers.

As I discussed my assessment for each of the seven concepts, the seven top managers from the first evaluation, along with the CEO, responded to specific thematic findings, which include:

- Bettercare values patients and profit more than staff – ‘Their contribution has been less valued and I think based on this information it does produce a them and us perspective' and 'If you value the staff, they value the patients.'
- Defensive reasoning by top managers – ‘…being able to admit that is the first step to moving forward' and ‘It’s about triple loop thinking, asking why are you thinking that way.’
- Low pay is a demotivating factor for care workers – ‘Pay can be re-worked...we just have to be creative about it’ and ‘We need a better paid team.’
- Problems with internal integration – 'I accept it’s happening’ and ‘There's got to be a way we can address this.’
- Learning is mostly based on codified and explicit knowledge sharing – ‘I'd love to get away from that and maybe your model will help us’ and ‘We are going from five manuals down to one.’

The responses above demonstrate that these top managers thought reflexively, conceptualised the issues, generated ideas to ameliorate problems and were committed to organisational change. When I informed the COO I would be returning in October and December to repeat my interviews, he responded, ‘I think we need to work hard…before you start picking it up again.’ I took his response to mean he was committed to the continuing process of EALIM’s adoption.

6.4.5.1 Reflexive outcomes

Although most top managers explicitly validated my cycle-one findings and showed signs of double loop learning, I reasoned there may not be sufficient time

to realise significant cultural change before I commenced gathering information in November 2012 for cycle three – post implementation of EALIM. With this thought in mind, I decided to roll out a series of EALIM mini-seminars in order to galvanise organisation wide commitment to EALIM and gather information on participants' acceptance and resistance to its concepts.

6.4.6 Participants' responses during EALIM seminars

Participants' responses during EALIM seminars and mini-seminars found below are categorised in accordance with each concept I presented.

6.4.6.1 Responses to EALIM's ethical concepts

While I presented EALIM's core values, most participants responded with positive comments, indicating their explicit acceptance of them. Middle managers comments include 'Compassion is intrinsic to all aspects of care,' 'Altruism is a strong value,' 'When we first qualified, that's what nursing was all about,' I've been sitting here smiling for about five minutes' and 'You're bringing back old virtues and values into care that have been lost for years.' I interpreted middle managers' comments to mean they strongly identified compassion and altruism as core healthcare values. However, after I proposed that compassion could be developed through practice, one middle manager in November's seminar appeared to disagree when she said, 'I think people have it or they don't.' In response, two other managers retorted 'You can teach somebody to be compassionate' and 'Compassion tends to rub off on others,' implying a perception that compassion could be cultivated in and through role modeling and practice.

Participants' who made comments during my presentation on CSR seemed inclined toward corporate philanthropy, community volunteering and environmental sustainability. For example, several participants in most seminars described their charity fund raising efforts and expressed an interest in future corporate philanthropic projects, while others explicitly affirmed their commitment toward recycling with comments such as 'You've got to recycle' [assistant manager] and 'We should educate our patients to recycle' [staff nurse]. These responses

indicated participants' were inclined toward participating in CSR activities – an interpretation consistent with the cycle one finding in which middle managers and frontline staff espoused the value of social responsibility.

6.4.6.2 Responses to EALIM's adaptive concepts

During my presentation on chaos theory, there were fewer responses from participants in all the seminars, which could have meant the subject was unfamiliar to them. However, most participants showed explicit support of EALIM's dual methods of ordinary management (i.e., rational, formal and analytical) and extraordinary management (i.e., creative, informal and intuitive). Their responses include 'If you have a manager who is just formal the whole time, they never know what's going on in the unit because staff are too scared to approach them' [assistant manager], '…you have to use your gut feeling [assistant manager] and '…managers should be flexible in using either approach' [middle manager]. Furthermore, one middle manager from November's seminar gave a narrative regarding how a 'hug' and 'a bit of loving' enabled one staff member to change from being one of the 'weakest' to one of the 'strongest' members of her team. Her narrative suggested she had an informal and caring approach – an interpretation congruent with the cycle one finding in which middle managers used a humane leadership approach.

In regard to the use of intuition, one middle manager from November's seminar gave a narrative regarding how he used his 'gut feeling' to avoid dismissing a staff member and another manager in January's seminar described using her 'gut feeling' when making recruitment selection decisions. While these responses suggested support for the use of intuition, not all managers agreed to its use. For instance, one middle manager stated 'I prefer to be policy led…when problems hit the ground, that makes you a little bit guarded about using your gut feelings,' while another espoused, 'I see policies and procedures as the complete safety thing.' I interpret these two middle managers' responses to mean they experienced anxiety when departing from the dominant schema of using policies and formal systems.

6.4.6.3 Responses to EALIM's learning concepts

During discussions of triple loop learning (Flood and Romm, 1996), participants' responses include 'With reflexivity… you can have a better understanding of why you set those goals and why you want to achieve them' [assistant manager], 'If we did that and made that a part of our routine, that would also help to deal with a lot of the attitude problems' [middle manager] and 'I frequently ask myself why I am doing things a certain way' [middle manager]. These responses suggested triple loop learning resonated with participants, who seemed to understand the value of its adoption. However, one assistant manager from February's seminar remarked, 'This is hard for people, they are so fixed in their way sometimes,' denoting a perception that triple loop learning would be problematic because people find it difficult to change their thoughts and behaviours.

During a discussion on communities of practice, participants from most seminars explicitly agreed with the idea of managers meeting regularly to share best practice and several staff nurses similarly agreed with regards to meeting nurses from other units to share knowledge.

Several managers from the November and February seminars explicitly agreed with trans-disciplinary project teams and made a point that no one from the clinical team was involved in the design of the buildings. Their point seemed to imply, integrating ideas from across disciplines could have provided a more durable design to company facilities. However, most participants in all seminars did not comment on EALIM's story telling and boundary spanning methods, implying they did not find these methods as valuable as the other learning methods I presented.

6.4.6.4 Responses to EALIM's improvement concepts

In all seminars, the only improvement techniques participants positively responded to were voice of the customer (VOC), the five whys, nominal group technique (NGT) and Pareto principle. A variety of participants responded to my presentation of these techniques with nods of agreement and utterances including 'Yes,' 'Definitely' and 'Sounds good.' In regard to VOC, one middle manager from the

November seminar stated, ‘Staff should be involved in this process as they often know what makes patients happy and unhappy.’ His response not only implied agreement with VOC, but also with EALIM’s tenets of democracy and collaboration. In relation to the Pareto principle, two participants commented ‘Yes, the big issues…those patients that take up our time for weeks on end’ [staff nurse] and ‘Focusing on the biggest needs’ [middle manager]. These participants implied they understood the importance of focusing on the vital problems they experienced from day to day.

6.4.6.5 Responses to EALIIM’s ten tenets

From the ten tenets I presented, participants only commented on the quality chain, servant leadership and practice-based learning. Responses to the quality chain include ‘I think that's what I'm trying to teach staff’ [assistant manager], ‘If staff are supported their needs will be met, then they will support the needs of patients’ [assistant manager] and ‘If you are not getting your needs met, how are you going to help the service users?’ [care worker]. Although these participants appeared to accept the quality chain concept, one middle manager from January’s seminar appeared to disagree when she said, ‘You can't just serve the needs of staff; you have to serve the needs of patients.’ I interpreted her response to mean staff should be focused on being patient-centric.

Responses from participants indicated they agreed with servant leadership, which include ‘It fits into the first aspects of ethics you were talking about, doing unto others…’ [middle manager], ‘If you make people happy, you will get production’ [care worker] and ‘We can be an example to others’ [assistant manager]. These types of responses indicated that participants recognised the value of servant leadership as a principle for transforming followers.

Comments in relation to the tenet of practice-based learning include ‘People don’t learn by reading a policy but by what they are shown practically…staff need to see how it’s done’ [middle manager], ‘Working alongside them gives them the confidence’ [assistant manager] and ‘…a person who can sit in the office, never

shows their face and just says “you do that”…you don't build a team like that' [assistant manager]. These comments implied that participants supported practice-based learning and understood the importance of tacit knowledge sharing.

6.4.6.6 Reflexive outcomes

Since participants seemed confident in sharing their criticisms or misgivings of EALIM during seminars, I did not perceive them to assuage their concerns because of my perceived position in the organisation. Consequently, I relied on their responses as an authentic account of their views.

6.4.7 Responses to Quaker space

During the Quaker space seminar I delivered in August 2012, most top managers responded with positive comments, indicating their agreement to its principles. These include ‘The term without judgment from the slides is an important issue,’ ‘I find this valuable’ and ‘I think the challenge with this is if someone gives you an answer that you think is pretty daft, rather than telling them that won’t work we should think about using questions…to get them to a place where they move on to something else.’ Furthermore, the operations manager gave a narrative of how he ‘used some of the principles of Quaker space’ during a group session with nurses and care workers to help reconcile their differences. He remarked, ‘It was useful in getting them to better understand each other’ and ‘I was impressed with how honest they were.’ His narrative suggested the adoption of Quaker space principles could enable greater transparency and inter-subjective understanding among staff. Although most top managers indicated commitment to adopting Quaker space, the CEO seemed to differ when he remarked ‘When incidents happen, there is pressure from the CQC to deal with those responsible and a blame culture can't be helped.’ I interpreted the CEO’s response to mean he was inclined toward the use of defensive reasoning, since he appeared to justify blaming others for incidents.

6.4.7.1 Reflexive outcomes

I was not surprised by the CEO's defensive response (i.e., 'a blame culture can't be helped') because he had demonstrated the use of defensive reasoning in a previous evaluation meeting in which he supported the use of defensive routines. I therefore felt he could block the cultural change that was necessary for EALIM's successful adoption.

6.4.8 Summary of key findings of acceptance and resistance to EALIM's adoption

The adoption of EALIM influenced a change in company policy that shifted the emphasis from explicit knowledge sharing through centralised training courses, to practice-based knowledge sharing at each local site. However, staff nurses were resistant to share knowledge with care workers, because of their perceived fear of loss regarding their position and power. In addition, staff nurses were resistant to collaboration, which they attributed to their perceived threat of the advancing role of care workers.

Three top managers also showed resistance to EALIM. During evaluation meetings, they used rationalisations to defend their use of managerial control. However, the greatest resistance was shown by the marketing director and operations director, who both indicated more commitment to managing processes and productivity, than to engaging with and encouraging employees. However, most top managers expressed a positive response to EALIM's adoption and accepted the need for cultural change. Furthermore, evaluation meetings played a critical role in allowing top managers to re-interpret their organisational world, recognise the unintended consequences of their action strategies and generate ideas to ameliorate organisational problems. Among all top managers, the COO expressed the greatest commitment toward EALIM's continuing adoption, which appeared to be driven by his recognition of the need for cultural change.

During EALIM seminars, middle managers and frontline staff signified their acceptance of most EALIM concepts and methods. Whilst they explicitly agreed

with EALIM's core values, middle managers in particular, strongly identified compassion and altruism as core healthcare values. Participants also inclined toward corporate philanthropy, community volunteering and environmental sustainability. Although most middle managers explicitly agreed with EALIM's ordinary and extraordinary management methods, some managers experienced anxiety with departing from the formal schema of using policies. However, most participants appeared to agree with the concept of triple loop learning, including the use communities of practice and trans-disciplinary project teams. While story telling and boundary spanning methods attracted the least response, participants supported the Pareto principle, VOC, five whys and NGT improvement techniques. With regards to EALIM's tenets, participants responded positively to the quality chain, servant leadership and practice-based learning. Although the CEO resisted the use of Quaker space, most top managers expressed agreement with its principles, implying it could enable greater responsible learning among staff.

6.5 EALIM's Impact on Organisational Improvement

Findings in relation to the impact EALIM had on organisational improvement are found below and are organised in accordance with the specific themes that emerged during EALIM's implementation. These themes include a positive change to board meetings, a top management restructure, less bureaucracy and more empowerment, a reduction in codified knowledge sharing, the use of community groups (an initiative which emerged during EALIM's adoption) and how corporate philanthropy strengthened perceptions of Bettercare.

6.5.1 A positive change in board meetings

During an informal discussion with the CEO in November 2011, I shared my interpretation of the chairman's controlling intervention in board meetings. Upon hearing this, although the CEO said he felt 'frustrated because he [the chairman] constantly stops conversations in mid-flow,' he admitted the matter had not been addressed with the chairman. I perceived the CEO's response to mean he had been repressing his feelings due to excessive conformity pressures. However, after I suggested making board meetings more informal and less structured (in

accordance with EALIM's extraordinary management approach), he committed to 'pilot test' this new approach for 'three months' at his house to create a more informal setting. A few days later he emailed all directors to inform them of the changes and stated these would commence from December 2011. A copy of his email can be found in appendix 16.

On the morning of the board meeting, the CEO spontaneously asked me over the telephone to chair the meeting because he and the chairman could not attend. After agreeing to his request, I started the meeting by giving participants the autonomy to choose how they wanted to proceed. Following a short discussion among participants, they began a forty-five minute review of outcomes from the previous month. During this time, participants freely discussed issues at length, produced emergent ideas and agreed on new action plans without any intervention from me. For the remainder of the meeting, participants took turns sharing their monthly reports, during which time I only intervened with the occasional question to clarify an issue or to prompt specific participants for their opinions when they seemed quiet. I took this approach to redistribute power among participants and allow them the autonomy to self-organise the meeting.

Later that afternoon, the facilities director and operations manager gave me their perceptions of the board meeting and although the CEO had not attended, he gave me feedback from other directors who had attended. Their comments include '…discussions were a lot easier and more people got involved as opposed to one person talking and everyone else listening,' 'I felt more included…we should be able to be free' and 'Directors said they were more involved…discussions were more productive.' These comments indicated freedom and egalitarianism were distinguishing features of the meeting that seemed to improve discussions and generate better inclusion. Participants also stated, 'We made a lot of decisions,' 'This is the first time we tried to look at the root causes and why something was happening' and 'Everyone is contributing towards solutions…there were a lot of new ideas and improvements to the action points.' Their responses signified the

changes introduced at the meeting, improved idea generation and participants' decision-making and problem solving capabilities.

Given I had chaired the meeting, I decided to attend another board meeting in August 2012 as a total researcher, to examine the sustainability of these improvements. The CEO chaired the board meeting and began proceedings by asking, 'What shall we talk about? I'm open to ideas.' I construed his opening question as a stark contrast to the highly rigid and agenda driven board meetings I observed in the first cycle. Furthermore, members did not appear restrained in challenging each other's views or suggesting alternative strategies to the status quo. For example, during a debate regarding staff room space, the CEO remarked, 'I just don't like any staff room bigger than two people standing.' In response, the COO retorted, 'You've got to be humane about it' and the operations manager remarked, '…even if they [staff] are not going to eat or drink, they need to have that 10 to 15 minutes break away.'

6.5.1.1 Reflexive outcomes

After the December board meeting, I was sceptical as to whether the improvements could be sustained once the chairman returned to chair board meetings, because of his rigid and controlling leadership style. However, after I attended the board meeting in August 2012, I was pleasantly surprised to find the informal and less structured approach had been maintained, since I thought behavioural norms relating to the former board meeting style could have resurfaced.

6.5.2 Top management restructure

During an evaluation meeting in May 2012, the CEO and I discussed the leadership styles of both the chairman and COO. In the discussion, he described the COO as someone who was 'good at problem solving' and 'getting people together,' but with regards to the chairman, he remarked '…he hadn't made any contribution for years' and '…what this [pointing to my handouts] revealed is to what extent it was negative.' I construed the CEO to mean he was unsatisfied with

the chairman's leadership role and was contemplating a top management restructure. Later that month, the CEO informed me the chairman's post was made redundant and he had given the COO 'more power to lead' and 'line manage' all directors. I therefore interpret a link between the process of EALIM's adoption and a change in top management structure.

At the focus group in July 2012, while the COO was giving a progress update on the organisational changes he introduced since the last meeting (in April), I asked what took him so long to introduce some of them. He replied 'The chairman was the obstacle' and gave various examples, illustrating how the chairman consistently resisted change efforts. These examples include the following:

- In one meeting, the chairman 'walked out' after the COO proposed the operations director should chair operational meetings.
- In another meeting, after the COO proposed a review of how risks were rated in inspection audits, the chairman became 'angry' and said 'how dare you.'
- Two months after the informal changes were introduced to board meetings, the chairman 'reverted to the same agenda as before' and 'had a lot of control.'

The above examples suggested the chairman consistently resisted power sharing and collaboration. Furthermore, when I asked who made the decision to dismiss the chairman, the COO replied, 'I made that decision and since he left we've been rolling…it's only now he's been vanquished can the organisation move on.' His reply implied the chairman's departure facilitated the adoption of EALIM and enabled positive organisational change.

6.5.2.1 Reflexive outcomes

After the CEO informed me that the chairman's post had been made redundant, I was unclear as to who made the decision to dismiss him, which is why I asked the COO in the focus group. Given the chairman's historical role in the organisation and the authoritative figure he symbolised, I was surprised by the COO's decision

to dismiss him. I therefore perceived the COO's decision as both creative and courageous.

6.5.3 Less bureaucracy and more empowerment

In the July focus group the COO claimed that since the CEO had given him 'more responsibility and authority to lead,' he felt 'trusted' and 'able to make more decisions.' One of the first decisions the COO described was to 'devolve the authority to the next level and then to devolve it down again.' His account denotes that being empowered with 'more responsibility' created a requisite 'trust,' allowing the transference of empowerment down the hierarchy. Both the COO and care director gave the following examples, elucidating how this empowerment was transferred down the line:

- Top and middle management involvement in localised training – 'We got rid of all the external training…so the idea is that all of the training is done internally on site' and 'We've all got a topic each and managers consistently go round the units giving the same message.'
- Integration of HRM at middle management level – 'Each manager is responsible for their own HR' and 'They're managing HR on a day to day basis...like hiring and firing.'
- Less managerial control from top management – 'In the past it's always been "this is how you do this" but now we say, "tell me what you've done about it" and 'Our role is about support and guidance, rather than prescriptively telling people what to do.'

These examples signify the COO created organisational changes to reduce bureaucracy and empower middle managers with greater choice and responsibility for the quality of their own work. In response to hearing about these changes, I asked how everyone was coping. The COO replied, 'Do you remember when you did the feedback [in the evaluation meeting], you talked about chaos theory and I think you wrote an article about it...well everybody embraced it.' His reply suggested top managers acceptance of EALIM's adaptive concept had enabled a

psyche for change – that is, they felt less anxious or more mentally prepared for change.

6.5.3.1 Reflexive outcomes

I came away from the focus group feeling that the timing of the COO's new leadership responsibilities had been fortuitous, as I perceived him to be a strong protagonist of EALIM who was committed to positive organisational change.

6.5.4 Less codified knowledge sharing

In the July focus group, the COO also described making a significant change to the policy manuals. He stated, '…we reduced the policy manuals from five to two,' creating an overall reduction in policies and procedures by '75 percent.' This outcome indicated the organisation had become less dependent on codified knowledge sharing. The COO also claimed the reduction in policy manuals had 'gone well' and supported a 'coaching culture.'

Members of the clinical team who attended the focus group in August 2012 corroborated the COO's claim of a 'coaching culture.' During the meeting, they described their involvement in 'microteaching' frontline staff, which include consistently visiting different units across the organisation to 'observe,' 'coach' and 'teach' staff during activities with patients. For example, one therapist stated, 'I go round the units observing them [staff]. I make them aware of their behaviour and then make them aware of the consequences of their behaviour. It's really helpful to them.' Another therapist described how her 'role' was to 'empower occupation and engagement in occupation.' Their descriptions implied knowledge sharing had shifted from a codified context, to an approach that lent itself to tacit knowledge sharing through practice and reflection.

6.5.4.1 Reflexive outcomes

After reflecting on participants' interactions within focus groups, I became aware of how much I shaped discussions. Nevertheless, I perceived many of the ideas for changing organisational practices had evolved directly from group members,

which holds greater propensity for success compared to ideas imposed on group members (Gill and Johnson, 2010).

6.5.5 Community groups – a trans-disciplinary initiative

In January 2012, I asked participants at the focus group for suggestions regarding how EALIM's ethical values could be adopted across the organisation. During the discussion, the COO suggested using 'community groups.' He described them as twenty-minute daily morning meetings that could take place in the main communal area of hospitals and care homes, so local patients, staff, managers and clinicians could collectively discuss ideas and agree 'what's going to happen for the day.' He stated this community group initiative could 'Bring ethical issues to the fore…provide structure to the patient group as well as staff' and '…bring the important decision-making of the unit to staff and patients, rather than the typical hierarchy of management.' I was impressed by the COO's proposed initiative because it embodied trans-disciplinary team working and was consistent with EALIM tenets of democracy, collaboration and empowerment. Before the focus group ended, participants suggested various ways in which community groups could be implemented and the COO committed to discuss its adoption with middle managers and the clinical team.

In the February focus group, the COO confirmed community groups had been 'piloted' in one hospital and claimed '…activities for patients is one of the big issues that became considerably better because of the group meetings' and 'patients are making decisions as well.' The COO's account implied the use of community groups had improved patient activities and at the same time, empowered patients to shape the service they received. At the end of the focus group the COO said he would 'roll it out' across the organisation.

During an informal discussion with the operations manager in April 2012, I asked him how community groups were progressing. He replied, 'They are going great. They involve both patients and staff in planning activities, how the shift would run, what the patients would like to do and who would be doing one-to-one work with

patients.' His comments suggested community groups were a focal point for communicative interaction and their use had enabled the redistribution of power from the hierarchy to both staff and patients. The operations manager also claimed 'activities are better organised' and 'staff nurses are not the only ones making decisions.' His response corroborated the COO's claims that community groups had improved patient activities and enabled shared decision-making.

In the April focus group, the COO and care director confirmed community groups had been implemented in 'every unit' and each manager was 'responsible for the community group happening every day.' The care director described being 'really surprised' after he attended a community group the previous day, where he observed a patient who instead of 'normally sitting in the background without saying much,' was 'quite assertive about what she wanted to do.' The care worker who attended the focus group also added, 'This morning one of the patients chaired the community meeting…you can really see it's boosting her esteem really. It was just nice that she could sort of have the conversation with her fellow service users and speak to them, because usually she's quite intimidating to the others and for her to be able to talk to them reasonably rather than shouting was really encouraging.' According to these two empirical accounts, patients' participation in community groups seems to have enabled greater confidence in their self-advocacy and more meaningful interaction with others.

6.5.5.1 Reflexive outcomes

Although the COO claimed community groups had improved patient activities, after some reflexive thinking I realised he could have been subjectively biased towards its success, since he had created the initiative. For this reason, I gathered information from other participants who attended community groups, in order to confirm or disconfirm the COO's claims.

6.5.6 Corporate philanthropy strengthened perceptions of Bettercare

During the field trip to India in January 2012, I noted participants' comments during our visit to the slum in Mumbai and the location of the school and orphanage. Their comments include 'If these children did not come here, what future would they have' [operations manager], 'The happiness and the smiles on the children's faces as they were receiving their food, that's what it comes down to' [compliance manager] and 'The project is so touching because you can see the children are happy, they are clean, they've got shelter' [administrator]. Their comments implied that meeting felt needs like 'food,' 'shelter' and 'happiness' was an important aspect of the project that made participants recognise its humanitarian impact. On the evening before our departure, I asked participants to describe what the experience of the trip meant to them. Their responses include 'What I really like is that we are an organisation back in England that cares, that will help people' [compliance manager], 'The love that [shareholders] have...I've been taught a powerful lesson to love and to give' [administrator], '…that we've had an involvement to help people, was really touching for me' [care worker] and 'It's an honour to be involved' [project coordinator]. I interpreted participants' use of words such as 'love', 'care' and 'help' to signify ego ideals that they identified with Bettercare and its shareholders.

The following month, the marketing director emailed information of the India project to various purchasers, which included a link to a YouTube video of the trip. The marketing director informed me she had received eight responses from purchasers and stated, 'All the responses had been very positive.' These responses include 'The work certainly is amazing…the film illustrates the tremendous impact made for the local community and benefits for the children,' 'Wow that's really impressive in these days of austerity' and 'It looks like a very special project…congratulations on making a difference elsewhere.' These responses indicated external stakeholders commended Bettercare for its philanthropy and valued the social impact of the project. Furthermore, participants who had been at staff meeting presentations of the project or had seen the project on YouTube, made positive comments during focus groups and EALIM mini-

seminars. Their comments include ‘It's nice to know the work we’re doing with clients here is making a difference around the world’ [care worker], 'The thing that was fairly striking for me is you see the funds going to the right people' [care director], ‘The India project was good’ [care worker] and 'I was very proud to be part of a company that would put their money that way [staff nurse]. These comments indicated participants had identified the project as a worthy social cause and valued the organisation’s economic contribution.

6.5.6.1 Reflexive outcomes

My experience of the trip changed my worldview because it stimulated awareness of the privileged way of life I took for granted and made me realise how much my understanding was being shaped by the research.

6.5.7 Summary of key findings of EALIM’s impact on organisational improvement

The use of EALIM’s extraordinary management approach in board meetings appeared to generate autonomy and egalitarianism among participants. These features led to improvements in participants’ discussions, decision-making and problem solving capabilities.

The process of EALIM’s adoption led to a positive top management restructure, facilitating greater empowerment down the line. This empowerment manifested in less bureaucracy and managerial control, enabling middle managers to have greater autonomy over the quality of their own work. Top managers’ seemed more prepared for change as a result of accepting EALIM’s adaptive concept. EALIM’s adoption also influenced a significant reduction in codified policies and procedures, and enabled a shift from codified knowledge sharing to tacit knowledge sharing in and through practice and reflection.

Perhaps the most significant initiative supporting EALIM’s adoption was the organisation wide implementation of community groups, since the concept of these groups was consistent with EALIM’s constructs of democracy, collaboration,

empowerment and trans-disciplinary team working. Not only did these groups allow the redistribution of power and decision-making from the hierarchy to both staff and patients, but they also enabled patients with greater confidence in their self-advocacy and more meaningful interaction with others. Finally, corporate philanthropy strengthened perceptions of Bettercare. Participants who attended the field trip indicated a sense of shared pride in being associated with Bettercare, and employees and external stakeholders who viewed the video of the trip admired the social and economic impact of the project.

6.6 Discussion

While other TQM studies show that middle managers resisted TQM efforts (e.g., Beer, 2003; Coulson-Thomas, 1992; Thiagarajan and Zairi, 1997a; Zink, 2007), findings from this study indicate otherwise, which could be attributed to middle managements strong identification with EALIM's moral values of compassion and altruism. While chaos theory attracted the least response during seminars, most middle managers explicitly agreed with EALIM's adaptive methods of ordinary and extra-ordinary management and gave examples supporting their use. This finding resonates with the notion from Stacey (1996, p.275) that organisational members operate in two systems – a 'shadow system' of socialisation and informal support and a 'legitimate system,' representing the dominant schema of policies and procedures. Although two middle managers expressed anxiety with departing from the schema of policies, the rest supported the use of intuition and informality. This finding suggests most middle managers were occupying a 'creative space,' which Stacey (1996, p.185) argues is a prerequisite for evolutionary change. In other words, most middle managers seemed mentally prepared to depart from technocratic and bureaucratic schemas.

The significant reduction in Bettercare's policies and procedures was a vital step towards dismantling a bureaucratic paradigm, characterising healthcare management (Nwabueze, 2004). Although healthcare organisations warrant the use of written rules and procedures due to their highly regularised environments (McSherry and Pearce, 2007; Parkin, 2009), a procedure-laden approach leads to

a culture of codified knowledge sharing, which to all intents and purposes is detached from tacit kinds of knowledge, learned through experience and practice (Collins, 2013; Newell et al., 2009). The impact EALIM had on shifting learning to a practice-based context was a positive step towards ameliorating deficiencies in staff knowledge, since practice-based learning holds potential for greater inter-subjective understanding and mean-making (Hislop, 2009; Newell et al. 2009).

Nevertheless, not all organisational members were inclined to share knowledge. The fear of losing power and position that impelled staff nurses' resistance to knowledge sharing, exposed a deep anxiety with maintaining their sense of identity (Stacey 2010) and is consistent with the narcissism I interpreted among staff nurses in the first cycle. While a healthy amount of narcissism is vital for developing a sense of self-worth, having too much (i.e., dysfunctional narcissism) can cause character problems (Kets de Vries, Carlock and Florent-Treacy, 2007). According to Schwartz (1999), narcissistic characters typically fear anything posing a threat to their self-interests and is a precursory emotion that can trigger a spiral of other emotions like anxiety, aggression and hostility (Gabriel, 1999). The interplay of these emotions seemed evident when a group of staff nurses attempted to overthrow middle management efforts to empower care workers with greater responsibilities. This situation perhaps illustrates the complex emotional constellations that shadow organisations, which many TQM studies overlook.

The resistance staff nurses showed towards collaboration is emblematic of individuals with dysfunctional narcissism, which according to Kets de Vries, Carlock and Florent-Treacy (2007), tends to undermine teamwork and shared decision-making. While there is no suggestion in this study that all staff nurses were narcissists, their resistance to collaboration is consistent with other TQM studies (e.g., Joss, 1998; Kanji and Moura e Sá, 2003; Potter, Morgan and Thompson, 1994). At Bettercare, the operations manager's contestation with a staff nurse who subverted the shared decisions made in a community group, symbolised the paradigmatic conflicts between TQM concepts of empowerment

and participation, and a clinician's commitment to administrative authority and professional autonomy (Short and Rahim, 1995).

Staff nurses were not the only organisational members to display resistance to EALIM's adoption. During evaluation meetings, the three top managers who used rationalisations to defend their use of managerial control signified single loop learning, which reinforces existing theories in use (Argyris, 1993). According to Flood and Romm (1996), single loop learning can result in an obsession with means and ends that precludes wider questions in relation to the fairness of practices, which seemed evident in the case of two directors who were unwilling to question the appropriateness of their lack of social interaction and appreciation of staff. These directors' use of managerialism resonates with the argument from Lewis, Passmore and Cantore (2011) that organisational leaders with hectic schedules often suppress meaningful human contact and social relationships in the interest of productivity. The implications of this sort of technocratic managerialism include a sense of deep detachment between leaders and followers and the production of negative emotions, inhibiting improvement (Lewis, Passmore and Cantore, 2011). Although I attempted to stimulate double loop learning from these two directors, my efforts were met with the same defensive reasoning they used to justify their actions. I therefore identify with Argyris' (1993) argument that when participants' sense of competence is highly dependent on their defensive routines, efforts to re-educate those individuals will be likely met with the same reasoning the intervener is attempting to change.

The CEO also exhibited defensive reasoning during the Quaker space seminar, since he resisted alternative ways of thinking outside of his conventional mental paradigm (Argyris, 1993). According to Argyris (1991), defensive reasoning not only prevents people from discovering new ways of learning, but also from identifying their contribution to organisational problems. Conversely, the seven top managers who attended my first evaluation meeting responded positively to my findings and showed signs of double loop learning. This outcome supports the notion from several authors that feedback of the researchers' analysis is a vital

stage in action research, which encourages alternative ways of engaging organisational issues (Gill and Johnson, 2010; Schein, 2010). In particular, my analysis allowed these seven top managers to re-interpret their organisational world from a care workers perspective. This process could be explained as a rudimentary form of 'projective identification,' which in its simplest form involves projecting a part of one's self (ego) into another person (the object) to better understand 'what it feels like to be in their shoes,' forming the basis for empathy and affective decision-making (Armstrong, 2005, pp.72-73). These top managers' openness to adopt alternative ways of thinking was a considerable step toward Bettercare becoming a learning organisation (Argyris, 1991).

What also facilitated change among these seven top managers was their acceptance of EALIM's adaptive concept, particularly in relation to chaos theory. Their acceptance seemed to enable a psyche for change and supports the notion from complexity authors (e.g., Senge, 2006; Stacey, 2010) – that is, adopting a complexity way of thinking allows individuals to positively embrace uncertainty. A limitation of many other TQM frameworks (e.g., Besterfield et al., 2003; Deming, 1986; Hoyle, 2007; Nwabueze, 2001a; Oakland, 1993) is they do not adequately address the emotional aspects of organisational life that block change (i.e., the fear and anxiety that change evokes), since TQM systems are 'fundamentally cybernetic in nature' (Stacey, 2010, p.39).

The adoption of EALIM's adaptive methods also yielded positive changes to board meetings. For instance, the egalitarianism and autonomy generated from changing board meetings to a more informal structure were consistent with the conditions of 'communicative rationality' (Habermas, 1978, p.2), meaning participants had autonomy to engage in open debate and express their assertions in a climate excluding non-rational coercive influences (Habermas, 1978). Since these conditions influenced improvements to board members problem solving and decision-making capabilities, this research supports the notion that the use of communicative rationality could bring about a more ethical and morally sensitive

culture of improvement (Ahmed and Machold, 2004; Hazlett, McAdam and Murray, 2007; McAdam and Leonard, 2003).

Another positive outcome during this cycle was the impact corporate philanthropy had on participants' perception of Bettercare. According to Shwartz (1987), when an organisation becomes an ego ideal, it becomes an object holding the promise of a return to a loving world. This intra-psychic process seemed realised when participants who attended the field trip identified Bettercare with ego ideals of 'love' and 'care.' In such cases, Gabriel (1999, p.90) argues the organisation symbolises an 'omni-benevolent mother with whom the individual fuses.' Two employees appeared to experience this fusion when they remarked, 'we're an organisation back in England that cares' and 'the work we're doing with clients here is making a difference around the world.' Although not all participants indicated fusion with the organisation, employees and external stakeholders perceptions of Bettercare were strengthened as a result of the social and economic impact of the project. This outcome supports the argument from Kotler and Lee (2005) that adopting corporate social initiatives engender positive perceptions of an organisation.

A key prerequisite for EALIM's successful adoption was the commitment of the COO and care director, evidenced by their consistent attendance to focus groups and active implementation of agreed action plans. This finding supports many other TQM studies showing top management commitment and visible involvement were key factors for its successful adoption (Coulson-Thomas, 1992; Fotopoulos and Psomas, 2010; Thiagarajan and Zairi, 1997a; Zairi, 1994). However, EALIM's adoption would have probably been thwarted had the COO not made the courageous decision to dismiss the chairman, since findings indicated the chairman was an autocratic leader who often resisted power sharing and collaboration. Although Metcalf and Ben (2012) argue an autocratic leadership style could be useful in times of crisis and solving social dilemmas, Nwabueze (2001a) asserts this style is not conducive to the adoption of TQM since it calls for a participative leadership style, posited on collaboration and empowerment. The COO emerged as such a leader, since one of the first decisions he made after the

CEO 'trusted' him with 'more authority' was to transfer empowerment down the hierarchy – a significant prerequisite for EALIM's adoption. Although the psychoanalytic literature on organisations typically explains psychological transference as a pathological phenomenon, i.e., projection of negative archaic experiences into the present (Gabriel, 1999; Kets de Vries, Carlock and Florent-Treacy, 2007), in this context it involved the projection of a positive experience, i.e., trust and empowerment by the CEO. This is an important point, since the TQM literature suggests soft factors such as trust and employee empowerment are key enablers for its adoption (McAdam, Leitch and Harrison, 1998; Powell, 1995; Wilkinson and Witcher, 1992). The finding that the COO empowered middle managers with greater choice and responsibility for the quality of their own work is consistent with what Deming (1994) called for and supports the work of other authors who argue middle management involvement in TQM is a key factor for its success (McAdam, Leitch and Harrison 1998; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a).

Another finding, which demonstrated the proliferation of empowerment at Bettercare, was the company-wide implementation of local trans-disciplinary community groups. These groups empowered patients and staff from divergent disciplines with local decision-making capabilities, which led to improvements in patient activities. This finding is congruent with research from Joss (1998), who found multi-disciplinary groups were a major success in producing different perspectives on problem solving. Community groups also enabled patients with greater confidence in their self-advocacy, which appears to be a novel finding, since my search of the healthcare management literature yielded no evidence of the adoption of quality improvement initiatives improving patient self-advocacy.

6.7 Summary and Conclusion

Integrating Quaker Space and appreciative methods into EALIM's conceptual framework denoted the reflexive nature of this AR inquiry, since these were added to counteract Bettercare's culture of managerial control and top managements' lack of appreciation toward care staff.

At Bettercare, the adoption of EALIM guided a significant paradigm shift that de-centered the hegemony of top management and reduced the bureaucracy characterising healthcare firms. Key prerequisites to EALIM's adoption include commitment and visible involvement of key executives who consistently attended focus groups and implemented agreed action plans; feedback of my baseline assessment to top managers, which triggered double loop learning; and the departure of the chairman whose autocratic leadership style posed a barrier to pragmatic change. Perhaps the most significant prerequisite to EALIM's adoption was the democratic and participatory leadership style of the COO, who transferred empowerment down the hierarchy, allowing middle managers greater autonomy over the quality of their own work. Empowerment was also proliferated through local community groups, enabling patients and care staff with greater decision-making capabilities.

The application of EALIM's extra-ordinary management method in board meetings generated conditions consistent with Habermas' (1978) communicative rationality, leading to improved decision-making and problem solving. Furthermore, top managers who acknowledged EALIM's adaptive concept of chaos theory were more prepared for change, the lack of which is a limitation of many other TQM frameworks since they are essentially cybernetic. Although most top managers showed the requisite commitment for EALIM's adoption, some top managers used rationalisations to justify their use of defensive routines. This defensive reasoning was a barrier to change since it prevented these top managers from discovering new ways of learning.

While other TQM studies found middle managers resisted TQM efforts (e.g., Beer, 2003; Coulson-Thomas, 1992; Thiagarajan and Zairi, 1997a; Zink, 2007), findings from this study indicate otherwise, a situation that may be attributed to middle managers' strong identification with EALIM's moral values of compassion and altruism. Middle managers who signified the greatest acceptance of EALIM were those occupying a creative space, a prerequisite for evolutionary change.

EALIM's adoption created a shift in knowledge sharing from a codified context to a practice-based approach, which various authors (e.g., Hislop, 2009; Newell et al., 2009) argue has the potential for greater inter-subjective understanding and mean-making. In the face of this epistemological shift, staff nurses continued in their resistance to knowledge sharing and collaboration because of a fear of losing position and power – characteristics consistent with dysfunctional narcissism.

Despite these challenges, EALIM's adoption led to a direct improvement in patient care, evidenced by improvement in patient activities and patients' increased confidence in their self-advocacy. To the best of my knowledge, improvement in patient self-advocacy is a finding that appears missing from the quality literature in healthcare management. Another positive finding during this cycle was the social and economic impact of corporate philanthropy, which strengthened employees' and external stakeholders' perceptions of Bettercare. However, it is unclear whether employees enhanced perception of Bettercare could generate increased organisational commitment, an area of interest I will explore in the next cycle – the post implementation of EALIM.

Chapter Seven: Cycle Three – post-implementation of EALIM

7.1 Introduction

This chapter provides details of the third and final AR cycle of this research study and represents my evaluation of EALIM's impact after its implementation at Bettercare. Using a similar format to the previous chapter, I begin with a narrative describing how I gathered information during my three months of fieldwork through the research methods I deployed. Findings from all my research encounters are then structured in themes and evaluated against findings from my baseline assessment in chapter five to elucidate EALIM's overall impact on organisational culture and improvement. According to Bryman and Bell (2011, p.58), adopting longitudinal analysis of this kind provides insights into the 'time order of variables,' which strengthen the inference of causal influences to particular outcomes. The full template I used to construct these key themes is located in appendix 17. Key findings are then discussed in light of theories from the literature and findings from other TQM studies, in order to illuminate their implications and importance (Bryman and Bell, 2011). In the final part of this chapter, conclusions are reached in relation to the overall outcomes and limitations of EALIM's adoption at Bettercare.

7.2 Research Methods

My fieldwork during this cycle spanned from November 2012 to January 2013 and included thirty-four qualitative interviews, one focus group and one participant observation of an evaluation meeting. A detailed account of my fieldwork activities is given in the following subsections.

7.2.1 Interviews

During the months of November and December 2012, I carried out thirty-four qualitative interviews with participants from different positions and disciplines across the organisation, as I wanted to generate the maximum variation of information. The purpose of these interviews, consistent with those carried out in

cycle one, was to gather information on participant's perspectives, emotions and experiences around the seven concepts I wished to explore.

Although I attempted to re-interview all 26 participants from the first cycle, I could only interview 15, as some had either left the organisation or were unavailable due to work absence. While I recognise being unable to re-interview all participants from the first cycle could have made an impact on the robustness of research findings, this situation was beyond my control and reflects the difficulty of researching healthcare contexts, characterised by dynamic environments and employee shortages (Mosadeghrad, 2013; Parkin, 2009).

Since the time I commenced my fieldwork in July 2011, the employee population at Bettercare had increased by 120. I therefore interviewed an additional 19 participants to reflect this increase. During this cycle, I interviewed eight top managers, five middle managers, four head office workers, three staff nurses, four senior care workers and 11 care workers, across seven locations. As in cycle one, interviews with head office workers and those in management positions were arranged by appointment. Although my visits to hospitals and care homes were arranged in advance, interviews with frontline staff (i.e., staff nurses and care workers) were limited to those available during their shifts.

During November my schedule involved interviewing up to seven people per day, which left me feeling somewhat drained. Therefore, during the month of December I limited my schedule to a maximum of four interviews per day, which gave me sufficient time to recuperate and reflect on each interview before the next one proceeded. As in cycle one, I ceased interviewing after I deemed a theoretical saturation point had been reached, meaning enough information had been gathered to inform the concepts I was exploring (Bryman and Bell, 2011).

7.2.2 My final focus group

The final focus group took place in December 2012 for the purpose of reviewing the preceding 12 months of EALIM's adoption. Email invitations were sent to all 12

participants who had attended previous focus groups and six participants attended: the COO, the care director, the operations manager, the compliance manager, a clinical therapist and an interview consultant who expressed a desire to attend. The meeting was held at Bettercare's training suite and lasted for approximately one hour.

7.2.3 Final evaluation meeting

After I completed analysing the information gathered from interviews and the focus group, I scheduled a meeting with top managers for the end of January 2013 to gain their feedback on my findings. I reasoned this feedback process would not only give them the opportunity to validate or critique my findings (McNiff and Whitehead, 2011), but also allow them to make an informed decision as to EALIM's continued adoption.

From the 12 email invitations I sent, nine top managers attended: the COO, the care director, the operations director, the operations manager, the compliance manager, the interview consultant and three senior managers who had been promoted from middle management positions. Although the CEO, marketing director and financial controller were absent, I did not deem another evaluation meeting was warranted, since a sufficient number of key top managers had attended. The evaluation meeting was held at Bettercare's head office and lasted for approximately two and a half hours. Using a laptop and large screen, I presented the key findings of my analysis.

7.3 Findings from Interviews and the Focus Group

Findings in relation to EALIM's overall impact on Bettercare are structured in accordance with the seven concepts I explored (i.e., perceptive value of Bettercare, power relations, motivation, ethics, adaptability, learning and improvement). Each of these concepts include the main themes that emerged from my analysis of interviews and the focus group. These thematic findings are supported with empirical evidence and compared against my baseline assessment in cycle one. When referring to findings from my baseline assessment in cycle

one, I include numerical codes in parentheses from tables 17 and 18, for ease of reference. Where appropriate, I also include the number assigned to each participant from table 10, so interview responses can be distinguished between groups.

7.3.1 Perceptive value of Bettercare

Findings in relation to participants' perceptive value of Bettercare are specified in the following subsections.

7.3.1.1 Corporate philanthropy generated pride among care staff

A common finding among middle managers and frontline staff was Bettercare's philanthropy in India produced an organisational identity that acted as an object of pride in the minds of employees. Interview responses supporting this finding include 'At the time the India project was launched, care staff were saying how proud they were of being involved with the company' [14], 'I felt proud listening to stories from those who went to the India project' [18], 'The India project was something really great and something to be proud of. Staff talked about it' [27] and 'I think it was really good they were helping people across the world…it drew me toward the company' [36]. Compared to the finding from cycle one in which care staff had a low perceptive value of Bettercare (1.3), the above empirical evidence indicated their perceptive value of the organisation had increased.

7.3.1.2 Corporate philanthropy created a moral perception of Bettercare

Interview responses from most middle managers and frontline staff implied Bettercare's philanthropy in India generated a moral perception of their employer. Their responses include 'People need to know the company is not just about shareholder wealth' [17], 'They are doing a good job helping the ones in need…it changed my perspective of [Bettercare]' [28], 'Giving back to society is such an important aspect of the company' [35], 'The company is not profit orientated and willing to give back' [38] and '…they have extended their values to other countries and I respect them for that' [39]. These responses suggested that because care staff valued altruism (i.e., transcending one's self to help others) as a moral ideal

and identified this ideal in Bettercare's philanthropy, they perceived their employer to be moral. Furthermore, the view that Bettercare was not 'profit' or 'money orientated' was stated by several middle managers and care workers, suggesting the perception identified from cycle one of Bettercare valuing profit more than staff (M2, C4, 1.4) had diminished, creating a more socially responsible view of the organisation.

7.3.2 Power relations

Findings with regards to participants' power relations are set out in the following themes.

7.3.2.1 EALIM generated a paradigm shift in top management culture

Evidence from interviews indicated EALIM's adoption had generated a paradigm shift in the thinking and actions of several top managers. For instance, the CEO claimed, 'EALIM helped me as a leader, particularly with empowering subordinates to come up with solutions…I'm autocratic but it's now more the exception than the norm.' The COO and care director also respectively claimed, 'EALIM has helped shaped my thinking…I have been able to listen more and facilitate other peoples decision-making' and 'EALIM helped me reflect on what I do and how I approach work. When I sit down with somebody, rather than telling them what to do, I explain more and seek their opinions.' These types of responses indicated the bureaucracy and managerial control identified in top management culture from cycle one (T1, T12, T13) had shifted toward democracy and empowerment.

This cultural shift among top managers was substantiated by middle managers whose interview responses include 'We have been more involved in client assessments whereas before it was only [the marketing director],' 'Now, I am involved with recruiting, perhaps seventy-five percent,' 'She [the operations director] doesn't make the decisions for me anymore, but supports my choice of decisions' and 'I am much more involved in decisions, which is probably down to your work and [the COO].' These responses not only confirmed my previous finding in cycle two of middle managers being empowered with greater autonomy

over the quality of their own work, but also indicated a reduction in power struggles between top and middle managers (2.5).

7.3.2.2 Conflicts between the CEO and other directors

Although I interpreted a reduction in power struggles between top and middle managers, accounts from interviews and the focus group indicated the occasional conflict between the CEO and other directors. For example, in her interview, whilst the marketing director implied she understood the CEO's 'responsibility to make the company financially viable,' she appeared to criticise him for 'imposing the decision to increase bed numbers' and added, 'It's about who is involved in those decisions and how they are made.' The marketing director's comments suggested she did not welcome the CEO's autocratic decision to increase bed numbers, because it conflicted with her governing value of democracy.

Moreover, during the focus group, the COO signified a similar perspective to the marketing director when he stated '[the CEO] sometimes makes impulsive decisions,' instead of 'sitting down with others and talking about issues constructively.' The accounts from both the COO and marketing director signified paradigmatic differences between them and the CEO, since they were more inclined to collaboration and democracy than the CEO.

7.3.2.3 Less of a blame culture

Interview accounts from several top and middle managers indicated a decrease in the blame culture identified in cycle one (2.8). For instance, while the COO was describing the changes he made to inspection audits, I asked him what influenced these changes. He replied, 'I think this was quite a big EALIM thing. The old system was very entrenched and was the tool that drove the blame culture…now when there are problems they are fixed there and then.' I interpreted his reply to mean EALIM had played a significant role in his decision to change the focus of inspections from error detection, to error correction.

The operations manager appeared to validate the changes described by the COO when he claimed, 'The old [chairman] way of auditing was bureaucratic and scared people a little bit. The new audits are based on analysing and fixing problems during inspections…but managers are not reproved publicly, which means there's no blame culture here. I say to people, I don't blame you for making a mistake as long as you learn from it.' The compliance manager had a similar perception to the operations manager when he claimed, '…we've changed our audit process to have less of a blame culture and more of a fix it culture. Before, audits were coming up red, red, red and managers were being blamed. It must have been de-motivating for them.' The claims from both the operations and compliance managers implied a change in top management culture – namely, a reduced focus on blaming managers for their non-compliance.

The claims from these top managers were supported by comments from middle managers, which include 'Before, a lot of the auditing was de-motivating, it just focused on the gaps but now they identify how well units are doing,' 'Before you could be 99% compliant but that 1% made you non-compliant, which was discouraging' and 'The difference now is, audits are outcome based not procedure based…they tell me where to place my efforts.' The meaning I perceived from these comments is the new auditing approach engendered greater confidence among middle managers because they saw it as a constructive improvement tool.

7.3.2.4 Increased employee empowerment and involvement

Evidence from interviews suggested employees were empowered with more decision-making than before EALIM's adoption in cycle one, where managerial control was found to be dominant (T13, S11, 2.3). Two head office workers claimed 'I have more autonomy now' and 'I'm definitely more involved in decisions since the last time I was interviewed.' Care workers made similar claims when they said, 'I have been handed the allocation sheet from nurses a few times to select who is working with who,' 'Everyone on shift is very involved in planning and allocations' and 'Everyone is very involved in decisions…in the past we were not free.' Furthermore, several care workers described feeling 'supported,' 'more

confident' and 'happier' as a result of being empowered, suggesting a link between employee empowerment and job satisfaction.

The use of community meetings also played a role in generating increased employee involvement. For example, one care worker stated, 'There is a lot of interaction in these meetings. We get involved in running the service' and another remarked, 'The one thing I value the most is our community meetings. People didn't take them seriously at first, but now everyone is involved.'

However, interview responses from care workers in hospitals signified they were less involved in decision-making than those in care homes. While some hospital care workers stated staff nurses 'accommodate' or 'listen' to their 'choices' and 'preferences,' other hospital care workers gave descriptions such as, 'We are not involved in decisions on the running of the service, nurses in charge make those decisions and never ask me,' 'Staff nurses usually decide the allocation and tell you' and '…they [staff nurses] don't give you the choice.' Their descriptions suggested staff nurses were still dominant in their use of managerial control (S10), resulting in the exclusion of care workers from operational decision-making. Moreover, the emotional expression and tone of voice these care workers used when describing interactions with staff nurses, implied they were less satisfied than care workers from care homes.

7.3.2.5 EALIM's adoption had limited impact on staff nurse culture

Empirical accounts from interviews and the focus group indicated little change to staff nurse culture. For instance, several care workers made comments suggesting staff nurses were still focused more on administrative duties than hands on care (S13, 7.4). Their comments include 'When the alarms are pulled, nurses take time to come to us from the office,' 'If staff nurses were on the floor they could understand better. They are either in the office or doing medication' and '…most of the time staff nurses are in the office.'

During interviews with staff nurses, although they espoused values of ‘equality,’ ‘involving others’ and ‘working together,’ their action strategies appeared to undermine these values, which suggested their use of defensive reasoning. For example, when I asked staff nurses to describe how they lead shifts, two responded, ‘When delegating, I look at the skill mix of the staff and observe how they work. I’ve never allowed anyone to choose’ and ‘…we are the coordinators…care workers need to understand why we are asking them to do things.’ Their comments signified an underlying assumption of knowing more than care workers and a low tacit commitment to collaboration – an interpretation consistent with the staff nurse culture identified in cycle one (S3, S4).

When I asked one particular staff nurse whether any care workers refused her requests, she gave the following narrative. ‘One member of staff said to me in the handover, “I'm not going to be cooking today because I cooked yesterday.” I said we will discuss it after the handover but I've delegated cooking to you.’ Her narrative suggested that as a nurse, she assumed it was her professional prerogative to take control of the shift and it was the duty of care workers to cooperate with her. Furthermore, her management approach seemed predicated on managerial control (S11) and task-centred leadership (S12) – action strategies identified among staff nurses in my baseline assessment.

During the focus group, the COO shared his observation of a particular staff nurse he had encountered. He stated ‘We had a recent lady who used to work with us. She was a very young nurse and I saw the way she treated one of our senior care workers who was much older than her. She said, “right, this patient's room needs doing, you go there, do this, do that.” I just thought to myself that is not the right way…he did it because he was asked to do it and she was his superior, but she didn't win anyone over that way. No one wanted to follow her and it broke down.’ I interpreted the COO’s observation to mean the managerial control displayed by the staff nurse damaged relationships with care workers and undermined teamwork.

7.3.3 Motivation

The following subsections contain findings in relation to participants' motivations.

7.3.3.1 Corporate philanthropy increased organisational commitment

Interview accounts indicated corporate philanthropy had generated increased levels of organisational commitment. For example, one middle manager claimed, 'One staff was moaning about her wages, but after realising what the company was doing in India, she wanted to volunteer her pay rise to help projects like this.' This middle manager's claim was consistent with comments from most frontline staff, particularly care workers. For instance, when I asked what care workers thought of the India project, their interview responses include 'It changed me. Nothing will make me leave…I appreciate the work this company does,' 'It made me feel good and inspired me to work more so they can support the countries outside' and 'It drew me to the company.' Compared with the low care worker commitment found in cycle one (C3), these interview responses indicated an increase in care worker commitment to Bettercare and that corporate philanthropy inspired motivations to act toward the good of the organisation.

7.3.3.2 Low care worker pay was still a demotivating factor

Although care workers commitment to the organisation had increased as a result of corporate philanthropy, three care workers mentioned the issue of low pay. Comments such as 'The pay doesn't encourage you,' 'Good staff are leaving because of pay' and 'People ask why should I bother when I could earn more money elsewhere,' indicated low pay was still a demotivating factor for some care workers, as identified in cycle one (3.5). However, the proportion of middle managers and frontline staff who remarked on care worker pay during their interviews was considerably lower than those in cycle one interviews, suggesting the issue of low care worker pay had become less prevalent.

7.3.3.3 Practice-based training increased employee commitment to learn

Several top managers implied frontline staff was more committed to learn as a result of practice-based training (i.e., microteaching). For example, in her interview

the marketing director stated, ‘I've seen a change in attitude in that people want to learn and improve’ and in the focus group, the clinical therapist and compliance manager respectively claimed, ‘Staff are really responding to the microteaching’ and ‘People are attending training sessions more frequently. That's evidenced from the audits I did last week.’ Several middle managers expressed a similar view during interviews when they claimed, ‘Staff are more motivated to learn,’ ‘The microteaching has helped staff feel motivated and responsible for their own actions’ and ‘More people attend training.’ These claims were supported by care workers whose interview comments include ‘I love to go on training,’ ‘I’m not just working for the money, but learning to do the job,’ ‘The microteaching is good...it is easier to digest because sessions are shorter and quicker’ and ‘…next week they start makaton training and I'd really like to do that.’ The above comments also signified that care workers were less dependent on the kind of codified knowledge sharing prevalent in cycle one (C12, 6.1).

7.3.4 Ethics

Findings in relation to EALIM's impact on ethics and values are specified in the following subsections.

7.3.4.1 A change in top management values

Most top managers espoused shared values of ‘compassion’ and ‘social interaction,’ which were not implicitly or explicitly espoused during their interviews in cycle one. Moreover, these values seemed consistent with their action strategies. For instance, the care director, the operations manager and the compliance manager explicitly claimed EALIM had enabled them to ‘act’ or ‘be’ ‘compassionate’ to staff, while the COO claimed top managers had been ‘visiting sites on a regular basis to connect with the workforce.’ These accounts suggested top managers showed greater respect for employees and as such, were not as inclined to overlook the needs of frontline staff (2.2).

The COO’s claim of top managers ‘visiting sites on a regular basis’ was corroborated by middle managers who reported an increase in directors

engagement with staff, suggesting the lack of social interaction between top managers and frontline staff had improved since cycle one (4.2). Furthermore, during interviews several care workers stated they felt ‘valued,’ ‘inspired’ or ‘encouraged’ by directors during their ‘visits,’ signifying a decline in the ‘them’ and ‘us’ perspective found between top managers and staff in cycle one (2.7).

7.3.4.2 Compassion emerged as a commonly espoused value

During interviews in cycle one, only frontline staff explicitly espoused the value of compassion. However, during this cycle, most participants (i.e., top managers, middle managers and frontline staff) espoused the value of compassion, indicating compassion had become a commonly shared value during EALIM’s adoption. Responses supporting this finding include ‘I entered nursing on the basis of compassion’ [15], ‘Compassion is important to me. All these guys are vulnerable…we need to make things better’ [18], ‘I have to be compassionate when talking to staff’ [19], ‘Compassion is my first value’ [36] and ‘I went into nursing because of compassion’ [40]. The meaning I interpreted from these responses is participants perceived the value of ‘compassion’ as an intrinsic construct of quality care.

Several top and middle managers also stated ‘When you first spoke about EALIM and compassion, people embraced it’ [1], ‘EALIM helped to reinforce my value set’ [15], ‘EALIM reaffirmed our commitment to act in a compassionate way’ [20] and ‘I was able to identify with quite a few EALIM values. When we were recruiting, EALIM helped us focus on what people valued’ [40]. These types of responses suggested EALIM’s adoption guided the ethical norms and practices of some managers.

7.3.4.3 Staff felt more valued by the company

In regard to how well Bettercare valued its staff, middle managers explicitly stated they felt more valued during the preceding twelve months of EALIM's implementation. Their interview responses include ‘I feel more valued over the last twelve months. I am more involved in some of the decisions being made,’ ‘There’s

been an increase in the value I've felt. I have more decision-making power and involvement in recruitment…overall it's down to you and EALIM' and 'There has been a difference over the last year…I feel I'm being listened to.' These responses indicated their empowerment was linked to their job satisfaction – supporting the previous finding in subsection 7.3.2.4.

In response to my interview question of how well Bettercare valued participants, the proportion of care workers who stated they felt valued was almost double compared to those in cycle one. Interview responses supporting this finding include 'I feel very valued…my requests are always accepted by my manager,' 'I do actually feel quite valued…nurses say thank you,' 'I feel valued by the team and company…they are supportive' and 'I am valued...my manager appreciates what I'm doing.' What I interpreted from these responses is the perception of care workers being valued by the company was related to the support given to them from their leaders.

7.3.5 Adaptability

The following findings relate to the concept of adaptability.

7.3.5.1 EALIM enabled top managers to adapt

Interview responses from several top managers indicated their adoption of EALIM's adaptive concept enabled them to adapt and reduce their inclination toward stability and predictability, a cycle one finding (T3, 5.6). For example, when I asked the COO whether EALIM's complexity concept made any difference, he remarked 'EALIM helped to champion the need for the changes we have done and reduce the opportunities for stressful situations to arise even though we are much bigger. The organisation should never be sitting still...I don't mind a bit of chaos.' His response suggested he had undergone a significant change of mind since the first cycle where he expressed unacceptable feelings toward chaos (see page 148). The COO's interview response was similar to responses from other top managers who remarked, 'The adaptive aspect of EALIM has been important in terms of being open to new changes and challenges' and 'With EALIM there has

been a lightbulb moment where people from top level are learning to adapt and teach others to adapt.' Their responses implied EALIM's adaptive concept had underscored the necessity for change and ameliorated their anxiety toward uncertainty – an interpretation consistent with the cycle two finding – that EALIM's adaptive concept enabled top managers with a psyche for change.

7.3.5.2 Middle managers had greater flexibility

Compared to cycle one where I found that standardisation inhibited adaptation (5.2), evidence from interviews signified middle managers had greater flexibility to adapt company policies to the specific needs of their local services. For instance, one middle manager claimed she had 'reached an agreement' with her line manager 'to simplify the MARS [Medication Administration Record Sheet]' and allowed 'care workers to oversee the administration of medicines by the nurse.' Other middle managers also claimed 'I sometimes involve a member of staff from the units to do the audits, they also learn from the whole process. This was not always happening before' and 'We've been given flexibility for staff to work shorter shifts, it's made a hell [sic] of a difference to attendance.' These claims indicated increased flexibility had produced positive outcomes to staff learning and work attendance.

7.3.5.3 Staffing shortages had a negative impact on staff's ability to adapt

Despite an increase in flexibility, care workers from across several sites implied staffing shortages had a negative impact on their ability to cope with challenges to the service – a finding consistent with cycle one. Their interview responses include 'I know I have the flexibility on the length of my shifts but when you are short staffed, it's difficult to do the things you want,' 'The lack of staffing cover in times of absence is causing too much stress,' 'It is mentally and physically draining at the minute because of the lack of staff and demanding service users...sometimes we are trying to stretch ourselves too far' and 'When we are understaffed it is more difficult to deal with challenging patients.' These responses signified that staffing shortages generated problems with internal integration – aligning resources and

working methods to meet the dynamic needs of the service (Schein, 2010) – a finding consistent with cycle one (5.5).

7.3.6 Learning

Findings in relation to EALIM's impact on learning are stated in the following subsections.

7.3.6.1 Emergence of a perceived learning culture

Responses from interviews and the focus group indicated the emergence of a perceived learning culture at Bettercare. Interview responses from top and middle managers that support this finding include 'There is a lot more emphasis on learning' [2], 'The culture allows for people to learn from their own desire and effort' [17] and 'There's now a theme of learning in the organisation' [19]. Their perception of a learning culture was shared by focus group participants, whose responses gave insights as to why they thought a learning culture had emerged. These include 'Learning in the organisation has increased because we are microteaching on the unit and staff make a proactive effort to develop their knowledge...it's certainly changed the culture' [COO], 'Staff are asking more detailed questions' [operations manager] and 'What I've observed is staff get to see the people that deliver the training around the units and ask them questions about this or that during the shift' [care director]. I interpreted their responses to mean the use of practice-based training stimulated meaningful interaction between them and their educators, increased their commitment to learn and was more relevant to the learning needs of frontline staff than centralised training courses.

Interview responses from care workers appeared to support the views of focus group participants. These include 'Microteaching is helpful...they [trainers] show us how to do the MDT notes and complete incident reports,' 'Trainers show us how to look after clients' and 'Local training is more specific to clients.' These responses indicated the use of practice-based training had created greater tacit knowledge sharing between educators and staff.

What further supported the perception of a learning culture was participants' increased use of reflexive learning. In cycle one, a lack of reflexive learning was found (6.6.), since only five from the twenty-six participants I interviewed indicated its use. However, in this cycle, fourteen from the thirty-five participants I interviewed indicated the use of reflexive learning. These were four top managers, five middle managers, two head office workers and three care workers. Their descriptions include 'I look inwardly and question what I believe in and what other people believe in' [8], 'I reflect all the time. Everything you do has an impact on the patient' [41] and 'I constantly reflect and look at how I can change what I do' [42]. These descriptions suggested their use of reflexivity had allowed them to critically examine their own thinking, the impact of their behaviour and consider alternative ways of thinking and doing.

7.3.6.2 Practice-based training increased staff knowledge and competence

Empirical evidence from interviews and the focus group indicated company-wide practice-based training was effective in increasing staff knowledge and competence. For example, during a discussion on 'microteaching,' focus group participants claimed 'The knowledge wasn't there before, whereas now you can see its way across the board' [compliance manager] and '…it's raising staff awareness' [clinical therapist]. These claims were corroborated by interview responses from care workers such as 'Local training has improved learning, at last it makes us aware,' 'Microteaching has helped learning in the team,' 'Microteaching makes us capable' and 'Micro-training gives everyone knowledge of how to deal with vulnerable adults.'

With regards to the effectiveness of microteaching, middle managers' comments include 'The microteaching is more effective because you can re-enforce it on the unit…whereas doing training centrally was not patient specific,' 'It [microteaching] is more practical because it's delivered on site' and 'Microteaching is unit based, de-escalation training is implemented with our service users rather than a centralised course where some techniques are not applicable.' Their responses implied microteaching was more effective than the centralised training used in

cycle one, because it merged theory with practice and was tailored to the specific needs of each patient group.

7.3.6.3 Greater experimentation and innovation

Interview responses from the CEO and COO indicated EALIM's adoption enabled greater experimentation and innovation. For instance, the CEO stated ‘EALIM helped me trust the ideas of subordinates’ and gave examples of different ideas which had been implemented since EALIM's adoption. These include ‘…recruitment of clinical healthcare workers,’ ‘…putting C&R trainers on every rota’ and the use of ‘key cards by each staff member on duty that lists the triggers causing patient aggression.’ During the focus group, the COO also implied there was greater innovation as a result of EALIM's adoption when he stated, ‘I think what others now get is through EALIM, a culture has been opened that allows people to have crazy ideas and sometimes they are very good ones.’

Interview responses from several middle managers suggested they had more freedom to implement their own ideas than before EALIM's adoption. Responses supporting this finding include ‘I now have some of my staff doing shorter shifts...before we didn't have that flexibility,’ ‘The issue of pay came up in the weekly managers meeting today and we looked at ideas on how to make the hourly pay more attractive for staff’ and ‘I sometimes involve a member of staff from the units to do the audits...this was not happening before.’ Although these responses signified a reduction in the kind of bureaucracy that stifled experimentation and innovation in cycle one (6.5), responses from head office workers and frontline staff did not include examples or descriptions of their involvement in idea generation, suggesting their contributions to innovation were lacking.

7.3.7 Improvement

The following subsections contain findings in relation to quality improvement.

7.3.7.1 Increased collaborative improvement among top & middle managers

Interview accounts during this cycle indicated the lack of collaborative improvement and problem solving found in cycle one (7.3) had improved and that top and middle managers were less reliant on a classical quality control method of inspection (T14, M13). Although inspection audits were still used, top managers implied 'weekly managers meetings' – new forums the COO had initiated, were driving most of the improvements. For example, several top and middle managers claimed weekly managers meetings were used to 'drive the business forward' [2], 'learn about what's happening in the company' [5], 'share best practice' [17] and 'discuss problems' [20]. Not only did I perceive these descriptions to be consistent with a community of practice (one of EALIM's learning methods), but they also implied a culture of collaborative improvement had emerged between top and middle managers.

Evidence of increased collaboration during inspection audits was also present. During interviews, middle managers reported being actively involved in inspection audits, whereas prior to EALIM's adoption only the chairman and the compliance manager carried out audits. Middle managers' descriptions include 'I now visit other units doing audits, which gives me in-depth awareness of CQC standards,' 'The audit style has changed…I'm constantly involved in audits' and 'Doing audits helps me understand how units should be run.' These descriptions signified middle management's involvement in inspection processes had increased their knowledge of CQC and operational requirements and at the same time, reduced their reliance on top managers for improvement (M18) – a cycle one finding.

Despite the finding of increased collaborative improvement among top and middle managers, interview responses from head office workers and frontline staff included very few instances of their participation in quality improvement methods, suggesting collaborative improvement was not widespread.

7.3.7.2 Practice-based training enabled service improvements

During interviews, several top and middle managers implicitly and explicitly claimed microteaching had a positive impact on service improvement. Their responses include 'Staff are empowered to deal with aggression through better training…microteaching contributed to service improvements' [2], 'When clients are aggressive, I can see staff using the right interventions...the microteaching has helped their performance and effectiveness of interventions' [27] and 'Micro-training is more effective and specific to the patient group' [40]. These responses suggested practice-based training had improved staff interventions with aggressive patients.

7.3.7.3 Improved patient independence

Interview responses indicated an increased focus on patient independence. For instance, only one participant during interviews in cycle one espoused the value of patient independence, compared to nine participants during this cycle. These were two top managers, two middle managers and five care workers. Examples of their espoused values include 'Helping clients become more independent' [29], 'Seeing clients more independent' [32], 'Patients learning new skills' [33] and 'More independence with patients' [40]. Furthermore, the espoused value of patient independence appeared consistent with the action strategies described by various participants. For instance, when I asked one middle manager whether EALIM made a difference to service quality, she claimed, 'Before EALIM was introduced, we were making the decisions and the focus was on nursing, instead of creating independence. What we now do is let people [patients] do things for themselves.' Her claim was consistent with responses from several care workers, such as '…before, we had a different approach. It was like our job was to babysit clients as opposed to now, where it's more therapeutic,' 'Staff are working more to help patients as opposed to keeping them' and 'The care approach has changed from care-taking patients, to helping them become independent.' These kinds of responses support the finding that EALIM's adoption contributed to an improvement in patient independence.

Several participants also implied trans-disciplinary community groups played a role in improving patient independence. Two care workers remarked, ‘In community meetings, we'll ask clients what they need’ and ‘Community meetings involve patients in making decisions,’ while one middle manager claimed, ‘We do community meetings daily. The difference it's making is patients are more involved in making choices and planning their activities.’ Their responses not only support the cycle two finding that community groups empowered patients to shape the service they received, but they also empowered patients with greater choice.

Notwithstanding, responses from one care worker (during an interview) and a clinical therapist (during the focus group) implied inconsistencies existed between what was decided among patients and what was delivered in practice. Their respective responses were ‘Community meetings are good but what is discussed and requested does not always happen’ and ‘…we emphasise choice and giving back control all the time, but there are still some punitive attitudes we are trying to turn over.’

7.3.7.4 Inconsistencies in service quality

Whilst several top managers indicated an improvement to the high variance in service quality found in cycle one (7.5.), their responses indicated inconsistencies in quality among local services. For example, in the focus group the COO stated, ‘There have been improvements but I clearly feel we've got another year of EALIM before we are going to get this business where it needs to be...some units perform better than others.’ Moreover, the operations manager and marketing director respectively commented, ‘EALIM helped improve services but I can't say there have been sweeping changes in all areas’ and ‘There are inconsistencies across the units because of the way managers lead, especially at [hospital B]...it is improving but I still have sleepless nights. When I'm on call, the majority of calls are from there.’ The marketing director’s comments implied most of the service difficulties were concentrated at hospital B, a view shared by the care director when he remarked, ‘I think EALIM has been welcomed by everyone but it hasn’t been successfully implemented at [hospital B]…the manager may not be the right

leader…there were two incidents over the weekend where patients were not being looked after properly.' The care director implied the problems with service quality at hospital B stemmed from poor leadership of the unit.

Interview responses from care workers appeared to support the care director's view. When I asked three care workers from hospital B to describe their experience of the way the manager leads, their responses include 'There are problems here, clients are ignored and people don't feel safe. If a person pulls the alarm it could take five minutes for somebody to come...when I first joined [two months ago] I was told I would meet with the manager every month, but that hasn't happened,' 'Organisation in the unit is bad...I'd like to do activities with patients but we don't have any equipment' and 'I feel there is no leadership here, someone needs to say "this is what's going to happen." On Sunday I had a bad shift. Patients were acting out and I pulled the alarm but it took a long time for someone to come. That made me feel unsupported.' The meaning I interpreted from their responses is the poor management and leadership at hospital B, contributed to a lack of patient care and made staff feel unsafe.

7.3.7.5 Staff nurses' use of managerial control harmed patient care

During a focus group discussion on the culture of staff nurses, the clinical therapist shared the following perception: 'I've seen so many examples of care workers who know their patients really well. They know the definite no-nos and the things that encourage patients...then nurses will just sweep in and say something inappropriate perhaps and staff are left to pick up the pieces again. Patients react to an environment of control, they'll say "If you give me no choice, I'm going to be angry," so our incidents rise.' Her perception was consistent with the remarks of two care workers during interviews, which were 'Nurses undermine the decisions of patients...if they spent more time with patients they would understand them better' and 'Half the nurses can be absolutely lovely and the other half can be snappy. There's one particular nurse who is snappy with patients and just walks away when there is an incident.' The meaning I understood from these accounts is

the punitive approach and use of managerial control among staff nurses, was detrimental to patient care.

7.3.7.6 Staffing shortages were a persistent barrier to quality patient care

Interviews responses from middle managers and frontline staff indicated staffing shortages had a negative impact on patient care, a finding consistent with cycle one where staffing shortages inhibited service quality (7.8). Responses supporting this finding include 'Staff morale is always difficult in times of staff shortages' [14], 'We need more staff which is why service users are difficult to manage and limits us from going out with them' [31], 'When we are short staffed you can't achieve your goals, which causes a lot of conflict among patients' [37] and 'If people cancel and you are short staffed, it's difficult to do the things you want to do' [42].

Furthermore, comments from two middle managers signified a link between staffing shortages and low care worker pay. Their comments include 'It is difficult to recruit care workers because of the low wages...pay has to be more competitive' and 'Most care workers in exit interviews tell me they are not leaving because they don't feel supported, but because of monetary issues.'

7.3.8 Summary of key findings from Interviews and the focus group

Employees' perceptive value of Bettercare had increased since the first cycle, as corporate philanthropy generated pride among care staff and a moral perception of their employer. Empirical evidence also suggested corporate philanthropy had diminished employees' perception that Bettercare valued profit more than staff, creating a more socially responsible view of the organisation.

In regard to power relations, EALIM's adoption created a shift in top management culture from one involving blame, bureaucracy and managerial control, to democracy, collaboration and empowerment. While this cultural shift enabled middle managers with greater autonomy over the quality of their own work and reduced power struggles between top and middle managers, it also generated the

occasional conflict between the CEO and other directors who were more inclined toward collaboration and democracy than the CEO.

Empirical evidence also suggested increased employee empowerment resulted in greater job satisfaction. However, care workers in hospitals were less empowered and less satisfied than those from care homes because of staff nurses' dominant use of managerial control, which damaged relationships with care workers and undermined teamwork. EALIM's adoption had limited impact on staff nurse culture, since they signified the same cultural themes as those identified in cycle one – that is, an underlying assumption of them knowing more than care workers, a low tacit commitment to collaboration, as well as action strategies involving managerial control, task centered leadership and greater focus on administration than hands on care.

In terms of motivation, corporate philanthropy increased organisational commitment and inspired participants' motivations to act toward the good of the organisation. However, despite an increase in employee commitment, low pay continued to be a demotivating factor among care workers, although not as prevalent as before EALIM's adoption. Another finding was that practice-based training increased employee commitment to learn.

With regards to ethics, empirical evidence suggested EALIM created a change in top management values involving their adoption of compassion and social interaction. Top managers' adoption of these values made them less inclined to overlook the needs of frontline staff and increased their engagement with employees, which reduced a 'them' and 'us' perspective. Furthermore, interview accounts indicated EALIM guided the ethical norms of several top and middle managers and that compassion became commonly espoused as an intrinsic value of quality care. Another finding during this cycle was middle managers and frontline staff felt more valued due to increased empowerment and support from their leaders.

Interview accounts from several top managers indicated their adoption of EALIM's adaptive concept ameliorated their anxiety toward uncertainty and enabled them to adapt. Moreover, after EALIM's implementation, middle managers had greater flexibility to adapt company policies to the specific needs of their local services, which produced positive outcomes in terms of staff learning and work attendance. However, despite this increased flexibility, staffing shortages remained prevalent across the organisation and had a negative impact on frontline staff's ability to cope with challenges to the service.

In terms of learning, empirical evidence indicated the emergence of a perceived learning culture, evidenced by increased commitment to learn, tacit knowledge sharing and the use of reflexive learning. Practice-based training was effective in increasing staff knowledge and competence because it merged theory with practice and was tailored to the specific needs of patient groups. This study also found greater experimentation and innovation within the organisation, evidenced by increased freedom among middle managers to implement their own ideas. However, interview accounts indicated head office workers and frontline staff's contributions to innovation were lacking.

In regard to quality improvement, empirical evidence showed a culture of collaborative improvement had emerged among top and middle managers, evidenced by weekly managers meetings and increased collaboration during inspection audits. However, interview accounts from head office workers and frontline staff indicated they lacked participation in quality improvement methods.

Evidence from interviews showed practice-based training had improved staff interventions with aggressive patients, which links to an improvement of patient care. Also, evidence existed of EALIM's adoption contributing to an improvement in patient independence and that community groups empowered patients with greater choice. However, inconsistencies were present between what was decided among patients and what was delivered in practice. Inconsistencies were also found in service quality among local services, most of which were concentrated at

hospital B because of poor management and leadership. Other barriers to patient care within the organisation include staff nurses' use of managerial control as well as staffing shortages linked to low care worker pay.

7.3.9 Reflexive outcomes

During interviews and the focus group, I was conscious of the potential for participants' assuaging their concerns about EALIM's adoption, or buttressing me with responses they thought I wanted to hear. To counter these potential outcomes, I intentionally probed participants for examples and stories to support their claims and attributions, emphasising their responses would remain confidential. I also prompted them to share any experiences that were a cause for concern. I was therefore reasonably satisfied participants had provided authentic accounts of their experiences, feelings and perspectives.

After reflecting on the approach I used to gather information from participants, I realised how much of a conversational practitioner I had become, since I encouraged free flowing conversation, allowed participants to express themselves without interrupting and avoided any defensiveness on my part. However, after completing my analysis, I became aware I had not sufficiently explored top managers overall experience of EALIM's adoption, the use and impact of EALIM's improvement techniques and the influence my monthly articles had on participants. I therefore planned to explore these areas in the evaluation meeting.

7.4 Findings from my Final Evaluation Meeting

During my presentation of findings, most top managers appeared to implicitly and explicitly validate my findings by nodding their heads and with responses such as 'I agree with you,' 'You are right,' 'This is where we are now' and 'Of course.' However, the operations manager appeared to contest my finding in regard to the poor management and inconsistent service quality at hospital B when he remarked, 'I know for a fact things have improved there.' In response, the COO added, 'I've talked to staff there [at hospital B] and I think what you've got is more good days than bad days.' I interpreted these responses to mean they were

slightly defensive toward my finding at hospital B and the COO could have implied I had interviewed staff at hospital B on a 'bad day.' The care director also stated, 'I think when you [referring to me] talked to the staff, they felt you were someone external and that you probably got a much more truthful story from them.' What I understood from the care director's statement is the staff at hospital B were more comfortable disclosing sensitive issues to me than directors, because they socially identified me as someone removed from the hegemony of management.

Whilst I presented my findings on staff nurse culture, top managers had a conversation about why staff nurses were resistant to EALIM's adoption. Their remarks and explanations include 'When I was director of nursing at [a previous organisation], people used to refer to nurses as "qualified" and called care workers "unqualified" and I thought that was really damaging because my view was that everyone was qualified to do the job we employed them to do,' 'I think some of this goes back to their nurse training,' 'Compassion is lacking in nursing,' 'It's the profession, its different to what we did…this goes back to project 2000 when it [nursing] became exam-based and the real work was taken out. When we did our training there was more observation and experience' and 'I think that's what the issue is. They just want to hold onto this thing that "I'm a nurse" but don't understand what it means to be a nurse.' The essence I interpreted from this conversation was that top managers deemed the traditional meaning of nursing had been eroded due to changes in the training and professionalisation of nurses, which promoted divisions between them and care workers and placed greater emphasis on educational ability than practice-based experience and virtuous care.

When I presented my finding that staffing shortages had a negative impact on patient care and how this was linked to care workers' low pay, the COO responded, 'I think there is a commitment in the room to ensure we reward people appropriately…it's the key issue in the business…it's difficult for me to get through to the financial controller when he can't understand the variances. There's risk versus budget.' The COO's account suggested that although he and the operational team were committed to increasing care worker pay, the financial

controller's resistance on budgetary grounds, signified a lack of commitment to organisational democracy. To ameliorate this impasse, the COO proposed to create 'savings' by reducing 'waste' in other areas of the business to fund a 'better salary range' for care workers. Other proposals participants put forward include 'quicker cycle time on recruitment,' 'increase the supply of bank workers' and 'put more time to train the nurses and support them to change.' I interpreted their proposals to mean the operational team was committed to finding creative solutions to ameliorate obstacles to service quality.

After I asked top managers to share their overall experience of EALIM's adoption, their responses included 'The EALIM programme has been positive. It's been well received by purchasers as well. At the time it was launched there was much discussion in the media about values of compassion and values of nursing and we were seen to be ahead of the game,' 'People embraced it and took it on board,' 'What EALIM brought me was that it was the first time in my career I had heard anyone else talk in this way. To talk like this in other organisations at a senior management level would be seen as very un-macho' and 'I'd like to implement it fully so our whole business plan is structured around EALIM. We would review our every day practices and meetings through an EALIM lens...I think that could improve its implementation.' I interpreted their comments to mean they had internalised EALIM as an ideal – meaning, they incorporated EALIM within the self as an archetypal model germane to a healthcare context.

When I asked top managers for information regarding their use of EALIM's improvement techniques, the COO answered, 'As you know I am a bit of a Six Sigma boy and there is some crossover with EALIM. My use of Pareto's and 5 whys is an example of that crossover.' Two other top managers also stated, 'I remember we used the nominal group technique (NGT) in board meetings' and 'I was with [a middle manager] the other day and she mentioned so many issues that she didn't know where to start. I then referred to Pareto's and we worked on the top twenty-percent of issues.' Although their responses indicated they had

used some of EALIM's improvement techniques, they did not indicate to what extent these techniques impacted service quality.

When I explored the impact of my monthly articles, top managers' responses signified these helped to underpin EALIM's concepts in their minds and had positively influenced the adoption of EALIM among employees. Responses supporting this finding include 'The articles glued concepts together in my mind,' 'They [the articles] helped me reflect on what I do and how I approach work, even life,' 'I found them really helpful. They became talking points and I remember employees telling me they enjoyed reading them' and 'They [the articles] made a big difference…staff also talked about them…they brought the idea of learning to the fore in peoples minds.' The COO also remarked, 'The biggest thing I took from the monthly articles, apart from the enjoyment of reading them, was the concept that the workforce was not to be treated like naughty children but as adults. These were articles with a meaning but were generally able to be understood. I think they were very powerful in helping drive the culture change to where we are at today, which is better than where we were, but we have a little way to go yet.'

7.4.1 Summary of key findings from the evaluation meeting

While most top managers validated my findings, two top managers contested the finding regarding poor management and inconsistent service quality at hospital B.

With regards to staff nurses, top managers attributed their resistance of EALIM to their nurse training and professionalisation, which promoted divisions between them and care workers and placed greater emphasis on educational ability than practice based experience and virtuous care.

In terms of care worker pay, although the operational team was committed to increasing care workers' pay, the financial controller's resistance showed a lack of democracy.

With reference to top managers' experience of EALIM's adoption, most top managers indicated they had internalised EALIM as an ideal model for healthcare. Although the monthly articles underpinned EALIM's concepts in their minds and positively influenced its adoption among employees, top managers did not indicate what impact EALIM's improvement techniques had on service quality.

7.4.2 Reflexive outcomes

The evaluation meeting not only allowed participants to validate and critique my findings, but also enabled me to gain new knowledge by thinking with others. For example, listening to top managers' conversation about why staff nurses were resistant to EALIM's adoption created new insights I had not previously contemplated, i.e., the training and professionalisation of nurses.

7.5 Discussion

Various authors argue TQM requires a cultural revolution that has generally proved elusive to management (Beer and Nohria, 2000; James, 1996). However, this research showed otherwise, since EALIM's adoption created a cultural change among top managers involving less blame, bureaucracy and managerial control, along with more democracy, collaboration and empowerment. This outcome supports the research of Shortell et al. (1995) who found TQM implementation is likely to succeed using an approach emphasising decentralisation and empowerment. The cultural change among top managers' at Bettercare appeared influenced by their internalisation of EALIM, which strengthens Zabada, Rivers and Munchus' (1998) assertion that the internalisation of TQM is a necessary prerequisite for cultural change. Nonetheless, two top managers did not show the requisite commitment to EALIM's value of democracy, which perhaps demonstrates the problematic application of quality initiatives within organisations in which divergent stakeholders hold opposing interests (Gomes, Yasin and Yasin, 2010; Zabada, Rivers and Munchus, 1998).

The finding that EALIM guided ethical norms and influenced most top managers' adoption of compassion and social interaction, supports the notion that a

reorientation of values and beliefs are required for TQM's successful implementation (Mosadeghrad, 2013; Nwabueze, 2001a). Top managers' commitment to compassion and social interaction resulted in increased engagement and respect for employees, which various authors argue are critical factors for the success of TQM (Coulson-Thomas, 1992; Fotopoulos and Psomas, 2010; Thiagarajan and Zairi, 1997a). Furthermore, the finding that participants commonly espoused compassion after EALIM's adoption, may suggest compassion holds potential to become a 'substantive hyper-norm' (Carney, 2006, p.112) – that is to say, a widely accepted moral value that could guide human behaviour within healthcare organisations.

Although EALIM's adoption created cultural change among top managers, it had limited impact on staff nurse culture. This finding exemplifies the difficulties involved with changing employees deeply entrenched beliefs and commitments derived from their socio-historic milieu (Hatch, 2013; Kegan and Lahey, 2001; Rassin, 2008). Staff nurses' underlying assumption that they knew more than care workers, their low commitment to collaboration and their lack of hands on care demonstrated this point, which several top managers attributed to nurses' training and professionalisation. Top managers' suggestion that nurses' training and professionalisation contributed to divisions with care workers because of greater emphasis on educational ability than practice-based experience, is consistent with research findings from (McCabe and Garavan, 2008) – an area of literature I had not previously explored. Their study of 40 nursing staff found the nursing profession fostered greater solidarity among professionals than non-professionals and that some nurses felt the 'current nursing regime was too academic' – representing a 'move away from the traditional, more "hands on" approach towards patient care' (p.537). To ameliorate this predicament, McCabe and Garavan recommend the nursing curriculum include leadership development, be more focused on strengthening nurses' practice capabilities and for employers to create initiatives linking nurses' professional development with organisational goals to enhance their commitment.

Despite the lack of collaboration between staff nurses and care workers, a culture of collaborative improvement emerged among top and middle management. This collaborative improvement influenced and was influenced by EALIM's adoption, evidenced by increased middle management involvement in inspection audits and by weekly management meetings that focused on problem solving and sharing best practice. Middle management involvement in these processes is consistent with other TQM studies, which found the creation of meaningful roles for middle managers in QI processes was a critical success factor (McAdam, Leitch and Harrison 1998; Pande, Neuman and Cavanagh, 2000; Thiagarajan and Zairi, 1997a). However, Bettercare's lack of employee participation in quality improvement methods and innovation was unfortunate and not dissimilar to other TQM healthcare studies which found the creative contribution of employees was lacking (Mosadeghrad, 2013; Potter, Morgan and Thompson, 1994). Deming (1986) spoke about the importance of every employee being involved in the quality effort, situated on a belief that the best ideas emanate from people who do the job.

Although the creative potential of Bettercare's entire workforce was not maximised, the increased freedom of middle managers' implementing their own ideas was a step in the right direction. According to Stacey (1996, pp.171-185) providing organisational members 'creative space' not only supports evolutionary change, but also new decision-making capabilities causing the 'creative destruction' of dominant schemas (e.g., standardised company policies) that inhibit creativity. This outcome was evident at Bettercare, since middle managers were given increased flexibility to adapt company policies to the specific needs of local services, which produced positive outcomes to staff learning and work attendance.

The increased autonomy among middle managers was a vital step in the devolution of power from top management, which various authors purport to be difficult in a healthcare context due to high regularisation (Jefferson, 2002; Parkin, 2009). Consequently, adopting a complexity way of thinking is particularly warranted within a healthcare context, since it calls for leaders to dismantle bureaucratic processes stifling self-emergence and change (Litaker et al., 2006;

Stacey, 2010). However, one caveat to this approach is too much autonomy could plunge organisations into chaos (Smith and Humphries, 2004; Stacey, 1996). To avoid this predicament, the ideal approach is to balance autonomy with some control so as to stimulate creativity without falling into disintegration – an approach Stacey (1995, p.481) describes as 'bounded instability.' In the previous cycle, this ideal approach was realised by the COO's decision to devolve authority and reduce policies to the essential few, which played a significant role in generating the creative space middle managers needed to implement their own ideas to their local services. This is an important point, since a comparative study by Øvretveit (1997) of TQM implementation in European hospitals found that hospital managers who applied their own service quality ideas to their local service contexts had greater success than managers who did not – an area of literature I had not previously considered.

The COO's decision to devolve authority and reduce company policies was no easy task, especially when one considers the dominant management and bureaucratic paradigm that exists within healthcare (Litaker et al., 2006; Parkin, 2009; Smith and Humphries, 2004). In this context, the finding that the COO's decision was influenced by his adoption of EALIM's adaptive concept was important. As he put it, 'EALIM helped to champion the need for the changes we have done…I don't mind a bit of chaos.' The finding that EALIM's adaptive concept ameliorated top managers' anxiety toward uncertainty was equally important, since a healthcare study by Mosadeghrad (2013, p.158) found 'resistance to change' to be a key barrier to TQM implementation, because TQM was perceived as a 'source of fear and anxiety.' For this reason, the finding that EALIM's adaptive concept enabled top managers with a psyche for change presents an advantage over other TQM models that do not commonly include a complexity perspective, since they are largely designed through a Newtonian paradigm of reductionism, objectivism and linear causality (Dooley, Johnson and Bush, 1995; Sanford, 1992).

Middle managers were not the only organisational members to be empowered, since head office staff and care workers reported more involvement in decision-making. This finding is of particular importance to EALIM's adoption, as various studies show the successful implementation of TQM depends on employee empowerment (Powell, 1995; Talib and Rahman, 2010; Thiagarajan and Zairi, 1997a). The premise here is that empowering employees creates trust, affords greater decision-making and encourages responsibility for the quality of their own work. While this research study did not show a link between increased employee empowerment and service quality improvement, it did find a link between increased employee empowerment and greater levels of job satisfaction. Pfeffer (2010) argues job satisfaction and happiness in one's work is essential for the wellness of employees and an important determinant of corporate sustainability.

Notwithstanding, this study found care workers within hospitals were less empowered and less satisfied than their counterparts in care homes because of staff nurses' dominant use of managerial control. According to Lewis, Passmore and Cantore (2011), controlling others not only discourages meaningful human interaction but also promotes alienation. These implications were evident at Bettercare, as the controlling approach from staff nurses damaged relationships with care workers and undermined teamwork. Staff nurses' lack of collaboration with care workers can be viewed as a patterning of social inclusion-exclusion, predicated on their ideologies and identities as professional nurses. Stacey (2010) argues one of the ways in which power differentials are maintained among cultural groupings is when differences are given an ideological form. This point was expressed when one staff nurse stated '…we are the coordinators…care workers need to understand why we are asking them to do things.'

Another implication of staff nurses' use of managerial control was it harmed patient care, a finding which supports the research of Potter, Morgan and Thompson (1994) who found authoritarianism to be detrimental to quality improvement efforts. Various authors purport gaining commitment from clinicians is a paradoxical challenge to the adoption of TQM, as it is impeded by an adverse culture of

professional bureaucracies (Badrick and Preston, 2001; Kanji and Moura e Sá, 2003). Drawing from the work of Mintzberg, Badrick and Preston (2001) assert that members of professional bureaucracies typically rely on their own ethical codes and expertise, as well as seek to take control of their own work and the administrative decisions affecting them. In view of these characteristics, it is no wonder EALIM had limited impact on staff nurse culture. To overcome these cultural barriers, Badrick and Preston suggest TQM practitioners should build alliances with clinical professionals and involve them in implementation strategies – ideas that could be adopted as recommendations of this research.

In his summary of major barriers to TQM implementation in healthcare, Mosadeghrad (2013) lists employee shortages, along with poor management and leadership. This view is supported by this research, which found inconsistencies in service quality from poor local leadership and that staffing shortages negatively affected staff's ability to cope with service challenges. However, inconsistencies in quality among local services are perhaps to be expected, since Zeithaml, Parasuraman and Berry (1985) argue that services are prone to variability because of their heterogeneous nature. The view from other healthcare studies that low pay is a barrier to service quality (e.g., Nwabueze, 2004; Talib, Rahman and Quereshi, 2011), is also supported by this research, since a link was found between care worker pay and staffing shortages.

Despite these barriers, this study found the adoption of EALIM generated improvement in patient independence, a finding lacking in the TQM literature. Moreover, most healthcare studies I searched indicated no direct improvement to patient care as a result of TQM implementation, which is a common criticism of TQM adoption (e.g., Joss, 1998; Kanji and Moura e Sá, 2003; Nwabueze and Kanji, 1997; Øvretveit, 2000; Potter, Morgan and Thompson, 1994; Brashier et al., 1996; Zabada, Rivers and Munchus, 1998). The role trans-disciplinary community groups played in empowering patients to shape their own local services is consistent with the assertion from Bell (2004) that not enough is being done within healthcare firms to involve service users in improving services – a view that

Owusu-Frimpong, Nwankwo and Dason (2010) attribute to resistance from clinicians who deem patient views as too subjective to be of any use.

Another factor contributing to organisational improvement at Bettercare was the adoption of practice-based learning – a tenet of EALIM. The finding that practice-based training increased staff knowledge and competence supports the writings of Hislop (2009) and Newell et al. (2009), who assert tacit knowledge sharing through shared experiences from one's own practice, holds greater potential for human development than codified and explicit knowledge sharing – methods TQM heavily relies on (Ribiere and Khorramshahgol, 2004). Practice-based training also had a positive impact on employee commitment to learn, a finding noticeably absent from my search of the TQM literature, perhaps because TQM theorists do not commonly advocate practice-based learning.

This research found that several top and middle managers perceived the emergence of a learning culture, evidenced by increased employee commitment to learn, tacit knowledge sharing and use of reflexive learning. Other findings supporting their perception include less blame, along with increased flexibility, experimentation, innovation, empowerment and collaborative improvement. My search of the organisational learning literature showed these findings have resonance with the characteristics of learning culture purported by other authors (e.g., Dodgson, 1993; Jensen 2005; Rushmer, et. al., 2004; Schein, 2010; Senge, 2006; Yang, Watkins and Marsick, 2004). Therefore, the perception a learning culture had emerged at Bettercare has some merit and indicates a considerable transformation from the defensive organisation I interpreted in cycle one. Schein (2010) and Senge (2006) argue learning organisations hold advantages, such as increased sustainability and competitiveness.

Another important development of this action research was corporate philanthropy generated pride among care staff and a moral perception of their employer, motivating them to act toward the good of the organisation. Although Stacey (2010, p.191) suggests strong corporate values could inspire employees with

‘compelling motivations,’ he gives little indication as to what these precise values are and the methods organisations could use to inspire such motivations. What this research demonstrates is that altruism is a specific value care staff morally admire (i.e., an ego-ideal), which they identified with Bettercare’s corporate philanthropy. The increased organisational commitment this corporate philanthropy generated, confirms Schwartz’s (1987) theory that when employees identify the activities of an organisation with their own ego ideals, this identification process creates positive action and employee commitment. Although Sellman (2010) asserts altruism is particularly valued among healthcare practitioners, according to MacIntyre (2007), society at large equates altruism with morality. An implication of MacIntyre’s suggestion in light of this research is that healthcare and non-healthcare organisations could potentially use corporate philanthropy to simply generate a moral perception of their corporate identity and extract stakeholder commitment. Using corporate philanthropy toward these ends is perhaps nothing new, as Kotler and Lee (2005) state increasing numbers of executives are using corporate philanthropy and other CSR methods to market their organisations and advance business goals. However, from a Kantian perspective, using philanthropy as a marketing ploy to simply gain competitive advantage would be a beguiling and self-serving use of CSR. I therefore recommend that executives address social and environmental issues from an altruistic concern for people and the planet – a tenet at the heart of EALIM.

7.6 Summary and Conclusion

Although other studies on TQM initiatives have reported high failure rates (e.g., Beer, 2003; Kearney, 1992), overall findings of this study indicated EALIM's adoption was successful for the most part. The adoption of EALIM at Bettercare produced cultural change, marked by increased democracy, collaboration and empowerment – tenets of EALIM. Prerequisites for this cultural change include top management's commitment to and internalisation of EALIM, which supports findings from other TQM studies (e.g., Thiagarajan and Zairi, 1997a, Zabada, Rivers and Munchus, 1998). Another prerequisite for cultural change was the adoption of EALIM's adaptive concept, which ameliorated top managers' anxiety toward uncertainty and resistance to change. As such, EALIM's integration of complexity theory presents an advantage over other TQM models, since they do not typically include complexity concepts. Top management's adoption of complexity was also instrumental in the creative destruction of dominant schemas of managerialism and bureaucracy, which generated the autonomy middle managers needed over the quality of their own work.

EALIM's core values guided the ethical norms of top and middle management, resulting in increased engagement and respect for employees, which various authors argue are critical factors for TQM success (Coulson-Thomas, 1992; Fotopoulos and Psomas, 2010; Thiagarajan and Zairi, 1997a). Another outcome of EALIM's adoption was participants commonly espoused 'compassion' as an intrinsic construct of quality care, suggesting compassion could be used as a substantive hyper-norm within healthcare to guide human behaviours, rather than to control them. However, EALIM's adoption had limited impact on staff nurse culture, particularly in regard to their low commitment to collaboration, lack of hands on care and use of managerial control – characteristics that may be attributed to their socialisation as nursing professionals. These characteristics were barriers to service quality, since they undermined teamwork and harmed patient care. Other barriers to service quality include staffing shortages, low care worker pay and poor leadership – findings consistent with other TQM studies (e.g., Mosadeghrad, 2013; Nwabueze, 2004; Talib, Rahman and Quereshi, 2011).

Despite these barriers, EALIM's adoption generated improvement in patient independence, a finding lacking in the TQM literature. Other improvements found in this study include increased employee commitment to learn, reflexive learning, flexibility, experimentation and innovation, along with greater collaborative improvement between top and middle management. Factors that contributed to these improvements were the use of trans-disciplinary community groups, the adoption of practice-based training, the creation of meaningful roles for middle managers in QI processes and increased empowerment. Increased employee empowerment was also linked to greater job satisfaction, an important determinant of corporate sustainability. However, care workers in hospitals were less empowered than their counterparts in care homes, due to staff nurses' use of managerial control – a pattern reflecting their ideologies and identities as professional nurses. Moreover, the creative contribution of employees toward problem solving and innovation was sparse, a finding congruent with other TQM studies (e.g., Mosadeghrad, 2013; Potter, Morgan and Thompson, 1994).

Two important developments of this action research were, Bettercare transformed from a defensive organisation to a learning organisation and that corporate philanthropy generated a moral perception of Bettercare, which inspired increased levels of organisational commitment.

Chapter Eight: Conclusion of the Thesis

In drawing this thesis to a close, this chapter summarises the main outcomes, implications and limitations of the research, its original contribution to practice and knowledge, along with recommendations for taking EALIM forward. I then note some final reflections on my entire research journey, especially in regard to its impact on my professional practice and personal life.

8.1 Summary of the Thesis

Currently, UK healthcare is facing an unprecedented quality crisis (Siriwardena, 2011) despite a plethora of public policy and quality initiatives over the last thirty years (McSherry and Pearce, 2007). Although the reported success of TQM initiatives in manufacturing spawned a quality revolution in the 1980s (Besterfield et al., 2003), TQM's crossover into healthcare services yielded mixed results (Kanji and Moura e Sá, 2003; Yasin et al., 2004). Consequently, the purpose of this research was to critically examine the applicability of TQM within a healthcare environment and use those findings to devise an innovative, sustainable QI model that could be adopted and evaluated within a private healthcare setting. This research purpose was realised in the development of EALIM – an ethical, adaptive learning and improvement model that was adopted and evaluated at Bettercare.

Following a reflexive study of the literature, a qualitative Action Research (AR) methodology was chosen, as this allowed understanding of contextual factors and the internal logic of human action, and possessed features germane to the participatory context of adopting EALIM within my own organisation. Over a longitudinal period of eighteen-months, empirical evidence was gathered in three AR cycles: 1) pre-implementation, 2) implementation and 3) post-implementation. Information from these three cycles was analysed and findings were presented in the preceding chapters of this thesis to answer the research questions. In summary, answers to these questions are found overleaf.

8.1.1 What changes were needed to EALIM's conceptual framework?

In the first cycle, the virtue of compassion was integrated within EALIM's moral anchor. This change made the QI model even more germane to a healthcare context, since compassion is a morally admired construct commonly associated with caring professions (Sellman, 2010). During the second cycle, Quaker space and appreciative methods were integrated within EALIM's conceptual framework. Denoting the reflexive nature of this AR inquiry, these methods were added to counteract Bettercare's culture of managerial control and top managements lack of appreciation toward care staff.

8.1.2 What acceptance and resistance did participants exhibit?

During cycle one, the chairman showed the greatest resistance toward EALIM, which seemed predicated on his reliance on bureaucratic management and managerial control. However, in the second cycle, the chairman was dismissed from Bettercare, a situation that enabled the adoption of EALIM because his autocratic leadership style had posed a barrier to pragmatic change. Other prerequisites enabling EALIM's adoption include the commitment and visible involvement of key executives, double loop learning and the participatory leadership style of the COO who devolved power to middle managers, allowing them greater autonomy over the quality of their own work. While other TQM studies found middle managers resisted TQM efforts (e.g., Beer, 2003; Coulson-Thomas, 1992; Thiagarajan and Zairi, 1997a; Zink, 2007), findings from this study indicate otherwise, a situation that may be attributed to middle managers' strong identification with EALIIM's moral values of compassion and altruism. However, staff nurses resisted EALIM's tenets of knowledge sharing and collaboration, characteristics consistent with dysfunctional narcissism that served to maintain power differentials between them and care workers.

8.1.3 What impact did the model have on organisational culture?

Key findings from cycle three showed EALIM's adoption at Bettercare produced cultural change marked by increased democracy, collaboration and empowerment – tenets of EALIM. Prerequisites for this cultural change include top management's

commitment to and internalisation of EALIM as well as their adoption of EALIM's adaptive concept, which ameliorated their resistance to change. EALIM's core values also guided the ethical norms of both top and middle managers, resulting in increased engagement and respect for employees – characteristics various authors argue are critical for TQM success (Coulson-Thomas, 1992; Fotopoulos and Psomas, 2010; Thiagarajan and Zairi, 1997a). Another outcome of EALIM's adoption was that participants commonly espoused compassion as an intrinsic quality of care, suggesting compassion could be used as a substantive hyper-norm within healthcare to guide human behaviour. Perhaps the most important impact of EALIM's adoption at Bettercare was that it generated a learning culture. However, EALIM had limited impact on staff nurse culture, particularly in regard to their lack of collaboration with care workers and use of managerial control, characteristics that may be attributed to their socialisation as professional nurses.

8.1.4 What impact did the model have on organisational improvement?

EALIM's adoption was for the most part, successful in generating organisational improvement. In cycle two, EALIM's adoption led to improved decision-making and problem solving within board meetings, improved patient activities and increased patient confidence in self-advocacy. In cycle three, other improvements include increased reflexive learning, flexibility, innovation, collaborative improvement between top and middle management, along with patient independence. Factors contributing to these improvements were the use of trans-disciplinary community groups, the adoption of practice-based training and employee empowerment – factors other TQM studies suggest are essential for successful TQM adoption (Powell, 1995; Talib and Rahman, 2010; Thiagarajan and Zairi, 1997a). Nevertheless, care workers in hospitals were less empowered than their counterparts in care homes due to staff nurses' use of managerial control, which undermined teamwork and harmed patient care. Other barriers to service quality include staffing shortages, low care worker pay and poor leadership – findings consistent with other TQM studies (e.g., Mosadeghrad, 2013; Nwabueze, 2004; Talib, Rahman and Quereshi, 2011). Despite these barriers, corporate

philanthropy generated a moral perception of Bettercare and inspired increased levels of organisational commitment.

8.2 Implications and Limitations of the Research

There are two major implications of the development and adoption of EALIM during this research. Firstly, EALIM presents an alternative approach to quality improvement that holds advantages over conventional TQM approaches (see table 9) and secondly, it has the potential to innovate and transform care practices in healthcare firms. This potential is especially important within healthcare environments, as they are dominated by bureaucracy and compliance to arbitrary standards, which tend to stifle innovation and undermine substantive caring values (Nwabueze, 2004; Parkin, 2009; Sellman, 2010). Furthermore, in the context of failing healthcare services, findings from this study could enlighten healthcare executives and practitioners elsewhere, of key factors that may improve their own practices and the delivery of quality patient care.

In the face of these implications, a limitation of this AR study is its results should be treated with caution, since the knowledge produced is tentative and limited to a specific socio-historic context (Gill and Johnson, 2010; McNiff and Whitehead, 2011). Consequently, these findings should not be generalised across healthcare sectors, as each organisation is idiosyncratic in nature and bound by its own contextual factors. For this reason, an assumption that the results of this study could be accurately replicated would be tenuous, particularly among public healthcare organisations because they possess inflexible hierarchies and are driven by greater bureaucracy and external politics than private healthcare firms (Nwabueze, 2004; Rod and Ashill, 2010). Nonetheless, in contexts where there is organisation wide commitment to EALIM's core values and where managers commit to a participatory style of leadership, I would argue some of the results of this study could be replicated.

Other limitations of this AR study include a possible impact on the robustness of research findings from being unable to reinterview all particpants from cycle one,

along with a lack of information from participants regarding the adoption of Quaker space and appreciate approach methods. Nevertheless, as long as all the above mentioned limitations are acknowledged, outcomes from this research can enhance our understanding of healthcare management, provide practicable insights for those implementing QI initiatives and offer an alternative QI model for researchers and practitioners to explore.

8.3 Original Contribution to Practice

This AR study made a novel contribution to my own practice as a quality consultant. Evidence from my reflexive notes suggest this AR study enabled me to develop reflexive and productive reasoning skills, enhance myself as a political entrepreneur, i.e., develop a repertoire of political strategies (Coghlan and Brannick, 2010) and evolve into a conversational practitioner, i.e., hosting conversations and listening for shared meanings (Lewis, Passmore and Cantore, 2011). These attributes played a creative role in enhancing my practice and equipped me to build relationships with others who function with different mental models – in other words, I learned to develop trust with those from different disciplines and gained insights from their diverse ways of thinking. Furthermore, during my reflexive examination of the literature, I developed a deep interest in the use of power in organisations and a concern for the emancipatory interest (Flood and Romm, 1996; Nielson, 1993) – elements I adopted in my own practice and in the development of EALIM. As a consequence, this research not only made an original contribution to my own practice, but also transformed my worldview.

With regards to participants, findings from this research indicated EALIM's adoption made a creative contribution to their professional practice. For instance, EALIM's adoption transformed the culture at Bettercare from a defensive organisation to a learning organisation and guided a significant paradigm shift that de-centered the hegemony and bureaucracy of top management. Examples of how the adoption of EALIM made a positive impact on the practices of top managers include their reduced anxiety toward uncertainty and resistance to change, increased engagement and respect for employees, greater collaboration

with middle managers, as well as improved decision-making and problem solving capabilities within board meetings. Furthermore, the evaluation meetings in cycle two triggered double loop learning among most top managers, enabling them to critically examine assumptions influencing their behaviours, recognise the unintended consequences of their actions and affectively re-interpret their organisational world. Since the above examples reflect the determinants of research quality offered by Reason and Bradbury (2006,), i.e., 'quality as relational praxis' and 'reflexive-practical outcomes' (pp.346-347), this research can be relied upon as an efficacious contribution to professional practice.

This AR study also had a creative impact on the practices of both middle managers and employees. This impact was evidenced by increased employee empowerment, commitment to learn, reflexive learning, flexibility, experimentation and collaborative improvement – outcomes demonstrating Reason and Bradbury's (2006) choice points of 'quality as engaging in significant work' and 'emerging inquiry towards enduring consequence' (pp.348-349). Moreover, the finding that corporate philanthropy generated a moral perception of Bettercare is another exemplar of how this research made a novel contribution to practice, since it inspired increased levels of organisational commitment.

In a wider context, EALIM's adoption made a positive impact on patients' experience of service quality, evidenced by an increased focus on patient independence, improvement in patient activities and patients' increased confidence in their self-advocacy. Since most TQM healthcare studies I searched do not indicate a direct improvement to patient care (e.g., Joss, 1998; Kanji and Moura e Sá, 2003; Nwabueze and Kanji, 1997; Øvretveit, 2000; Potter, Morgan and Thompson, 1994; Brashier et al., 1996; Zabada, Rivers and Munchus, 1998), this study demonstrates an original contribution to the practice of TQM within a healthcare context.

8.4 Original Contribution to Knowledge

The creation of EALIM as an innovative and sustainable quality improvement model can be added to the stock of TQM and CQI theory as an original contribution. Although authors and theorists have examined conceptual linkages between TQM and CSR (e.g., Ghobadian, Gallear and Hopkins, 2007; McAdam and Leonard, 2003), TQM and CT (e.g., Dooley, Johnson and Bush, 1995) and between TQM and KM (e.g., McAdam, Leitch and Harrison, 1998; Ribiere and Khorramshahgol, 2004), to the best of my knowledge no other author has conceptually examined the differences and linkages between all four organisational theories (CSR, CT, KM and TQM). I am also not aware of any other author who has integrated all four of these theories into one conceptual framework, distinguishing EALIM from other QI frameworks – especially TQM. As illustrated in table 9, the advantages resulting from integrating all four organisational theories include moral capitalism, substantive rationality, shared vision, triple loop learning, humane ideology, complexity paradigm and stakeholder focus. The creation of EALIM's moral anchor also presents a novel contribution to TQM theory, since reflexivity, compassion and altruism are largely overlooked in TQM models because of their predication on cybernetic learning (Dooley, Johnson and Bush, 1995) and formal rationality (Grey, 2013). EALIM is therefore relatively unique by comparison to other TQM models.

As well as extending TQM theory and method, EALIM also expands the foundations of quality management within healthcare. For example, EALIM's ethical values of altruism and compassion address Carney's (2006, p. 112) concern that 'not a single moral model' exists in healthcare management and shifts the focus from the dominant paradigm of healthcare quality, i.e., adminstering technical aspects of care (Bell, 2004), to delivering virtuous care (Armstrong, 2006; Sellman, 2010). Although other authors support the concept of integrating moral virtues within a quality paradigm (e.g., Ahmed and Machold, 2004; Armstrong, 2006), this research takes this concept further by integrating moral virtues within a workable QI framework – representing the next stage of quality evolution.

Another exemplar of this research is EALIM's integration of complexity theory, which calls for leaders to adopt an informal, intuitive and courageous approach towards dismantling bureaucratic processes and traditional hierarchies – characteristics limiting an organisation's propensity toward change (Ashkenas, 2011; Litaker et al., 2006; Stacey, 2010). Since these characteristics damage QI initiatives in healthcare contexts (Nwabueze, 2004; Parkin, 2009; Shortell et al., 1995), EALIM's integration of complexity theory presents an advantage over other TQM models because these are largely designed through a Newtonian paradigm of equilibrium and linear causality (Dooley, Johnson and Bush, 1995; Sanford, 1992).

Furthermore, the research outcome that EALIM's adoption enabled patients to develop greater confidence in their self-advocacy appears to be a novel finding, since my search of the healthcare management literature yielded no evidence of the adoption of QI initiatives improving patient self-advocacy. This finding is particularly important for patients with a learning disability or mental illness because they typically lack opportunities to contribute to their own lives and shape the service they receive (Bell, 2004). From this perspective, this finding demonstrates an essential element of research quality – namely, 'quality as engaging in significant work' (Reason and Bradbury, 2006, p.348).

Finally, the use of psychoanalytic concepts in my analysis of information also presents a novel contribution to the TQM literature. Although researchers have used psychoanalysis as a method of analysis, to the best of my knowledge, its use in this inquiry presents a first step in the research of TQM. As a result, important findings were produced regarding why participants exhibit maladaptive defensive mechanisms, such as fear of loss regarding position and power, perceived threats to self-identity and survival, anxiety toward risk and uncertainty. It follows that these findings could guide interested others to better understand and ameliorate resistance to QI initiatives – outcomes exhibiting the quality of this research towards 'enduring consequence' (Reason and Bradbury, 2006, p.349).

8.5 Recommendations for Taking EALIM Forward

Others may wish to take this research further by exploring the use of EALIM in both private and public healthcare organisations or perhaps in other service contexts where a corporate social ethic is of paramount importance. Alternatively, researchers and practitioners may wish to use this research to explore various themes, such as the development of a moral framework for their business context, the adoption of complexity perspectives in management, the use of practice-based learning, as well as the applicability of Quaker space and appreciate methods.

For those involved in change programmes, decision makers should be especially aware of what it is they are committing to and what obstacles they will meet along the way. Since healthcare is fraught with a complex amalgamation of diverse disciplines and professional bureaucracies (Mosadeghrad, 2013; Øvretveit, 1992), I recommend future practitioners of EALIM or other QI initiatives build alliances with clinical professionals and involve them in implementation strategies to reduce their resistance (Badrick and Preston, 2001). A barrier to EALIM's adoption was a staff nurse culture characterised by a lack of collaboration with care workers, greater focus on administration than hands on care and use of managerial control. Since these characteristics may be attributed to staff nurses' socialisation as nursing professionals, I advocate the recommendations of McCabe and Garavan (2008) – namely, the nursing curriculum include leadership development, be more focused on strengthening nurses' practice capabilities and that employers link the professional development of nurses with organisational goals to enhance their commitment. To counteract the dysfunctional narcissism found among some nurses during this research, I also recommend professional nursing bodies and nursing practitioners place greater emphasis on substantive caring values of altruism and compassion, as these are critical characteristics for delivering 'morally good care' (Armstrong, 2006, p.112).

Finally, to avoid inconsistency between theories espoused and theories in use, I recommend that others wishing to adopt EALIM ensure they not only espouse EALIM's values and tenets, but also particularise them in their everyday work with

others – thus providing a personal exemplar of action. As William Shakespeare (1564-1616) wrote in Coriolanus, 'Action is eloquence, and the eyes of the ignorant more learned than the ears' (Shakespeare, 1964, p.73).

8.6 Reflection on my Research Journey

When I first embarked upon this doctoral research journey, I was not fully aware of what I would encounter because my experience up to that point had been limited to a practitioner. However, as I reflexively engaged with the literature and my own organisational world through the eyes of a researcher, I was able to question what I knew (i.e., make the familiar more strange), consider alternative theoretical approaches (i.e., make the strange more familiar) and examine social entities from multiple perspectives (Hatch, 2013; Tietze, 2012). The outcome of this reflexive engagement was I experienced a level of triple loop learning (Flood and Romm, 1996) that not only transformed my professional practice, but also my worldview. For example, prior to this research, I viewed an organisation as an entity with a culture, but in the course of this research I began to view an organisation as a culture. From this perspective, I was able to see organisations as dynamically humane environments, which had implications on how I approached organisational theory and the kind of QI model I developed – EALIM.

This research also changed my view of culture from a singular to a differentiated perspective (Hatch, 2013). This change of view allowed me to see the complex reality of my own organisation, mediated by cultural groups with different ideologies and identities expressed in patterns of power relating, i.e., inclusion and exclusion (Stacey, 2007: 2010). It follows that my adoption of critical theory within an AR context was significant, as it allowed me to examine the use of power and develop an emancipatory interest toward changing power imbalances through democratically just practices (McNiff and Whitehead, 2011) – an approach at the heart of EALIM. This approach empowered me to evolve into a democratic practitioner – that is to say, I collaborated with others to reduce conflicts, devolve power and find democratic ways of working. In fact, the research outcomes I am most proud of relate to increased organisational democracy, e.g., increased

employee involvement and empowerment (particularly among care workers), along with improved patient self-advocacy and independence.

Another area that transformed my practice was becoming a conversational practitioner. For instance, before commencing this research I often listened to others with the aim of replying, but during this research, I learned to listen with the aim to understand – instead of speaking to be heard, I spoke to be understood. As a result of this transformation, understanding others and self are now personal goals of mine, which not only have positive implications for my professional practice, but for life itself. What supports these goals is my use of psychoanalysis – a discipline I developed during this research, allowing me to see the world with deeper insights and reflectively articulate what I see in the hope of generating shared understanding.

In closing, I could perhaps view the completion of this research journey as my arrival at a desired destination. However, I see it in a rather different way, namely, as an exciting journey that fanned a flame of curiosity in me – a life excursion that stoked a compelling appetite to embark upon further adventures toward creating and sharing knowledge.

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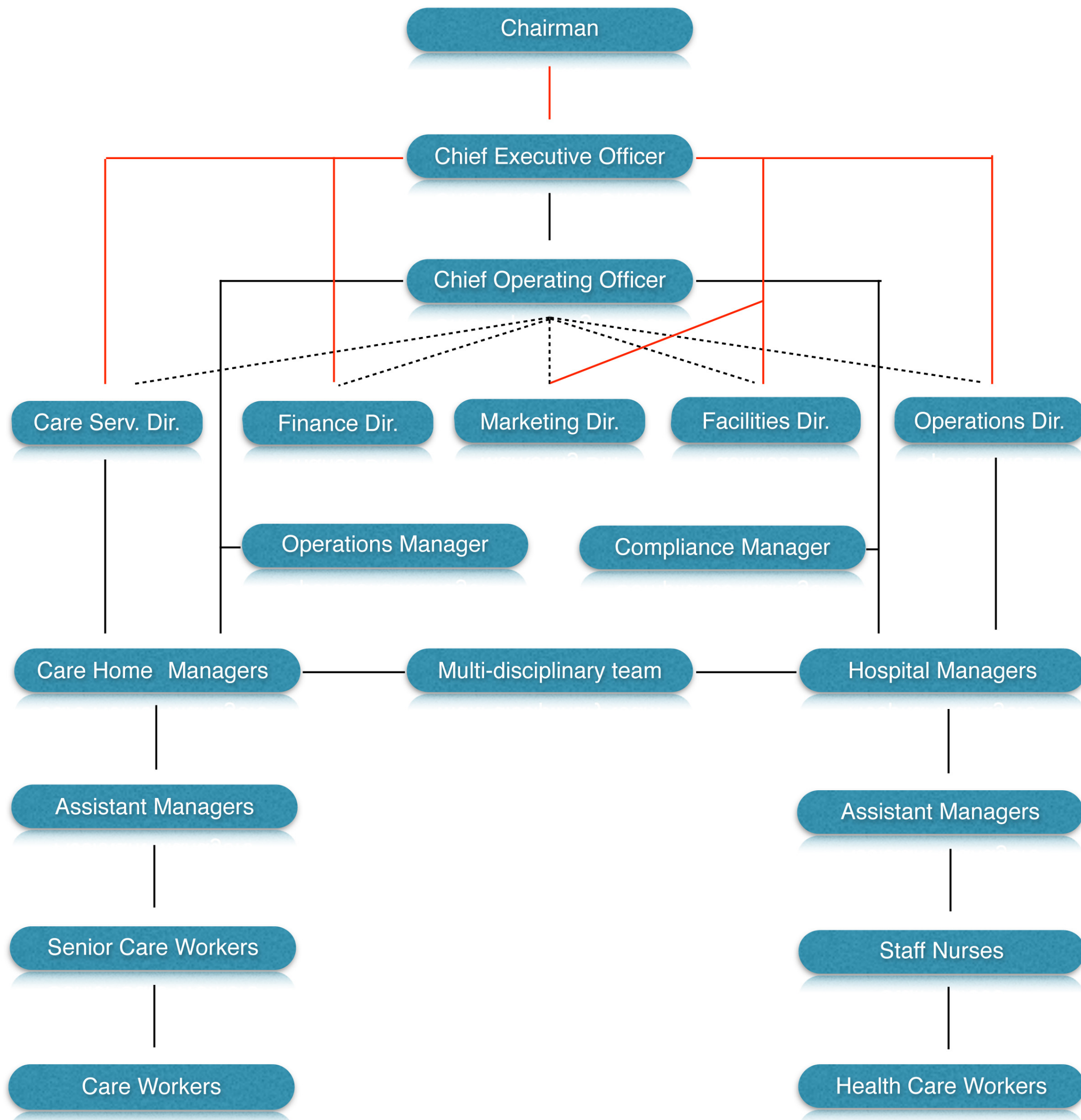
Appendix 1: Organogram of Bettercare



Notes:

- Solid black lines indicate links that were unchanged after top management restucture.
- Dashed lines indicate new links after top management restructure.
- Solid red lines indicate links that were removed after top management restructure.

Appendix 2: Letter of consent from Bettercare

30th September 2011

Dear Demetri,

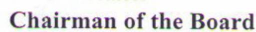
This letter confirms that you have been duly authorised to carry out an action research evaluation on the use of a new quality improvement (business excellence) model you are developing.

Your research has been discussed and approved by the board of Directors on 29th September 2011 and you have permission to begin forming a project team for the application and development of 'EALIM' (Ethical, Adaptive, Learning & Improvement Model) within , which includes the collection of company documents and data involving human participants (including patients) subject to their informed consent.

The 'informed consent' of our patients who do not have mental capacity are an issue and we would therefore ask you to ensure you closely consult with the clinical care team to ensure the purpose of your research is appropriately communicated each time data is gathered, so that patient rights are maintained.

Meanwhile, we look forward to being kept informed of the progress of EALIM's implementation and are hopeful that as an organisation, the model can better enable us to provide 'excellence' in our services.

Yours Sincerely,



Chairman of the Board

Registered in England & Wales

Appendix 3: Interview guide

Purpose

The goal is to gather descriptions of the life-world of the participant from their perspective through the use of a low degree of structure using open questions. In particular, the following pre-defined seven concepts will be explored: perceptive value of the organisation, power relations, motivation, ethics, adaptability, learning and improvement.

Start of the interview

After dispensing with the purpose and process of the interview, explain to participants that the information they share will be treated confidentially and my final report will not directly identify them. Before proceeding, ask them if they have any concerns and ensure their explicit consent to use the information they provide. Start the interview with open questions about the participant's work role and history, as this is an area they could feel comfortable in answering and open the flow of communication.

Phrasing of questions

Ask mostly open questions with some closed questions for obtaining clarification. Answers should be followed up with probing questions until where possible, the theme explored has been saturated. To elucidate meaning, encourage the use of storytelling and narratives by asking participant to recall examples, situations and incididents they've encountered.

Concepts and themes to explore

Whilst pre-defined a priori concepts and themes are to be explored, questions should not to be limited to them. Some themes may overlap and it may not be practicable to gather information on all themes due to time constraints. If answers do not fit within any themes, allow the discussion to take its course, as this could become an area of genuine interest. Rather than gathering uniform data, pursue

exceptions, clues and anything out of place, which may present greater value in the search for qualitative descriptions and meanings.

Finishing the interview

Finish on a positive note. Provide the participant with a final opportunity to make any statements not previously covered. Finally, thank the participant for their time and ask them if they want a copy of the final report.

Reflexivity

After the interview, make notes about my own feelings and thoughts on the process and how I performed. Reflect on whether any of my presuppositions had an impact on participants' contribution and how this could be lessened next time.

Concepts and themes

Perceptive value of the organisation

Perception of the organisation

E.g., what are your perceptions of the organisation?

E.g., can you think of a story/incident/situation that sums up what it means to be part of this organisation?

The participant's ideal organisation

E.g., describe the ideal organisation you would like to work for?

E.g., what would make the organisation better?

Power relations

Decision-making processes

E.g., how do those in charge usually make decisions?

E.g., how involved are you in the day-to-day decision-making of your unit?

Interactions between managers and employees

E.g., what makes you concerned/proud/angry/happy about the way those in charge communicate?

E.g., what stories or examples come to mind about the way managers lead?

Managers' perceptive value of employees

E.g., describe a situation that sums up how you see your staff team?

E.g., how would you describe your staff?

<u>Motivation</u>

Variables influencing employee commitment

E.g., what makes you satisfied in your job?

E.g., what aspects of your job are you most committed to?

Factors the participant finds motivating and de-motivating

E.g., what things inspire you the most and least in your job?

E.g., what aspects of your job do you find most rewarding?

<u>Ethics</u>

Participant's espoused values

E.g., what are the ethics you value most at work and why?

E.g., what do you value most in your job?

Conflicts between the company's values and the participant's

E.g., give me an example of a company policy or practice that you felt uncomfortable with?

E.g., have you faced a conflict between your values and that of the company's and if so, tell me about it?

How Bettercare values its staff

E.g., describe a situation that sums up your feelings about how Bettercare cares for you?

E.g., how do you feel the company treats its staff?

<u>Adaptability</u>

Normative emotions and behaviours when faced with change and uncertainty

E.g., think of an example of a huge change you faced at work and how it made you feel and act?

E.g., what kinds of challenges at work make you feel uneasy?

Participant's observations of how others deal with unintended consequences

E.g., how do people around you deal with unpredictable things that happen at work?

E.g., describe an unexpected situation that happened at work and how the team dealt with it?

Factors limiting the participant in overcoming challenges

E.g., what kinds of obstacles do you face at work when trying to solve problems?

E.g., what kinds of things stop you from doing your work properly?

Learning

Participant's learning methods

E.g., what methods do you use for your own learning?

Participant's knowledge sharing methods

E.g., how do you share knowledge with others at work?

Organisational knowledge sharing methods

E.g., how do people at work share knowledge with each other?

The extent reflexivity is used by the participant

E.g., how often do you think about your own thinking?

E.g., what goes through your mind when you are involved with a task?

Improvement

How the participant improves his/her own practice

E.g., how do you seek to improve what you do?

Factors limiting the participant from improving

E.g., what stops you doing your job the way you would like to?

The role of innovation in service improvements

E.g., can you think of a new idea that was developed at work and how that might have helped others to improve?

Perception of how the organisation is performing its service quality

E.g., how good/bad is the organisation at improving its quality and what else could it do to improve?

Appendix 4: EALIM seminar slides

"Progress is impossible without change, and those who cannot change their minds cannot change anything"

George Bernard Shaw

Why do we need a new quality improvement model?

Enquires...Failures...Abuse

UK healthcare services (public and private) has been the subject of many major inquiries and reported failures over the last decade.

The marked increase of such cases, expose the limitations of both the current obligatory Clinical Governance framework and other prevailing quality systems. (e.g. ISO, EFQM).

A Panorama investigation at Winterbourne View, exposed months of endemic abuse of vulnerable adults. The CQC are now stepping up its inspections of learning disability services (LD review - chaired by CQC on 29 June 2011).

The EHRC has said a major inquiry it's conducting into home care in England (to be published this November), has identified major problems, such as: elderly people not being washed regularly, no proper help with eating or drinking (June 2011).

The Health Service Ombudsman carried out an in-depth review of 10 reported cases and concluded that patients aged over 65 had suffered unnecessary pain, neglect and distress. Charities said the findings were "sickening", while the government admitted improvement was needed. (Feb 2011).

A survey carried out by the Health Foundation found there was significant variations of quality across services (2009).

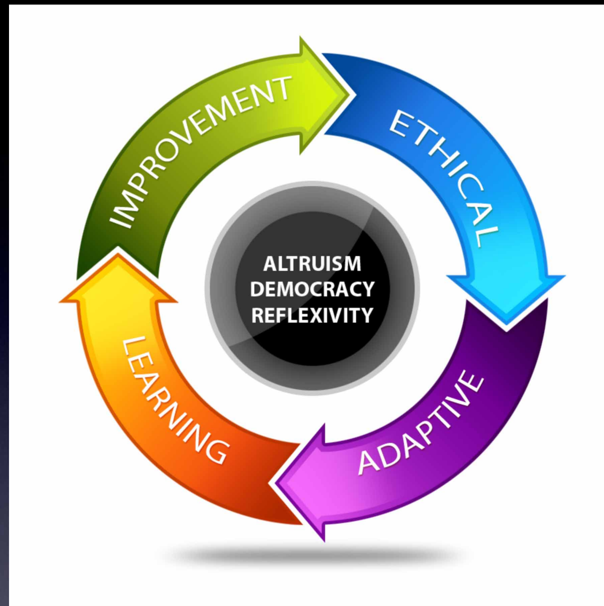
- A Commonwealth Fund International Health Policy Survey found 61% of participants saying healthcare systems needed complete redesign or fundamental changes (2008).
- A CQC investigation of learning disability services at Sutton and Merton PCT found a catalogue of physical and sexual abuses (2007).
- The Abraham Enquiry into the deaths of six vulnerable adults in NHS and Local Authority care found appalling abuses and neglect (between 2003 – 2005).

What can change the situation?

A holistic business excellence model - where everyone learns to improve their own practice.

A philosophy that is more than a way of organising, but a way of living & looking at the world; that values people & the planet above short term gain; that connects people to an ethic judged as intrinsically good.

An approach to learning that acknowledges the world as a complex place and the need to be innovative in the face of unpredictability.



Ethical Adaptive Learning & Improvement Model

'EALIM'

Benefits

We ALL learn to do things better.

Enables everyone to practice ethical values that reduce the risk of harm to others.

Potential to achieve more responsible learning and improvement from everyone.

Provides an opportunity to set ourselves apart from our competitors - to be industry leaders.

Allows everyone to be part of a vision they can be proud of.

Integrates four distinct concepts

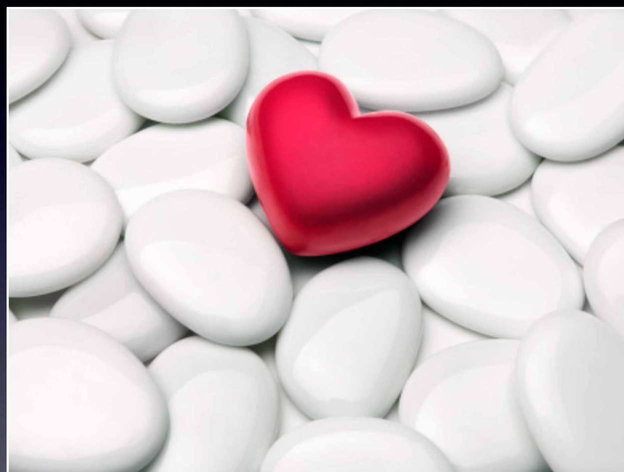
Ethical:- describes the core value - Kantian ethics

Adaptive:- denotes a flexible & fluid approach to spontaneous, emergent changes and complex uncertainties

Learning:- represents the importance of reflexive learning, innovation and knowledge sharing through human interaction

Improvement:- typifies the process of continuous improvement toward satisfying stakeholder needs

ETHICAL



A Kantian ethic - based on the premise of '*do unto others as you would have them do unto you*'. It views people as both the means and the end.

This ethic is the standard of judgement which drives the whole model, forming its'ethical anchor'.

This is contrary to the dominant paradigm of 'utilitarian ethics' (i.e. the greater good for the greater number), where people are treated as a means to an end (i.e. shareholder wealth).

The model holds a concept of Corporate Social Responsibility (CSR); an approach that demonstrates genuine care and ethical regard for people, society and the planet by contributing resources to improve quality of life and alleviate suffering.

CSR goes beyond the legal and financial duties of corporate governance by including ethical, ecological and social obligations toward society.

Corporate credo: publicising inspirational ideals & values

Shared vision: implementing a vision commonly shared

Stakeholder approach: the notion of 'boundarylessness'

Corporate philanthropy: cash donations to good causes

Corporate social marketing: support of change campaigns

Community volunteering: volunteering for good causes

Socially responsible business practices: environmental sustainability and protecting the wellbeing of employees

ADAPTIVE

This part of the model draws upon concepts derived from Complexity Theory (CT).

The majority of organisations pursue a perspective of stability, predictability, control and certainty. As such, they fail to adapt in a complex environment of emergent, sudden, unexplained, non-linear events of major change at organisational, societal and global levels.

Adopting a complexity perspective can enable an organisation to adapt, develop and learn new decision making capabilities, spontaneously self organise and generate new knowledge.

Mental model: welcomes disorder as a partner; uses instability positively; sees change as a necessity; understands that complexity is unavoidable.

Dual strategic methods:

1. Planned: - long term, rigid, incremental change
2. Emergent: - spontaneous, flexible, revolutionary change

Dual management methods:

1. Ordinary: - rational, formal, analytical
2. Extraordinary: - creative, informal, intuitive

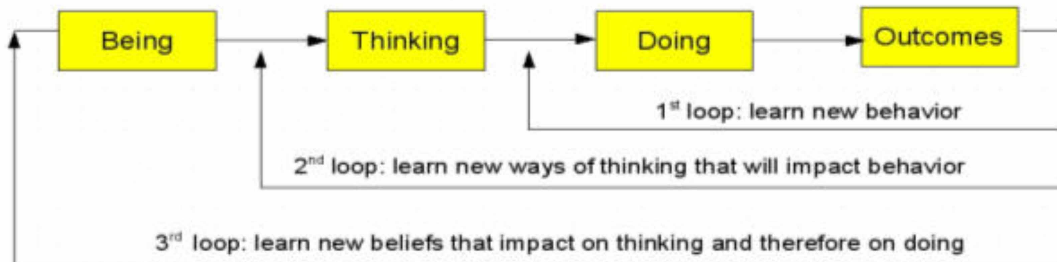
LEARNING

The '*learning*' dimension espouses concepts from the 'Learning Organisation' and 'Knowledge Management' (KM).

KM concepts allow the transformation of an organisations people & its interactive processes by creating, sharing and integrating explicit and tacit knowledge for the purpose of satisfying internal and external customer needs.

Sharing knowledge to empower individuals and teams must replace managerial control.

Triple loop learning: improving - new ways of doing; reflecting - new ways of thinking; transforming - new ways of learning



Communities of practice: practitioner based (homogenous) learning, sharing knowledge & best practice

Project teams: trans-disciplinary (heterogeneous) team working for projects, problem solving & building innovation

Story telling & narratives: as a means of implicit knowledge transfer & creating identity

Knowledge brokers/Boundary spanners: individuals as sources & facilitators of knowledge, who share & interact with different communities of knowledge (or disciplines)

IMPROVEMENT

Integrates precepts of Total Quality Management (TQM): working toward ‘excellence' by continuously improving the quality of every aspect of the organisation for the purpose of satisfying the implicit and explicit needs of internal and external customers.

The TQM perspective espoused here, involves small 'kaizen' steps of holistic improvements spanning processes and interactions (between employees; managers & employees; customers & employees as well as suppliers & employees).

VOC: continuously identifying dynamic customer needs

Five Whys: reactive technique for finding root causes

Force Field Analysis: forces that enable & inhibit goals

Nominal Group Technique: technique for gaining ideas for the detection and correction of errors

Affinity Diagram: Collaboratively arranging a large number of ideas for review and analysis

Pareto Diagram: The 'vital few and the useful many'

THE TEN TENETS

- **Moral anchor**: ethical values that guide decision making and behaviour
- **Exemplary leadership**: not 'top-down' but leaders as servants
- **Boundary-less collaboration**: removing boundaries internally and externally
- **Empowerment and democracy**: devolving power, removing conflicts, sharing decisions
- **Emergence and self-organisation**: allowing social order and self-formation to evolve through local human interaction

- **Learning and team-working**: sharing existing knowledge, and creating new knowledge
- **Practice-based learning**: learning in and through practice, tacit knowledge sharing
- **Continuous improvement**: small steps and break through improvements
- **Quality chain**: customer-supplier concept
- **Customer satisfaction**: satisfying the needs of internal & external customers

Appendix 5: Excerpts from observational notes

Board meeting at head office on 28th July 2011 at 10am

Directors present: chairman, chief executive officer, chief operating officer, care director, financial controller, facilities director and marketing director.

Five minutes before the start of the meeting, I entered the boardroom where I saw the chairman sat at the end of the table. He seemed prepared with his folder and note pad. He asked me whether I was attending the meeting. When I replied I was, his facial expression appeared surprised and claimed he wasn't aware. Once all the attendees gathered, the chairman started the meeting by systematically going through the last meetings action plan, which took approximately twenty minutes. The chairman then conducted the rest of the meeting with systematic prompts for each director to give a briefing on their reports in line with the agenda. When the COO began to discuss a new bonus scheme he had in mind, the chairman seemed to hastily respond with a request for a 'procedure to be written up for use across the organisation.' The chairman then appeared to hurry to the next item of the agenda. When the financial Controller mentioned there was an under spend of 'five hundred staffing hours' in one particular unit for the previous month, the CEO congratulated the team for 'saving the company money' and proposed the workforce be rewarded with 'a bonus.' Upon hearing this, the clinical director stated he was against awarding staff a bonus and began to explain why. He said there had been 'a complaint and subsequent investigation due to a SOVA incident.' The COO then asked the question of whether there was a correlation between the complaint/incident and the reduced labour hours for the month. The care director stated that in his opinion, he didn't believe there was, but the COO did not appear convinced as he said 'this should be followed up.'

A discussion ensued among directors about an incident at care home W (a newly opened residential home) relating to two reported incidents: 1) 'an altercation between two patients,' and 2) an allegation involving 'inappropriate touch.' The COO remarked that 'staff were slow in reporting' the 2nd incident to their manager,

who in turn ‘trivialised the incident’ before reporting it to the ‘director on call’ as a ‘green' status.’ The COO then stated, ‘after a review of the CCTV footage, the evidence suggests the manager should have reported it as an amber,' and claimed both ‘staff and manager’ should have ‘acted sooner’ in reporting the incident. The marketing director commented that a social worker was now asking for the 1st incident involving the altercation to be reported to the CQC as it had been described in an email to her as a 'fight'. The care director expressed concern that managers need to be careful in how they describe incidents to avoid unnecessary cause for alert. The CEO asked that all managers should receive training on communication of incidents as green, amber and red, to avoid this difficulty in future. When the CEO attempted to address a financial issue relating to the bonus scheme the COO had previously mentioned, the chairman stopped him and said, ‘the agenda has moved on’ and asked for the CEO to discuss that ‘outside of the board meeting’ with the relevant persons.

After the meeting ended, I praised the chairman for keeping the meeting to exactly one-hour (he didn’t appear to realise I was being sarcastic). The chairman responded by briefing me on the value of a ‘training course’ he attended when he ‘worked as a civil servant in a local authority’ on 'chairing meetings' and asserted, ‘meetings must be kept within an hour.’

Discussion with operations manager at head office on 31st Oct 2011 at 2pm

I walked through the door and noticed the operations manager sitting at his desk working. I started to have a chat with him about the focus group and he commented much of what we discussed couldn't have come at a better time. We then walked into the meeting room for some privacy where he began sharing about a CQC inspection at Hospital B and said ‘It did not go as intended.’ He then stated ‘there was a lot of tension in a recent operations meeting between me and managers,’ describing how they ‘blamed the shortfalls of knowledge on ineffective company training programmes.’ He said that in the operations meeting, he had been ‘arguing with certain managers,’ suggesting they should ‘make better use of the resources and take lead on teaching their own staff as opposed to depending

on head office to solve their shortcomings.' He also gave them an example of how he had 'rung 3 units in the middle of the night and not one night staff member had answered the phone,' claiming they had 'fallen asleep.' He told them, 'instead of letting night staff drift when on duty, you should be checking to ensue they make better use of their time, like analysing medication administration sheets.' The operations manager told me 'the learning concepts of EALIM are much needed right now,' and 'the whole system of training needs reviewing.' I then took the opportunity to explain EALIM's learning concepts to him. I also informed him I had made a mistake in today's focus group when I suggested forming a proposal to the board on the action plan we agreed. I said I regretted this suggestion as it gave a message inconsistent with the model. I explained we had 3 board members present in the focus group and thus should have encouraged everyone present to go forth and practice what was discussed, using their power and influence to spread knowledge of the concepts. The operations manager explicitly agreed with my idea and said he would 'take steps' to 'begin EALIM's implementation.'

Conversation with the care director in a taxi on 30th Nov 2011 at 5:30pm

During an informal conversation with the care director on the way to the Health Investor awards ceremony, he stated one of the 'CQC recommendations' from the recent unannounced inspection at hospital B, was that 'staff need to demonstrate an understanding of the training they receive.' He said 'its not just about attending training but developing knowledge from the training.' He also said, 'since the EALIM model was introduced, microteaching has been implemented on the units, which is more practice based.' He explained, 'instead of relying on classroom training sessions, the emphasis is on a question and answer approach in the units.' This is what he called 'microteaching. He informed me that managers were now microteaching staff on various subjects within the local units, then testing their understanding through an A4 set of questions, which staff must answer. Some of the subjects he described included 'incident reporting, diabetes, safeguarding, report writing and epilepsy'. He said, 'these are 'now being taught in practice during the shift, maybe in a handover or by spending a few minutes on duty discussing the knowledge that needs to be understood.' He also mentioned that

when he and other senior managers visit the units, staff knowledge was being tested randomly.

Trip to a slum in Mumbai, India on 21st Jan 2012 in the afternoon

The moment we arrived at the slum, we were welcomed by the sight of children playing near a maze of open sewage gutters that ran along the ground from each house. Houses were made from make shift materials such as corrugated steel sheets and tarpaulin, while others were made from rocks and timbers. The children seemed curious to meet us and before most of us were immediately aware, we attracted a crowd of residents that came out of their sheltered vicinity to see us. As we observed their humble way of life, I noticed a few teary eyes among participants, perhaps indicating how overwhelming the experience was for them.

EALIM mini-seminar at care home P on 4th Oct 2012 at 9am

This is the only seminar that I didn't capture on my voice records. I made a mistake in thinking my recorder was switched on when it wasn't. I've been very careful to ensure that written notes were only made from what I explicitly remember observing.

When I arrived, the manager actually greeted me with a kiss on the cheek. This is the first time a manager had kissed me. She then commenced to introduce me to her staff. The staff who arrived a few minutes after me, introduced themselves and I was then offered a cup of tea and some biscuits from female members of staff who had been making beverages in the kitchen. Two male members of staff helped me to rearrange the furniture to accommodate the best position for observing my slide show. We all sat down and I began my presentation of my EALIM slides. At first, everyone was quiet but I verbally prompted everyone to feel at liberty to comment. I encourage them to be critical if they disagreed with anything I presented, explaining this could assist me in further developing the model. There seemed to be an uncomfortable look on some employees' faces when I presented the slides on the scandals. When I presented the slide on the ethical aspects of the model, one Indian member of staff was really interested in

the charity work the organisation had been doing in India. I elaborated on the work the company had been doing there and mentioned there was another project we were funding in Parandwadi. He requested to be part of the next team visit to India. I took his name and said I would be in contact with him as soon there was news on the next visit. I asked if everyone had seen the 'Journey to India video'? They all replied no. I informed them it was on YouTube and encouraged them to watch it. As I progressed thorough the EALIM slides, one female employee to my right asked, ‘how can you ensure people follow the model and what would happen if people didn't?’ I replied by explaining that the model could not be imposed, as that would contradict the ethical values of the model. I emphasised that EALIM could only work on the premise that it's values and methods resonated with members of the organisation and those embracing it would spread knowledge of its values and concepts in conversations and discussions with others. I explained how I had hoped the articles and seminars would inform others of the value of EALIM, but there were no guarantee of its successful implementation. I said if people disagreed or chose not to follow the model, all I could do is try and find out why.

I asked those present if they had been receiving my articles? Out of the 6 people present, 4 explicitly said they had been. I asked how they found the articles? One female staff member said she hadn't read the latest one yet, but had been reading them every month and found them inspiring. Another said he liked them. Another said she had been receiving them but hadn't read any of them yet. One member of staff said she found them a little difficult to read. I said I could make them simpler and easier to read. When I finished the seminar, I asked everyone how they found it. Their comments included ‘it's a good model,’ ‘I hope people follow it,’ and ‘I like the ethics part.’ One person said they didn't know if people would follow it. I asked why? She said ‘it seems to be too ideal.’ Another person remarked, ‘if everyone follows the model, it could make a difference.’ After the meeting a member of staff called ‘N’ approached me whilst I was leaving through the front door and said, ‘I didn't know the company funded children's homes and a school. It's nice to know the work we’re doing with clients here is making a difference around the world.’

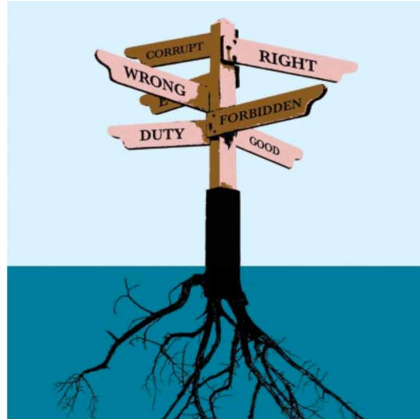
Appendix 6: Ealim articles

[Bettercare] Article, Issue 1, Jan

A Return to Moral Virtues

by James Sideras – Quality Consultant

Bettercare has begun a new way of thinking that will hopefully make it a better organisation, for both staff and patients. Towards this end, I am releasing an article each month with ideas and tips that if applied, could enable you to transform and improve your personal life and your profession. The first of these articles concerns moral virtues.



A Significant life is one that never loses sight of the significance of others. The motives for how we treat others are paramount. Instead of serving our self-interests by actions that seek recognition from others; we should value others from a motive that seeks their wellbeing. What's most important is not what we do, but why we do it.

The good will ethic

Immanuel Kant an 18th century philosopher invented the 'good will ethic'. This principle tells us we must never treat others as just a *means*, but as an *end*. This can be summed up in the golden rule, "*Do to others as you would have them do to you*".

Only when you do something out of good will for the other person can it be called moral action.

For example, if we care for patients because it satisfies our ego, this would be unethical because we are treating patients as a *means* to an *end*. On the other hand, if we care for patients because we want their satisfaction, we are treating them as <u>both</u> the *means* and the *end* and under Kant's moral law, this would be judged as intrinsically good. This idea is in keeping with the professional injunction that nursing should be primarily about regarding the interests of *others* rather than *self* (Nursing & Midwifery Council, 2008).

A false ideal

We live in a culture that has gripped civilisation with a false ideal of success, which has led many under the illusion that significance is a life bound with wealth, power, physical beauty or social status. People have tried to pursue this false ideal at a great cost, i.e. the more we try the more we sacrifice ourselves toward its end without due regard for our own moral character.

Preserving our future

This whole calamity raises the importance of moral virtues and how they have arguably been lost in society. One only has to look at the recent economic collapse and unscrupulous destruction of our environment to see how greed and the interest of *self* is not only harming the way we live, but the way future generations will live.

The lack of social virtues has gripped all aspects of society, including institutions such as healthcare providers.

Scandals such as Winterbourne view and the many recently reported healthcare failures have exposed violations of basic human rights and serve as a reminder that if ethics are ignored, even more damaging consequences will follow.

Others v Self

Florence Nightingale realised in the nineteenth century that nursing should not just be about clinical skills, but a profession founded on human values. The selfless concern for the well being of 'others' (altruism) was considered one of the most important nursing values. Research studies have shown that altruism is now one of the lowest ranked values among nurses. This may suggest that an excessive interest in

ones 'self' (narcissism), more closely represents society. It is unfortunate this change has perpetrated the healthcare profession, which by nature should exist to serve others. I believe there are those who have chosen the healthcare profession as a *means* to an *end*, i.e. who use it as a career or as a job to merely pay their bills.

Virtues v Rules

At present the care profession is dominated by rules, codes of conduct and clinical outcomes. The dilemma is that they are external requirements and as such, may not be compatible with the kind of person one is. However, a return to moral virtues focuses on character traits that enable one to habitually think, act and feel in certain ways, which are compatible with the 'beliefs' of care.

The virtue of compassion

Compassion is recognised as a crucial virtue needed to deliver morally good care and features highly in the NHS constitution. Compassion is not the same as sympathy (*sorrow*), but is a virtue that enables one to '*feel and identify with the other persons suffering, whilst wanting to alleviate it*'. 'Kindness', 'honesty' and 'patience' are other important virtues that are also seen as crucial for developing a therapeutic relationship with patients. *High-quality* care and *virtuous* care are synonymous. Nurses and care workers who exercise these virtues will help to prevent the devaluation of moral virtues and sustain healthcare practice.

Cultivating moral virtues is instrumental to leading a morally good life and helps one to think, act and feel moral.

Cultivating moral virtues

However, this can only start when individuals begin to question their own values and make the choice to consciously exercise moral virtues. How? By treating people as both the *means* and the *end*. To achieve this, we must begin to see the world in a different way. Practising moral virtues tends to enable people to do well in life and helps others do well too.

When we see how responsible we really are as humans, change will come!

Here are some quotes on Character which illustrate the concept of moral virtues:

"Character is doing the right thing when nobody's looking. There are too many people who think that the only thing that's right is to get by, and the only thing that's wrong is to get caught." (J. C. Watts)

"The best index to a person's character is (a) how they treat people who can't do them any good, and (b) how they treat people who can't fight back." (Abigail Van Buren)

"*Watch your thoughts, for they become words...Watch your words, for they become actions...Watch your actions, for they become habits...Watch your habits, for they become character...Watch your character, for it becomes your destiny."* (Frank Outlaw)

Looking beyond the 'Mirror'

by James Sideras

This months article takes us from a discussion on the need for ethics (addressed in the previous two articles), to examining how to become more ethical. In other words, making the necessary changes in our personal and professional lives that can lead us from just 'talking' about ethics, to actually practising them. But how do we do this? By learning something about ourselves through confronting our deepest unconscious assumptions. To do this, we must be ready to look beyond the mirror of what we normally see, even if it means feeling embarrassed by what we discover.

The big 'trap'

Dr Chris Arygris – a former Harvard University Professor, developed a theory by studying the behaviour of well over 10,000 individuals over a 50-year period. In short, his research suggests: *people say one thing but do another, then deny they are doing so.*

We say we are honest, caring and open to criticism, but many of us unconsciously act in ways that undermine these values

We are *'trapped'* by our own defensive behaviours caused by situations that are likely to be too upsetting, embarrassing or threatening to us. We then deny we are doing so and cover up the denial by making it undiscussable. These 'traps' inhibit learning and are anti-corrective of the very errors they create.

A universal human predicament

Of course, if challenged, most of us will not admit to the discrepancies we produce, because the process that produces them is mostly below the level of consciousness.

The consequence is that we reject any causal responsibility by blaming others or the 'system'. These patterns of behaviour are self-fuelling in that the actions or denials strengthen the defences that caused the problems in the first place. Dr Argyris claims this is not limited to just a single person, group or organisation – but is a universal human predicament that affects us all. The outcome is we fail to detect and correct the errors that can transform us into the kind of people we aspire to be.

If we want to develop virtues of compassion, altruism, honesty and courage; we must deal with the disparity between 'what we say' and 'what we do'

The first step

By facing up to our own personal responsibility, we can begin the journey toward genuine change. Hence, the first step to becoming free from 'traps' is to confront our-selves! During the battle of Lake Erie in 1812, Commodore Perry made a journal entry that developed into a classic phrase, "*We have met the enemy, and it is us!"* It is this recognition that enables us to look 'beyond the mirror'.

Another reason why we don't correct the inconsistency between 'what we say' and 'what we do' is because we feel it damages our self-interests or self-efficacy. Whilst in the short term, this process may injure our self-esteem; in the long term, removing these inconsistencies builds moral character and transforms our personal and professional lives. Understanding this benefit is important as it can create the psychological safety we need to remove 'traps' and begin the work of becoming more ethical.

Reflexivity

Most of us are only 'reflective' - that is to say we only look at surface detail. In other words, we only examine what we are immediately aware of, without introspection. However, being 'reflexive' cuts much deeper and requires us to look beyond what we immediately see, by examining what we are unaware of. How? By critically questioning:

- our own taken for granted assumptions
- our own beliefs, values & goals
- why we think & react the way we do
- the impact we have on others

Introspection is like the activity Plato described when he asked, "*Why should we not calmly and patiently review our own thoughts, and thoroughly examine and see what these appearances in us really are?"* Being 'reflexive' can make us conscious of what was once unconscious and allow us to deal with defensive behaviours, traps and their causes. The advantages are numerous, i.e. improve interpersonal relations, solve problems, resolve conflicts and encourage learning.

Leading the way

I believe that reducing traps is the largest challenge to increasing the level of effectiveness by individuals, organisations and societies. However, achieving this will require every admin person, care worker, nurse and manager to become a 'reflexive practitioner'. Leading the way in a world that's lost its moral compass is a journey that involves beating our own path of virtue. Walking that path 'reflexively' may generate twists and turns, surprises and disappointments in what we discover, but in the end – we find our true selves. Not only does this hold the potential for us to be better professionals, but better human beings.

Quotes to ponder on

"Life can only be understood backwards; but it must be lived forwards" (S. Kierkegaard)

"Know thyself, for once we know ourselves, we may learn how to care" (Socrates)

"Your visions will become clear only when you can look into your own heart. Who looks outside, dreams; who looks inside, awakes." (C. G. Jung)

The certainty of uncertainty

by James Sideras

In last months article, I gave examples of recent scandals reported in the media and discussed how just one persons unethical behaviour can start a chain reaction leading to large effects upon organisations & societies. We also looked at the complex and uncertain world in which we live and how we cannot know what's going to happen next. Will Greece exit the euro zone? Will there be another financial crash? Will I still have a job next month?

The reality is, we do not know what the world will be like tomorrow, except that it will be different and perhaps even more complex. In other words, the only thing we can be certain of, is that the future is uncertain.

Uncertainty should make us aware of our need to swiftly adapt to changes in our environment and learn new ways of working with each other

Sadly, many react to uncertainty by exercising more control over others or by creating even more rules to make their world stable and predictable. However, this approach can take us in the wrong direction, causing us to become rigid in our routines and less responsive to changes we must make to survive. Whilst organisations that are rigid may survive for a time, they are likely to fail when environments become stormy and unstable.

<u>The anxiety of uncertainty</u>

Why do we convince ourselves, that success is about trying to control and predict the world around us? Probably because a lack of control makes us feel *vulnerable* and uncertainty generates *anxiety*.

One of the reasons why we *'resist change'*, is because of the uncertainty of what that change will bring. Will it be good for me or will it be bad for me? Will it help me or harm me? When faced with instability or crisis, our default response is to seek comfort in what is familiar. However, this can unwittingly serve to repress what is called *'survival anxiety'* which can produce neurotic behaviours toward the people we work or live with.

<u>Neurotic Management</u>

In the business of management, this anxiety driven neurosis can often lead to: obsessive control over others, emotional stress, anger when others don't meet expectations or making threats against staff. Needless to say these behaviours can have damaging consequences upon staff, who can react with feelings of frustration, disrespect, lack of commitment, or even sabotage.

<u>Managing another way</u>

However, there is another way to deal with uncertainty. Instead of allowing 'survival anxiety' to be used as a force for harmful consequences, we could use it as a powerful motivating force for change - where we recognise that unless we change, bad things may happen to us as individuals, as a team or as an organisation. Instead of relentlessly pursing stability and control, we should recognise our need to: be adaptable, be more spontaneous, develop new ways of learning and be ready to experiment with new ideas.

Our way of thinking should be to welcome disorder as a partner, use uncertainty positively and see change as a necessity

When managers recognise the limiting affects of trying to control others and that they can't solve complex problems by themselves, perhaps they will begin treading a new path - an unbeaten path of faith that depends on others to help create solutions and improvements.

When we realise what *'teamwork'* should mean, we can involve others in making decisions that affect them and enable everyone to engage in a learning process.

Once this happens at [Bettercare], we should begin to see a learning culture emerge – where people are not afraid to swiftly adapt to changes and where flexibility is the norm, not the exception.

Quotes to ponder on

"Don't brag about tomorrow, since you don't know what the day will bring" (King Solomon)

"Be firm on principle, but flexible on method" (Zig Ziglar)

"The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself" (George Bernard Shaw)

2

Overcoming Learning Barriers

by James Sideras

In May's article, we discussed how anxiety about uncertainty can stop us from making necessary changes and how managerial control can cause staff to react with feelings of frustration and lack of commitment. This month's article, will focus on uncovering learning barriers, as well as the methods we can use to overcome them.

So many of us fall into the same trap over and over again, without being conscious of how we contributed to their making. We often think we are doing the right thing, but our own defensive routines (in the form of policies, practices and behavioural norms) stop us from detecting and correcting errors. Therefore, identifying learning barriers is a vital step in stopping the anti-learning and overprotective consequences of our actions. I will now discuss some of these barriers, which I believe are common to us all:

Barrier #1 – a 'win' or 'lose' mentality

With the Olympics round the corner, London is about to embark upon a historic moment where many athletes will gather to perform in the hope of winning an Olympic medal. However, when working in organisations, a 'winning' mentality can sometimes create unintended consequences. Trying to win arguments so others accept our ideas and goals whilst we ignore theirs, can alienate our colleagues and cause discouragement. This type of defensiveness avoids listening to others, limits team work, prevents new ideas from emerging and generates a 'blame' culture when things go wrong. However, we can overcome this barrier by having free and open discussion that encourages collaborative learning and group problem solving.

Barrier #2 – imposing control

Managers and leaders who impose their goals upon others and the way they should achieve them, are probably driven by an anxiety toward risk and are afraid of trusting others. This kind of controlling behaviour often makes followers dependant on their leaders, limits learning, fragments relationships and creates a 'them and us' culture. However, when leaders encourage joint decision making and choose to serve their followers learning needs, this can lead to greater responsibility, more trust and inspires commitment.

Barrier #3 – suppress negative feelings

We believe in telling the truth but in practice we choose to hide the truth. Why? Probably because we are anxious about how others might react if we were to challenge the norm. We say we are fair but often choose to suppress other peoples feelings when we see them as a threat to our way of thinking. However, leaving issues unspoken or making them un-discussable not only causes repression, but can cause barriers that prevent us from adopting new ways of thinking that may lead to improvement. Furthermore, when we make issues un-discussable or remain silent about our feelings, we cover up conflicts and drive issues underground where they fester into resentment, distrust or even gossip. Therefore, practising openness and transparency is vital to overcoming this barrier, which can result in improved relationships, respect and teamwork.

Barrier #4 – making untested assertions

We all have tendencies to make assertions or knowledge claims that are not validated or tested in any way. For example, we draw

conclusions about a person's character, without knowing enough about them. In other words, we often make inferences about situations and people without any kind of fact finding to test our attributions. Making assertions based on our biases or gut feelings without critically examining them, can lead to error, where we even distort the evidence to conform to our views. This can become an enormous barrier to learning, but can be overcome when we pursue a form of inquiry that keeps an open mind until we have the facts that support or reject our views.

Conclusion

I believe that overcoming learning barriers is probably the single most important challenge we face in gaining new knowledge. Overcoming them might even be more important than winning an Olympic medal, as the skills we learn in the process may hold the potential to transform our lives and shape our entire future for the better.

Quotes to Ponder on

"Neither comprehension nor learning can take place in an atmosphere of anxiety" (Rose Kennedy).

"You aren't learning anything when you're talking" (Lyndon B. Johnson).

"Real knowledge is to know the extent of one's ignorance" (Confucius).

"When we say we know, we usually don't know" (James Sideras).

Creating 'Quaker Space'

by James Sideras

In last month's article, I discussed five keys that can unlock our hidden potential. This month, we will look at how we can create sufficient space to foster greater learning and growth in others.

I'm sure we can all think of people (at work or family) who have not been shy in telling us what to do when faced with a challenging situation. While their intention may be to help, they are unwittingly making us dependant on them. Even when we are part of a team, we must remember that we are also individuals with a need to express our ideas without criticism from others. Individuals who never learn to differentiate themselves have trouble separating their thoughts from others, which can bring serious consequences in their lives. An environment that represses individuality can limit maturity, creativity and leadership. But what can prevent this predicament?

"***Generating Quaker Space is an approach for allowing individuals to be themselves, change, learn and grow in their own thinking."***

It's an approach that can help people to think and feel like capable and responsible adults who are confident in their own ideas. Sadly, bureaucratic organisations usually produce the exact opposite - employees who lack creativity and are dependant on leaders to make every day decisions.

Quakers

Since the 18th century the Quakers have been a powerful force in both business and social causes, having founded institutions such as: Barclays, Lloyds, Cadbury's, Sony, Oxfam, Amnesty International and Greenpeace to name but a few. Putting the Quakers religious beliefs aside, their success can be attributed to a way of looking at people, which involves: respecting each persons individuality; avoiding control of others; creating space for people to explore their own ideas and beliefs; and making others feel accepted regardless of their differences.

What is Quaker Space?

It is about allowing a person time to think deeply and be led by their own *'inner guide'* (intuition). The aim is to create space for the other to use the *'teacher within'* to find direction and discover changes open to them. Techniques that can help you achieve this in others are:

- Avoid prescribing answers to someone else's problem (no matter how tempting).
- Avoid leading questions (questions that imply the answer, e.g. "Have you thought of developing a budget to limit your spending?")
- Ask open questions that encourage the other to think of answers (e.g. "What could you do to avoid spending more than you earn?")
- Ask probing questions (questions that help to explore possible causes and consequences to a problem).

"One question can be more powerful than a thousand answers"

Being part of an organisation, team (or even family) that encourages this 'space' can develop more responsible learning and move people from dependence to a place of

autonomy and interdependence. This can result in:

- Reducing defensive behaviours that cause traps.
- Inspiring confidence in ones own abilities.
- Building trust.
- Better leadership for problem solving and improvement.
- Non-threatening relationships that allow others to admit their causal responsibilities and learn to change.

Achieving Quaker Space is easier said than done as it will require both practice and patience to unlearn habits of persuading others to see our point of view. However, once we've learned this approach, it can free others (whether they be employees, patients, family or friends) to blossom as more thoughtful, responsible and balanced individuals. Ask yourself, "What's stopping me from giving this a try?"

Quotes to Ponder on

"The more you trust your intuition, the more empowered you become, the stronger you become, and the happier you become" (Gisele Bundchen).

"Your sacred space is where you can find yourself again and again" (Joseph Campbell).

"Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom" (Victor E. Frankl).

"With freedom comes responsibility" (Eleanor Roosevelt).

Highlights were referenced from Kets de Vries, Carlock and Florent-treacy (2007)

Creating 'Quality'

by James Sideras

The theme from last months article was on 'Quaker Space' - a method for liberating others to solve problems for themselves. Over the next quarter, I will be discussing various other trouble shooting & improvement techniques, which if applied, could increase the quality of our work and lives.

The 'quality' revolution

Since the 1960's there's been a heightened awareness of 'quality' that is still prevalent today. From the goods we buy to the services we receive, many of us expect quality. However, what does *quality* mean?

There are so many definitions, but put simply - *quality* is about 'fulfilling expectations'

For example, when we buy a product, we expect it to perform; when we enter into a relationship, we have certain expectations from the other; and in terms of work, we are expected to meet customer needs. However, in the complex and often messy world we live in, we occasionally run into problems that hinder those expectations. Below are three principles or techniques to help us detect, correct & even prevent errors that limit us from achieving the desired quality in our work, relationships and lives.

The 'golden rule'

The golden rule is a simple but effective principle for improving our relationships: *"do unto others as you would have them do unto you."* When we don't practice the values we expect from others, this sends a confusing message to colleagues, friends or family that gives them a reason not to treat us in the way we desire. However, when we practice what we expect from others, this transfers an ethic that sets a benchmark for others to follow.

The '5 Whys?'

'5 Whys' is a question-asking technique to discover the root cause to a problem. Too often, we only address the consequences or risks to a problem, but not the underlying cause. By repeatedly asking the question 'why'?, we can peel away the layers of a problem just like the layers of an onion, which can lead us to the root cause. Very often, the answer to the first 'why' will prompt another 'why' and the answer to the second 'why' will prompt another (and so on), until we get to the origin of the problem. However, when using this technique, lets be prepared to face up to our causal responsibilities, i.e. our contribution to the errors and be willing to adapt our thinking and approach.

The 'Kaizen' way

Whether it be improving the quality of our work, our physical health or a relationship, the challenges we face can sometimes seem overwhelming or even frightening. When our goals seem too large, the anxiety we feel can send us into a 'fight or flight' response, where the 'thinking' part of the brain (the cortex) becomes restricted and sometimes shuts down. However, the good news is there is another path to improvement that doesn't require large leaps, but one that winds so gently up the hill that you hardly notice the climb. Enter 'Kaizen' - a Japanese philosophy for continuous improvement based on taking small, comfortable steps toward improvement. 'Kaizen' is captured in this powerful saying:

"*A journey of a thousand miles must begin with the first step"* (Lao Tzu).

Making daily low-key changes helps the human mind to bypass the fear that blocks creativity and success. Taking a large goal and breaking it down into simple, progressive steps, can provide a steady flow of improvement that can yield big gains in the long term. Start by:

- Taking small actions

- Solving small problems, even when you're faced with an overwhelming crisis

- Bestowing small rewards to yourself and others when small results are achieved

- Recognising the small but crucial moments that everyone else ignores

John Wooden, one of the most successful coaches in the history of college basketball, put it this way:

"When you improve a little each day, eventually big things occur... Not tomorrow, not the next day, but eventually a big gain is made. Don't look for the big, quick improvement. Seek the small improvement one day at a time. That's the only way it happens – and when it happens, it lasts."

When we follow simple techniques such as these, we can create improvements that can lead to greater quality in our work, relationships and lives. From today, let's think the 'golden rule', the '5 whys' and the 'kaizen' way as we journey toward success.

<u>Thoughts to ponder on</u>

"Practice yourself in little things, and thence proceed to greater" (Epictetus).

"There is no way to make people like change. You can only make them feel less threatened by it" (Frederick Hayes)

"You will never change your life until you change something you do daily" (Mike Murdock)

The Power of Appreciation

by James Sideras

This is the last [Bettercare] article I'll be writing and probably the most important. Whilst the previous three articles focused on valuable problem solving methods, the downside in using them is that we can often forget to *appreciate* the good work people already do.

'Organisations' are essentially human, as they are made up of people in relationship with each other

When we take a 'people centred' view in our place of work, we can begin to appreciate the social, psychological and emotional needs of those we work with and help them flourish. For example, when someone is appreciated, they often produce positive emotions which grows that area of their life because they seek the experiences they find most rewarding.

A belief in the power of appreciation is in contrast to a belief in criticism. Producing change through criticism often involves negative emotions which can include threats, coercion and fault-finding. However, pursuing change through appreciation involves positive emotions like compassion, kindness and being grateful toward others. In other words, effortless improvements can happen when people are made to feel confident, special and happy.

The best thing about showing appreciation, is that it's free

I recently carried out some interviews with [Bettercare] staff where I asked the question, *"What makes you most keen or happy to do your job?"* The two most frequent answers were, *"Being appreciated"* and *"Respect"*. Professor William James - a famous Psychologist once said, *"The deepest principle of human nature is the craving to be appreciated"*. When this need is overlooked, it can hold us back no matter how much we try to solve problems. Therefore, instead of narrowly focusing our energy on correcting behaviours and dealing with what's wrong, let's motivate ourselves (and others) by looking at what's right and the things that work.

Steps toward an 'Appreciative' approach

- One of the first questions we must ask is, "What are the values and behaviours we want to grow?" This involves discovering the common things people value most, no matter how small we think they are. Once we discover them, we should aim to practice them and make a daily effort to appreciate them in others. These might include: compassion, patience, tolerance, honesty, courage, respect, listening, teamwork, people centred leadership, etc.

- Each one of us has a deep seated need to be respected and listened to, but rarely do we take time from our busy schedules to stop and have conversation. As a result, there may be people at work (or even family) who are disconnected and have a profound sense of disorientation. However, making time for conversation and social interaction creates relationships, develops team work and a

sense of belonging. Regular conversations can also allow people to be honest and remove the mask that so often disguises their true selves.

- The world is often messy and unpredictable. Therefore, to deal with the complexities of today's world, more involvement from others is needed. Instead of managers acting as commanders and controllers, they should see themselves as educators and collaborators. Collaborative decision making not only enables workers to think for themselves, but corrects an imbalance of power that managers often hold. Allowing others to have a say on how they should work or participate in decisions that shape the future, can give them hope and a sense of value.

'EALIM' -A way of creating a better future

The values and methods I've explained over the last twelve months are taken from a model I developed called EALIM (Ethical, Adaptive, Learning and Improvement Model). The purpose of EALIM is to create a better future through a moral approach that puts people first and draws them into creative relationships for learning and improvement. I hope you've enjoyed reading these articles as much as I have writing them and am thankful to all those who've given me their comments. If you've missed any articles, you can download them from www.[Bettercare].co.uk. Finally, I truly wish you a Merry Christmas and a joy filled New Year!

Quotes to Ponder on

"Appreciation is a wonderful thing. It makes what is excellent in others belong to us as well" (Voltaire).

"Appreciation can make a day - even change a life. Your willingness to put it into words is all that is necessary" (M. Cousins).

"You bring out the best in yourself by looking for the best in others" (Gene Bedley).

"The aim of life is appreciation; there is no sense in not appreciating things; and there is no sense in having more of them if you have less appreciation" (G. K. Chesterton).

"The roots of all goodness lie in the soil of appreciation for goodness" (Dalai Lama.

Appendix 7: EALIM mini-seminar slides

Ethical Adaptive Learning & Improvement Model

'EALIM'

ETHICAL

- **Kantian ethic:** Where we treat others as the end and not just the means, i.e. '*do unto others as you would have them do unto you*'.
- **Compassionate care:** Being able to feel & identify with another persons pain or suffering and being moved to help them.
- **Philanthropy:** Donations to charities and good causes to improve the quality of life for the most disadvantaged in society
- **Responsibility for the environment:** Being green, recycling, using natural resources

ADAPTIVE

- **Complexity:** The world is complex, uncertain and unpredictable. To survive and succeed we must be adaptable to changing circumstances.
- **Fewer rules, more flexibility:** Have just enough rules to meet legal requirements. Have a plan but be ready to change it. Follow procedure but be willing to experiment with new ideas.
- **Use your head and your heart**: Be rational, but also use your feelings. Be analytical but also use your gut feelings. Don't just be formal, but be informal.

LEARNING

- **Less managerial control:** Constantly telling others 'what' to do makes them dependent on you, limits learning, causes frustration & creates a 'them' and 'us' culture.

- **Be an educator:** Sharing knowledge empowers others to understand why & how to perform tasks. Educating others makes them less dependent on you, creates trust & inspires commitment.

- **Avoid defensive behaviour:** Trying to win arguments, suppress feelings and blame others can limit learning and divide teams. Open discussions encourages learning, creates respect and reduces conflict.

- **Look in the mirror:** Question your own values and beliefs. Examine why you think and react the way you do. Look at the impact your behaviour has on others.

IMPROVEMENT

- **Quality chain:** Know who your internal customers and suppliers are
- **Five Whys:** Reactive technique for finding root causes to problems
- **Group problem solving:** Where problems are discussed and solved as a team, as opposed to solutions being prescribed by management
- **Nominal Group Technique:** for generating ideas

Benefits

- We ALL learn to do things better and make the organisation a better place
- Helps everyone to practice values that reduce the risk of harm to others
- Enables responsible learning & improvement from everyone
- Creates more supportive management, giving care workers greater freedom
- Can create an organisation we can be proud of

Appendix 8: Quaker space slides

Quaker Space

Meaning of 'Quaker Space'

- A place where people can be themselves
- Where people can change, learn and grow in their thinking
- Where leaders don't impose their ideas or decisions
- A space where others feel they can safely admit their own weaknesses and failures without judgement
- Where people are supported to follow their own innate 'guide'

Potential benefits to 'Quaker Space'

* Reduce defensive behaviours that cause self-fuelling traps and repeat problems
* Inspire confidence in ones own abilities
* Builds trust
* Creates more responsibility for problem solving
* Allows others to to see their mistakes and prevent repetition
* Frees followers from an unhealthy dependency on their leaders
* Generates greater learning

Achieving 'Quaker Space' for learning and improvement

AIM: To enable the 'other' to discover the power they have to tackle a problem and the changes open to them for improvement

* Avoid direct answers to problems
* No leading questions
* Ask 'open' questions that enables the other to gain a perspective on a problem, why it is happening and what are its consequences
* Focus on questions that elicit the other to solve the problem for themselves

Appendix 9: Cycle one template of organisational culture

TOP MANAGEMENT

Shared underlying assumptions

T1: Risk threatens our survival

  T1.1: Risk minimisation

T2: The organisation is a bureaucracy

T3: Create stability and predictability

T4: Low confidence in staff

T5: We know better than staff

T6: Work performance is valued above staff

T7: Commitment to profit maximisation

Espoused beliefs and values

T8: Intrinsic human values

  T8.1: Valuing staff

  T8.2: Listening

T9: Patient care

  T9.1: Patient centered care

T10: Social responsibility

  T10.1: Charity fund raising

  T10.2: Being green

T11: Collaboration

  T11.1: Working with people

Action strategies

T12: Bureaucratic management

  T12.1: Copious policies and procedures

  T12.2: Standardisation

  T12.3: Compliance

  T12.4: Centralised recruitment and training programmes

  T12.5: Use of formal rationality

T13: Managerial control

T13.1: Unilateral decision-making

T13.2: Control of discussions in meetings

T14: Classical quality control methods

T14.1: Reliant on inspection audits for detecting errors

T14.2: Audit meetings

T14.3: Lack of collaborative improvement and problem solving

T14.4: Were not identifying root causes to problems

T15: Risk minimisation

T15.1: Risk management

T16: Cost minimisation

T16.1: Low care worker pay

T16.2: Rewarding staff for saving money

T17: Codified and explicit knowledge sharing

T17.1: Use of centralised training programmes

T17.2: Use of policies and procedures

T17.3: Use of formal meetings

MIDDLE MANAGEMENT

Shared underlying assumptions

M1: Higher commitment toward patients and staff than to the organisation

M2: Bettercare values patients and profit more than staff

M3: Sharing knowledge empowers others

M4: Survive organisational life by conforming

Espoused beliefs and values

M5: Intrinsic human values

M5.1: Valuing staff

M5.2: Respect

M6: Patient care

M6.1: Caring for patients

M7: Social responsibility

M7.1: Supporting charities

M7.2: Recycling

M8: Staffroom space

M8.1: Privacy for taking breaks

M9: Higher pay for care workers

M10: Collaboration

M10.1: working together

M10.2: Teamwork

Action strategies

M11: Conform to formal systems

M12: Humane leadership approach

M12.1: Supportive

M12.2: Accommodating

M12.3: Friendly

T13: Classical quality control methods

T13.1 Reliant on inspection audits for detecting errors

T13.2 Audit meetings

M14: Solidarity with care workers

M15: Practice based learning and knowledge sharing

M16: Rely on top management for improvement

STAFF NURSES

Shared underlying assumptions

S1: Greater commitment to profession than to the organisation & patients

S2: Sharing knowledge with care workers threatens our identity

S3: We know more than care workers

S4: Low commitment to collaboration

Espoused beliefs and values

S5: Intrinsic human values

S5.1: Compassion

S5.2: Honesty

S6: Patient care

S6.1: Looking after patients

S7: Social responsibility

S7.1: supporting charities

S8: Staffroom space

S8.1: Privacy for taking breaks

S9: Higher pay for care workers

Action strategies

S10: Minimal knowledge sharing with care workers

S11: Managerial control

S10.1: Unilateral decision-making

S10.2: Low collaboration

S12: Task centred leadership

S13: Rely on management for improvement

S14: Focus on administration than hands on care

S15: Community of practice

CARE WORKERS

Shared underlying assumptions

C1: Leaders show me where and how to improve

C2: High commitment to patients and co-workers

C3: Low commitment to the organisation

C4: The company values profit more than staff

Espoused beliefs and values

C5: Intrinsic human values

C5.1: Compassion

C5.2: Respect

C6: Patient care

C6.1: Caring for clients

C7: Social responsibility

C7.1: Supporting charities

C7.2: Environmentally friendly

C8: Social interaction and appreciation

C9: Staffroom space

C10: Higher pay

Action strategies

C11: Cancel shifts to work with agencies for higher pay

C12: Use of explicit and codified knowledge sharing

C13: Reliant on formal systems

C14: Shared commitment and support among care workers

C15: Rely on leaders for improvement

C16: Collaboration

Appendix 10: Email inviting top managers to first EALIM seminar

Sent on 8th August 2011

Email heading: Invitation to attend a seminar on a new quality improvement model

Dear Directors and Senior Managers,

Some of you may already be aware that [The CEO] has agreed for me to present to you an innovative quality improvement model I developed as part of my doctoral research. The model presents an exciting opportunity for us to adopt a different approach to improving our services and holds the following potential benefits:

- Enable staff to practice values and virtues that reduce the risk of harm to others,
- Achieve more responsible learning and improvement from your staff,
- Enable all of us to 'do things better' and work together in ways that release innovation,
- Set ourselves apart from our competitors,
- Allow everyone to be part of a vision they can be proud of.

In order to discuss the concepts and methods of the model, I've arranged a 2-hour seminar directly after the board meeting on 25th August at head office, commencing at 11:30am.

I look forward to seeing you all on the day.

Regards,

James Sideras
Quality Consultant

Appendix 11: Excerpts from reflexive diary

24th August 2011

At the end of my presentation with board members, I remember feeling that I was perhaps too rhetorical with RH in my response to his objections. I also felt I could have given more time for others to respond to RH's objections, which could have taken the pressure away from me. In other words, I was perhaps a little too defensive of EALIM and decided that I should more explore why participants were being resistant so I could better understand their underlying assumptions.

6th October 2011

I feel a lot more reflexive these days. What I mean is, I'm more aware of my behaviour, its impact and the attitudes and assumptions I'm carrying. I find myself constantly asking questions like, 'Why do I think this way?' 'Why do I act the way I do?' and 'Where is the evidence for the judgements I make?' When I make a judgement or value-laden remark, I find myself asking, 'What leads me to this assumption?' Also, quite often now, when I hear myself saying what I think somebody's motivations or attitudes might be, I am questioning the validity of my interpretation and think of alternative interpretations I did not previously consider. This reflexive way of thinking can feel a little painful and unsettling at times, because it leads me to confront my own judgements and makes me uncertain about what I was previously certain about. It also makes me feel a little naked at times, as it exposes my own taken for granted assumptions.

24th October 2011

I've been reflecting on my research aims. Instead of having an objective of whether the EALIM model would work, my aim is now to to explore social change during the implementation of EALIM, as well as what impact EALIM has on organisational members ethics, adaptability, learning and improvement (the four concepts of EALIM). There should be no taken for granted assumption that EALIM will be effective. Instead, the aim should be to explore and explain changes in motivation, behaviour and power relations of as a result of EALIM's introduction.

31st October 2011

After the first focus group meeting today, I began thinking about my thinking behind why I had told members of the group that I would form a proposal to present to the board of Directors. After some thought, I realised I had said this out of an unconscious assumption that I needed explicit approval from those in authority to implement changes. However, after more reflection, I realised; there were already 2 board members present who had power to invoke change, the changes we discussed concerned a different tacit approach to thinking & learning that did not require the boards' approval and those present could use their discursive power to discuss and influence others peoples thinking and learning with whom they work with. I concluded that by seeking authoritative power to act, I had fallen into the trap of managerial control without even knowing. I also realised this assumption was only made known through my practice of reflexivity and had I continued under this assumption, the process of EALIM's implementation could have been unnecessary censored and tied up in levels of bureaucracy. Whilst I was relieved to have avoided this route, I began to ask myself, how many others in the organisation were tied to this kind of thinking, i.e., paralysed to act on their own intuition and ideas without approval from a higher authority. I now feel it is necessary to contact each member of the focus group to make them aware of my erroneous thinking and encourage them to go forth and practice what was discussed, to use their power of influence over others to practice the same.

15th November 2011

I've been reflecting on the discussions within the last focus group and questioning how involved group members were in terms of planning the action research of EALIM and analysing the results of my participant observations and interviews. I see the focus group as more than just a group interview, but as a forum where others can be involved as co-researchers. Whilst they should be enabled to freely discuss their own experiences, observations and perspectives, I'm conscious that if this action research is to be a cooperative and collaborative inquiry, focus group members should be involved in both planning the action and evaluating my research findings. Eliciting their interpretation of my interpretations, could add

valuable meaning to my understanding as well as conform or disconfirm it. Hence, this is something I aim to expand on at the next focus group.

23rd March 2012

What I am finding in my analysis of the qualitative data to date is that there isn't one cohesive organisational culture. The data is beginning to impress upon me the existence of many cultures, i.e., sub cultures that seem to interact with each other to produce patterns or ways of working. However, the patterns that emerge don't seem to have one dominant culture representative of the whole organisation.

10th May 2012

In todays evaluation meeting where participants discussed my analysis, the level of affirmation and confirmation surprised me. Before the meeting, I was expecting others to be defensive. I felt this way because I was making unspoken assumptions explicit and wasn't sure whether top managers would handle insights about their own culture, as this may have made them feel vulnerable.

16th May 2012

I arrived at the office for approximately 9am to set up for the evaluation meeting (with the marketing and operations director), scheduled for a 9:30am start. However, at 9:20am, the operations director informed me that she might not be able to attend because of an urgent interview with a member of staff who had been suspended due to a serious allegation. I asked whether her interview could have been arranged for 10:30am. She said she had other things to do after 10:30am. When I heard her response I remember feeling quite annoyed for several reasons. Firstly, because the evaluation meeting was arranged with plenty of notice, secondly, she could have arranged the interview after our meeting and thirdly, her answer implied her time was more important than mine. Despite these reasons, I find myself still asking why I was annoyed with her, which doesn't seem like an easy question to answer, as it requires a process of self-psychoanalysis. Nevertheless, by reasoning with my own emotions I shall attempt to find an explanation. Firstly, I suspect I felt annoyed because I have been unable to meet

with her since January, despite various attempts to arrange appointments. Typical excuses have been ‘I'm too busy,’ ‘I've been posted to Hospital B’ and ‘there's not enough time.’ Hence, I see a history of avoidance from her, which can be interpreted as a defensive behaviour. If so, the question of why her defensive behaviour made me angry still requires explanation. Perhaps this was because her avoidance made me feel castrated of power when what I was unconsciously looking for was her acceptance and unremitting cooperation with my goal of improving Bettercare. Or perhaps my anger was fuelled because I saw her behaviour as an obstacle to my unconscious phantasy of being a heroic individualist on a quest to make the world a better place. Although I may be speculating, these explanations flag up the issue of how unconscious images can mediate between the researcher and researched.

After reflecting on Hunt’s (1989) theories from her book entitled the 'Psychoanalytic aspects of field work,' I've come to realise that episodes of transference and counter-transference are to a certain extent unavoidable and that a failure to examine them can affect rapport between researcher and subject. Thus recognising why I felt angry with the operations director and how my counter-transference can damage my rapport with her helped me gain a better analytic understanding of our encounter. Instead of reacting in disappointment or anger, I should see her behaviour as the kind of resistance that can add more meaning to my research. After all, one of my research questions includes explaining why participants’ resist the adoption of EALIM. From this perspective, I now feel my encounter with the operations director was in fact positive and that I can now begin the process of analysing why she behaved the way she did, without my feelings affecting our relationship or distorting the data with my own defensive behaviour.

14th Nov 2012

I've been reading Lewis, Passmore and Cantore's (2011) book on Appreciate Inquiry and feel very excited. Its focus is on drawing people into a deeper relationship, as opposed to the utilitarian use of people in the interests of productivity. Its concern is not on solving problems but on appreciating people. In

this sense, it could be used to balance TQM's problem solving techniques, with an approach that values the good work people already do. It also seems highly ethical and has a close fit with EALIM's values and my action research methodology.

20th Nov 2012

I've realised how much of a conversational practitioner I've become. In interviews, I allow a free flowing conversation to take place whereby participants address any issue they like without me cutting them short, hurrying them up or expressing defensiveness. In this conversationalist approach, the values of participants soon become apparent. I often reflect on what participants have said then summarise the main points/themes back to them. I'm finding this can affirm their views, test my understanding and develop shared meaning. I believe this approach has allowed participants to be authentic about their views. Quite often, participants have revealed information to me that not even managers have been privy to.

4th Jan 2013

I'm into my 2nd week of analysing data from cycle three and the whole process feels rather intense. I have to keep motivating myself as analysing the data is becoming rather monotonous. I'm also conscious of staying true to the data by giving it the close attention it deserves. When I'm analysing, it feels like I'm submerging myself into a different reality that requires much reflection and deep thought. However, when I stop analysing (to take a break or because of personal demands), it feels peculiar for the first few seconds, as I have to re-orientate myself and psychologically restructure my mind to an existential reality.

15th April 2013

This AR project has been the most exhilarating and demanding learning process I have experienced professionally. The research process has altered my worldview and enabled me to become a collaborative practitioner. The research has also made me realise the importance of collaboration in my own practice and the extent to which collaboration needs to be cultivated in healthcare organisations across the whole spectrum of clinical and social care.

Appendix 12: Cycle one template of the seven concepts

1: Perceptive value of Bettercare

1.1: Bettercare provides quality patient care

1.2: Top managers hold a high perceptive value

1.3: Middle managers and care workers hold a low perceptive value

1.4: Bettercare values patients and profit more than staff

1.5: Bettercare should adopt more socially responsible business practices

1.6: Bettercare should increase pay for care workers

2: Power relations

2.1: Chairman's dominance

- 2.1.1: Controlled discussions in meetings
- 2.1.2: Chairmans' dominance appeared taken for granted

2.2: Top managers overlook the needs of front line staff

2.3: Top managers and staff nurses use managerial control

- 2.3.1: Lack of collaboration
- 2.3.2: Conformity
- 2.3.3: Unilateral decision-making
- 2.3.4: Chairman's control of discussions in meetings

2.4: Middle managers survive organisational life by conforming

2.5: Power struggles

- 2.5.1: Middle managers lacked autonomy
- 2.5.2: Between staff nurses and care workers

2.6: Humane leadership from middle managers

2.7: A 'them' and 'us' perspective between top managers and care workers

- 2.7.1: Top managers detached from front line staff
- 2.7.2: Care workers detached from top managers

2.8: Blame culture

- 2.8.1: Nurse blame care workers for mistakes
- 2.8.2: CEO blamed nurses for high service variations
- 2.8.3: Middle managers blamed shortfalls of staff knowledge on training

2.8.4: Ops. manager blamed mid. managers for shortfalls of staff knowledge

3: Motivation

3.1: Top managers are driven to provide a quality service

3.2: Middle managers hold high commitment to patients & staff

3.3: Care workers hold high commitment to patients & co-workers

3.4: Care workers hold low commitment to Bettercare

3.5: Low pay is a demotivating factor for care workers

3.6: Staff nurses hold high commitment to their profession

4: Ethics

4.1: All groups espoused patient care, social responsibility and intrinsic human values

4.2: Lack of social interaction between top managers and staff

4.3: Top management value performance and cost efficiency above staff

4.4: Lack of staffroom space for taking breaks

4.5: Low pay for care workers

4.6: Defensive reasoning by top managers

5: Adaptability

5.1: Good external adaptation

5.1.1: Quick to adapt organisational literature to changing CQC requirements

5.2: Standardisation inhibits adaptation to the local needs of services

5.3: Care workers use adaptive strategies to cope with challenges

5.3.1: Care workers use collaboration, shared commitment and support

5.4: Company training and policies are used as a defense against instability

5.4.1: Top manager use standardisation to reduce variableness in the service

5.5: Problems with internal integration

5.5.1: Staff struggle to adapt to increased aggression from patients

5.5.2: Staffing shortages impact on staffs' ability to cope with difficulties

5.6: Top managers seek stability and predictability

5.7: Copious policies inhibit flexibility and spontaneity

5.7.1: Copious policies generate anxiety toward being flexible

5.7.2: Copious policies restrict the use of nurse's professional judgment

6: Learning

6.1: Learning is mostly based on codified and explicit knowledge sharing

6.2: Middle managers empower others by knowledge sharing

6.3: Staff nurses shared minimal knowledge with care workers

6.4: Managerial control inhibits learning and creativity

6.4.1: Control of discussions inhibits collaborative learning and creativity

6.4.2 Managerial control inhibits emergence of ideas from staff

6.5: Bureaucracy stifles experimentation and innovation

6.5.1: Clinical governance meetings inhibit staff's emergent ideas

6.5.2: Reliance on formal systems and meetings

6.6: Lack of reflexive learning

6.6.1: Dominant use of single loop learning

6.6.2: Defensive reasoning among top managers and staff nurses

7: Improvement

7.1: Reliance on management for improvement

7.1.1: Middle managers rely on guidance from top managers

7.1.2: Staff nurses and care workers rely on feedback from middle managers fro improvement

7.2: Reliance on classical quality control

7.2.1 Use of inspections for error detection

7.2.2 Use of audit meetings

7.2.3: Focus is on reducing risks not root causes

7.3: Lack of collaborative improvement and problem solving

7.4: Staff nurses place greater focus on administration than hands on care

7.5: High variance in service quality

7.6: Bureaucratic processes inhibit service quality

7.6.1 Administration removes middle managers and nurses from patient care

7.6.2 Administration inhibits improvement

7.7: Copious policies are counter productive to improvement

7.7.1: Copious policies generate anxiety and confusion

7.7.2: Copious policies limit nurses' professional judgement

7.8: Staff shortages and turnover inhibit service quality

7.8.1: Staff shortages limit meaningful interaction & activities with patients

7.8.2: Recruitment inhibits managers from focusing on improvement

Appendix 13: Cycle two template

1. Acceptance and resistance to EALIM's adoption

1.1 Adoption of company wide practice-based training

- 1.1.1 Training is localised to each site
- 1.1.2 Training is taught in and through practice
- 1.1.3 Shift from explicit to tacit knowledge sharing

1.2 Staff nurse resistance to collaboration

- 1.2.1 Staff nurse resistance to the use of community groups
- 1.2.2 Subversion of shared decision-making
- 1.2.3 Use of unilateral decision-making
- 1.2.4 Staff nurses feel threatened by the advancing role of care workers

1.3 Staff nurse resistance to knowledge sharing

- 1.3.1 Reluctant to share knowledge because of fear of loss regarding position and power

1.4 Defensive reasoning from CEO, operations director and marketing director

- 1.4.1 Defensive of top management routines, i.e., managerial control
- 1.4.2 Use of maladaptive defensive mechanisms, i.e., blame, rationalisations
- 1.4.3 Greater commitment to managing productivity than to engaging with employees
- 1.4.4 Lack of commitment to social interaction and appreciation of employees

1.5 Evaluation meetings enabled commitment toward change

- 1.5.1 Feedback of cycle one findings stimulated double learning and commitment toward organisational change
- 1.5.2 Evaluation meetings prompted top managers to affectively reinterpret their organisational world
- 1.5.3 Top managers showed commitment to EALIM's continued adoption

1.6 Participants' responses during EALIM seminars

1.6.1 Responses to ethical concepts

- Most participants identified compassion and altruism as core healthcare values
- Participants showed inclination toward corporate philanthropy, community volunteering and environmental sustainability

1.6.2 Responses to adaptive concepts

- Few responses to chaos theory
- Most participants showed support for dual management methods
- Most middle managers showed support for an informal and intuitive management approach
- Two middle managers felt anxiety toward departing from formal policies and systems

1.6.3 Responses to learning concepts

- Most participants showed support for triple loop learning
- One assistant manager expressed doubts about achieving triple loop learning
- Most middle managers and staff nurses agreed with the use of communities of practice
- Several middle managers agreed with the use of trans-disciplinary project teams
- No responses to story telling and boundary spanning methods.

1.6.4 Responses to improvement concepts

- Positive responses to VOC, the five whys, NGT and Pareto’s
- No responses in relation to EALIM's other improvement concepts

1.6.5 Responses to the ten tenets

- Most participants accepted the quality chain, servant leadership and practice-based learning
- One middle manager disagreed with the quality chain concept
- No responses in relation to EALIM's other tenets

1.6.6 Responses to Quaker space

- Most top managers explicitly agreed with principles of Quaker space
- The CEO resisted the use of Quaker space and showed signs of defensive reasoning, i.e. blaming others

2. EALIM's impact on organisational improvement

2.1 A positive change in board meetings

2.1.1 Greater freedom and egalitarianism among board members

2.1.2 Improved discussions and better inclusion

2.1.3 Improved creativity, decision making and problem solving

2.1.4 More open debate

2.2 Top management restructure

2.2.1 Link between EALIM's adoption and a positive change in top management restructure, i.e., departure of chairman and greater empowerment to COO

2.2.2 The chairman had consistently resisted change efforts

2.2.3 Chairman's departure facilitated the adoption of EALIM

2.3 Less bureaucracy and more empowerment

2.3.1 Transference of empowerment down the hierarchy

- Top and middle management involvement in localised training
- Integration of HRM at middle management level
- Less managerial control from top management

2.3.2 Greater choice among middle managers over the quality of their own work

2.3.3 EALIM's adaptive concept enabled a psyche for change

2.4 Less codified knowledge sharing

2.4.1 Significant reduction in the number of policy manuals and procedures

2.4.2 Emergence of a coaching culture

2.4.3 Increased focus on tacit knowledge sharing in and through practice

- 2.5 Use of community groups
  - 2.5.1 The idea of daily community groups emerged from January's focus group
  - 2.5.2 Adoption of community groups enabled shared decision making and improved patient activities
  - 2.5.3 Community groups empowered patients with greater confidence in their self-advocacy

- 2.6 Corporate philanthropy strengthened perceptions of Bettercare
  - 2.6.1 Participants identified ego ideals of love, care and help with Bettercare and its shareholders
  - 2.6.2 External stakeholders valued the social impact of the India project and commended Bettercare for its philanthropy
  - 2.6.3 Staff valued Bettercare's economic contribution to the project

Appendix 14: Email inviting middle managers to EALIM seminar

Sent on 3rd November 2011

Email heading: Important invitation to launch a new quality improvement model

Dear Colleagues,

Most of you are aware I have commenced working within [Bettercare] as a Quality Consultant and as part of my doctoral studies I have developed an innovative Learning and Improvement Model for the private healthcare sector. The model is the first of its kind and has been gathering interest to the point where I've been approached to provide advice at Government level as part of a consultation within the long-term UK care market.

With the full support of the Board of Directors, I now intend to commence an implementation process across the entire organisation. At a time where uncertainty abounds (especially in regard to changes in approach by the CQC), the adoption of the model is even more needed. The benefit to you is that the model holds the potential to:

- Enable staff to practice values and virtues that reduce the risk of harm to others,
- Achieve more responsible learning and improvement from your staff,
- Enable all of us to 'do things better' and work together in ways that release innovation,
- Set ourselves apart from our competitors,
- Allow everyone to be part of a vision they can be proud of.

To launch the model I've arranged two seminars where through an informal presentation; we can discuss its concepts, methods and adoption. You and your deputies need only attend one of the seminars. The schedule is:

Tuesday 29 November

9am – 12:30pm: @ [Hospital B]

Attendees: [Hospital F manager], [Hospital F assistant manager], [Hospital B manager], [hospital B assistant manager], [Day Centre manager] and [Home B Manager].

Wednesday 30 November

9am – 12:30pm: @ [Day centre]

Attendees: [Hospital O manager], [hospital O assistant manager], [Hospital C manager], [Hospital C assistant manager], [Day Centre manager] and [Home W manager].

If you wish to switch dates between 29th and 30th please inform me by email. Also, if you wish to bring along a key person from your staff team (i.e. staff nurse, Snr Worker), please feel free. I'm very much looking forward to seeing you all on the day.

Regards,

James Sideras
Quality Consultant

Appendix 15: Email inviting top managers to evaluation meeting

Sent on 30th April 2012

Email heading: Evaluation meeting

Dear Colleagues,

I mentioned to most of you at the office earlier this month that I'm ready to present my findings from the interviews and observations I held. The purpose of an evaluation meeting is to collaboratively discuss your thoughts on my findings, identify desirable states of change and plan actions for the rest of the year. I'm very excited about this stage because this is probably going to be the most fruitful part of the research, as it holds the potential for others to begin learning what to change and how to improve individual and organisational practices.

In the evaluation I'd like to discuss some reoccuring problems in the organisation that I believe are circular and self-fuellling. I'm hoping that most will find the meeting enlightening, but some may find it challenging as my findings may prompt deep changes to unconscious assumptions regarding how we lead and organise.

After consulting with [the COO], I've scheduled an evaluation meeting at 2pm on 10th May 2012 for two hours. This should allow plenty of time to present my findings, answer your questions and discuss the way forward.

I look forward to your attendance and participation.

Regards,

James Sideras
Quality Consultant

Appendix 16: Copy of CEO's email to directors

Sent on 1st November 2011

Email heading: Board meetings

Dear Directors,

As the opportunity to have informal meetings has diminished I've looked to the board meetings as a source where real innovation can take place, and I'm sad to say without success, I'm talking about the real innovation that were used to achieving in leaps and bounds, and I'm saddened to say we are losing our ability to innovate beyond our competitors. To that end I'd like to experiment and change the format and I'd like to request your support.

Since we have become busier (exponentially over the last few weeks and months) I don't get the opportunities to have those extremely valuable informal discussions over lunch or in the office with you all that I used to have, where we used to discuss burning issues regularly and resolve them before they became problems. This, I'm sure has contributed to the escalation of issues of late, and it something that needs to be addressed.

I'd like to change the format from being agenda driven to a far less rigid board meeting structure, perhaps at my house (like we used to in the real old days at my parents home) where we are out of the office and the issues can temporarily be suspended while we discuss them. I'd like every director to discuss any burning issue that they are presented with at the time and for us all to contribute to the solution.

To be honest the board packs ought not to be explained as this is just a repetition of the enclosures, and only if there are questions should we even discuss them.

We just seem to be spending a great deal of time focusing on details and the rest of the month fire fighting, and that just won't do, so I'd like to be a little pro-active and tackle the issues head on, without constraint for time.

Once shared we can all contribute to the solution and once fully discovered, I would then appreciate the action plan & timescales.

It may be the November's board meeting over runs the hour mark we all aim for, it may even take 2 hours, but after we have caught up on all the issues, I expect it will settle down, but there are no guarantees as each month presents its own challenges.

I'm proposing we pilot test the next 3 board meetings and then evaluate. If it turns out to be a disaster we can always revert.

Also I would like to change the date of Novembers board meeting to 1st December. This gives us all plenty of time to digest the board reports and ask the questions. Also I welcome Jim attending which he cannot do on 24 November.

Let's try it for 3 occasions and see where we go from there.

Given we are starting a week later, perhaps we can start an hour earlier, say 9am (to accommodate Jim's request to join us), my house on Thursday 1st December. After this board meeting we can return to the usual last Thursday of the month.

Regards,

[The CEO]

Appendix 17: Cycle three template

1. Perceptive value of the organisation

1.1 Corporate philanthropy generated pride among care staff

1.1.1 The India project created an organisational identity that acted as an object of pride among employees

1.1.2 Employees' perceptive value of Bettercare had increased

1.2 Corporate philanthropy created a moral perception of Bettercare

1.2.1 Care staff identified moral ideals of compassion and altruism in Bettercare's actions of philanthropy

1.2.2 Care staff developed a more socially responsible view of the organisation

2. Power relations

2.1 EALIM generated a paradigm shift in top management culture

2.1.1 Top management culture shifted from bureaucracy and managerial control to democracy and empowerment

2.1.2 Middle managers were empowered with greater autonomy

2.1.3 Reduction in power struggles between top and middle managers

2.2 Conflicts between the CEO and other directors

2.2.1 The marketing director did not welcome the CEO's autocratic decision to increase bed numbers

2.2.2 The COO was more inclined to collaboration and democracy than the CEO

2.3 Less of a blame culture

2.3.1 EALIM's adoption enabled the focus of inspections to change from error detection to error correction

2.3.2 Reduced focus on blaming managers for their non-compliance

2.3.3 Middle managers perceived the new auditing approach as a constructive improvement tool that engendered greater confidence

2.4 Increased employee empowerment and involvement

2.4.1 Employees were empowered with more decision-making than before EALIM’s adoption

2.4.2 Link between employee empowerment and job satisfaction

2.4.3 The use of community meetings increased employee involvement

2.4.4 Staff nurses were still dominant in their use of managerial control

2.4.5 Care workers in hospitals were less empowered and satisfied than those from care homes

2.5 EALIM had limited impact on staff nurse culture

2.5.1 Staff nurses' action strategies undermined their espoused values, signifying defensive reasoning

2.5.2 Staff nurses' underlying assumptions and action strategies were consistent with those identified before EALIM's adoption

2.5.3 Staff nurse managerial control damaged relationships with care workers and undermined team work

3. Motivation

3.1 Corporate philanthropy increased organisational commitment

3.1.1 Corporate philanthropy increased care worker commitment to Bettercare

3.1.2 Corporate philanthropy inspired motivations to act toward the good of the organisation

3.2 Low care worker pay was still a demotivating factor

3.2.1 Three care workers implied their low pay was demotivating

3.3 Practice-based training increased employee commitment to learn

3.3.1 Staff were more committed to learn and improve as a result of practice-based training

3.3.2 Training attendance increased as a result of microteaching

3.3.3 Care workers were less dependent on codified knowledge sharing

4. Ethics

4.1 Change in top management values

4.1.1 Most top managers espoused shared values of compassion and social interaction

4.1.2 Top managers showed greater respect for employees

4.2 Compassion emerged as a commonly espoused value

4.2.1 Top managers, middle managers and frontline staff explicitly espoused the value of compassion

4.2.2 Compassion was perceived as an intrinsic construct of quality care

4.2.3 EALIM’s adoption guided the ethical norms of some managers

4.3 Staff felt more valued by the company

4.3.1 Middle managers and care workers felt more valued during EALIM's adoption

4.3.2 Care workers’ perception of being valued was linked to greater support and appreciation from leaders

5. Adaptability

5.1 EALIM enabled top managers to adapt

5.1.1 EALIM helped reduce the COO's unacceptable feelings toward chaos

5.1.2 EALIM's adaptive concept enabled top managers to adapt to change and reduce their inclination toward stability and predictability

5.2 Middle managers had greater flexibility

5.2.1 Middle managers had greater flexibility to adapt company policies to the specific needs of their local services

5.2.2 Increased flexibility produced positive outcomes to staff learning and work attendance

5.3 Staffing shortages had a negative impact on staffs' ability to adapt

5.3.1 Staffing shortages created issues with frontline staff's ability to cope with challenges to the service

5.3.2 Staffing shortages generated problems with internal integration

6. Learning

6.1 Emergence of a perceived learning culture

6.1.1 Increased emphasis on learning

6.1.2 Practice-based training stimulated meaningful interaction and tacit knowledge sharing between staff and educators

6.1.3 Increased commitment to learn

6.1.4 Increased use of reflexive learning

6.2 Practice-based training increased staff knowledge and competence

6.2.1 Microteaching merged theory with practice

6.2.2 Microteaching was tailored to the specific needs of each patient group

6.3 Greater experimentation and innovation

6.3.1 EALIM's adoption enabled greater experimentation

6.3.2 Middle managers had greater freedom to implement their own ideas than before EALIM's adoption

6.3.3 Head office workers and frontline staff had limited involvement in idea generation

7. Improvement

7.1 Increased collaborative improvement among top and middle managers

7.1.1 Less reliance on inspection audits

7.1.2 New weekly managers meetings were driving most of the improvements

7.1.3 Increased collaboration during inspection audits

7.1.4 Middle managers were less reliant on top managers for improvement

7.1.5 Head office workers and frontline staff lacked participation in quality improvement methods

7.2 Practice-based training enabled service improvements

7.2.1 Microteaching had a positive impact on service delivery

7.2.2 Microteaching improved staff interventions with aggressive patients

7.3 Improved patient independence

7.3.1 Greater focus on patient independence

7.3.2 EALIM's adoption contributed to the practice of patient independence

- 7.3.3 Community groups empowered patients with greater choice to shape the service they received
- 7.3.4 Inconsistencies between patient choice and service delivery

7.4 Inconsistencies in service quality

- 7.4.1 Inconsistencies in service delivery across units, particularly in hospital B
- 7.4.2 Poor management and leadership at Hospital B made staff feel unsafe and contributed to a lack of patient care

7.5 Staff nurses' use of managerial control harmed patient care

- 7.5.1 Managerial control among staff nurses was detrimental to patient care
- 7.5.2 Managerial control among staff nurses contributes to patient incidents

7.6 Staffing shortages were a persistent barrier to quality patient care

- 7.6.1 Staffing shortages had a negative impact on patient care
- 7.6.2 Link between care workers' low pay and staffing shortages