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ORIGINAL ARTICLE

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Organisational culture in 'better' group homes for adults with intellectual and developmental disabilities in England: A qualitative study

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Abstract

Background: Previous research identifies organisational culture as one of a number of factors associated with the quality of life outcomes of group home residents' with intellectual and developmental disabilities. This study aims to elaborate on the dimensions of group home culture in settings in England.

Method: Participant observations and semi-structured interviews with staff were carried out in two group homes. Field-notes, interview notes and transcripts were analysed using inductive thematic analysis by a researcher naïve to the project and the previous literature. Initial coding was re-examined after sensitisation to theorised models in previous literature to identify the most parsimonious fit. The two settings were rated and compared using a five-point Likert scale for each of the dimensions.

Results: The findings describe group home culture across seven dimensions. There were mixed ratings across the different dimensions reflecting inconsistencies in culture that were reflected in staff practice. The challenge in assigning a global rating of culture in group homes, which includes interactions across multiple staff and multiple residents over time, was highlighted.

Conclusion: The development of an observational measure of culture is highlighted as potentially helpful in understanding and responding to culture in services for individuals with intellectual and developmental disabilities.

KEYWORDS
adult, culture, developmental, disability, group homes, intellectual

1 | INTRODUCTION

Despite the introduction of the rights conferred by the UN Convention on the Rights of Persons with a Disability (United Nations, 2006), many people with intellectual and developmental disabilities, are not realising all, or even most, of these rights (see for example, Siska et al., 2018; Siska & Beadle-Brown, 2020). More than a million people with disabilities across Europe still live in residential services which, for the majority of individuals remain large, segregated and isolated from the remainder of society and with little choice and control for those who live there (Mansell, 2009). Even people living in settings considered more in line with Article 19 of the UN convention, have variable quality of life outcomes (Bigby et al., 2015; Bigby & Beadle-Brown, 2016a, 2016b; Bigby, Bould, & Beadle-Brown, 2019; Egli

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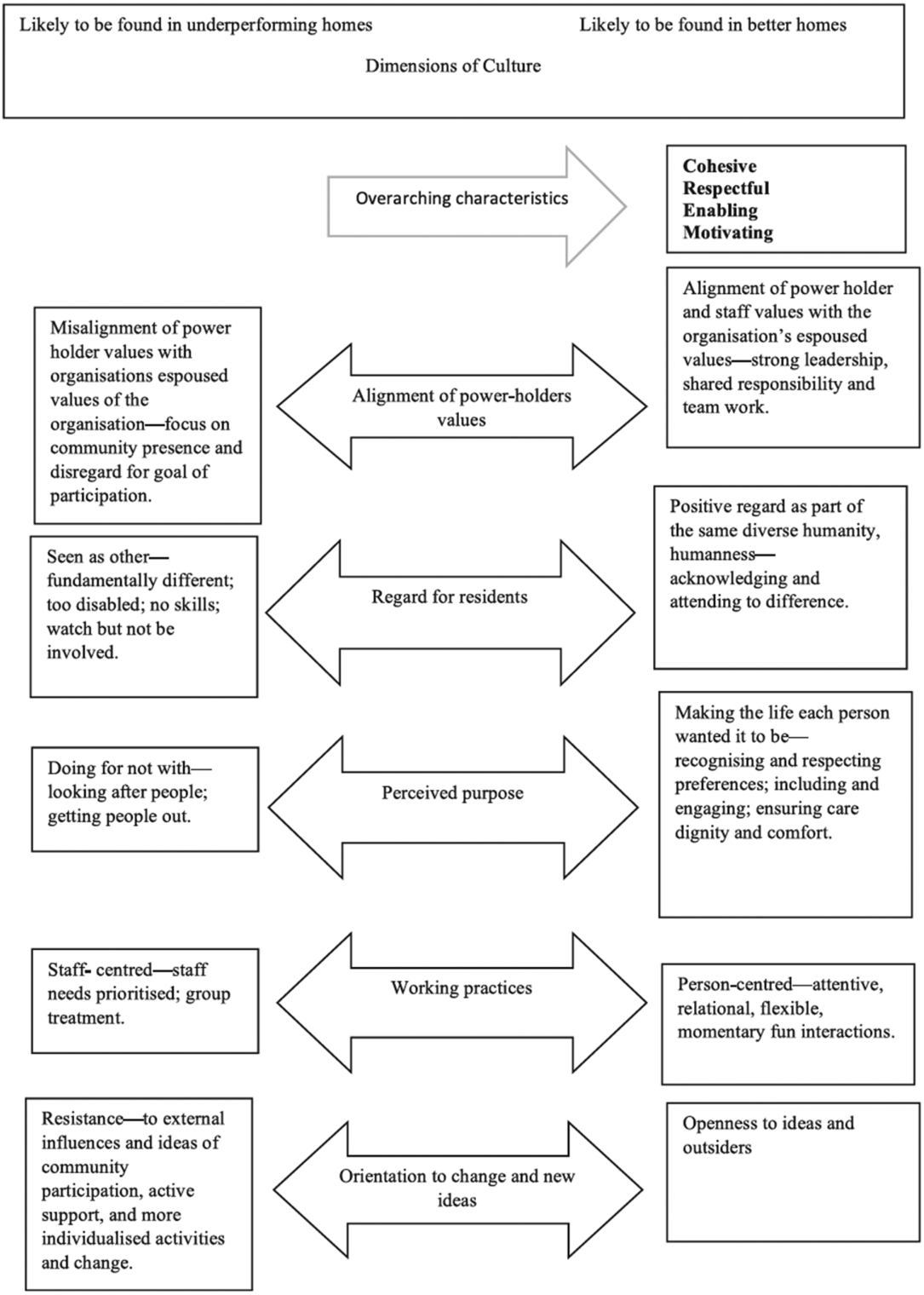


FIGURE 1 Dimensions of Group Home Culture (with permission from Bigby et al., 2012, 2015; Bigby & Beadle-Brown, 2016a, 2016b).

et al., 2002; Emerson & Hatton, 1994; Mansell, 2009; Tossebro, 1995).

Exploring the factors related to better quality of life outcomes for people with intellectual disabilities living in supported accommodation services, Bigby & Beadle-Brown (2016a, 2016b) identified five evidence clusters: frontline staff and managerial working practices; culture; organisational characteristics, policies and processes; necessary but not sufficient resources and settings; and the external environment. The cluster with the strongest evidence base was frontline staff and managerial working practices, and specifically, whether

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Subscale	Description	Score Interpretation
1. **Supporting Well-Being**	The extent to which staff members' shared ways of working are directed towards enhancing the well-being of each resident.	A higher score indicates that shared norms, patterns of behaviour, and ways of working are directed towards supporting the residents' well-being.
2. **Social Distance from Residents**	The extent to which there is social distance between staff and residents, where staff regard the residents to be fundamentally different from themselves.	A lower score indicates social distance between staff and residents. Conversely, a higher score indicates the absence of social distance between staff and residents.
3. **Valuing Residents and Relationships**	The extent to which staff value the residents and the relationships they have with them.	A higher score indicates that staff value the residents and the relationships they have with them.
4. **Collaboration within the Organisation**	The extent to which staff have a positive perception of organisational support and priorities.	A higher score indicates that staff have a positive perception of organisational support and priorities.
5. **Alignment of Staff with Organisational Values**	The extent to which staff members' values align with the espoused values of the organisation.	A higher score indicates greater alignment between staff members' shared values and the organisation's espoused values.
6. **Factional**	The extent to which there are divisions within the staff team that have a detrimental influence on team dynamics.	A higher score indicates an absence of divisions within the staff team that have a detrimental influence on team dynamics. Conversely, a lower score indicates divisions within the staff team that have a detrimental influence on team dynamics.
7. **Effective Team Leadership**	The extent to which the frontline supervisor engages in leadership practices that transmits and embeds the culture.	A higher score indicates that the frontline supervisor transmits and embeds a positive team culture.

FIGURE 2 Descriptions for the Group Home Culture Scale (with permission from Humphreys et al., 2020).

support is provided in a facilitative, enabling and empowering way – working with people, not doing things for or to people (often referred to as Active Support, e.g., see Mansell & Beadle-Brown, 2012). However, there is also growing evidence of the importance of service culture in determining outcomes (Bigby, Bould, & Beadle-Brown, 2019; Humphreys et al., 2020). Culture is often described as 'the way we do thing around here' and as Schein (2017) describes, comprises the shared unconscious assumptions among staff in a setting that are visible through their actions, as artefacts. and through espoused values.

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Previous ethnographic research using participant observation identified five dimensions of group home culture and gave examples of what this looked like in terms of staff practice, espoused values and artefacts at the negative end of each dimension in poorly performing group homes (Bigby et al., 2012) and the positive end of each dimension in better group homes in Australia (Bigby et al., 2015) (Bigby & Beadle-Brown, 2016a, 2016b) (see Figure 1).

Building on the ethnographic work described above, Humphreys et al. (2020) developed a scale for staff to measure culture in group homes. Using a theory-driven approach to item development, expert review and cognitive interview testing, they developed the 46-item staff-rated Group Home Culture Scale (GHCS) and evaluated its psychometric properties. Exploratory factor analysis on responses from 343 staff working in group homes in 10 non-government organisations across three Australian states identified seven dimensions which are measured by the seven subscales of the Group Home Culture Scale (see Figure 2).

Humphreys et al. (2020) explored relationships between culture and service user outcomes and found that high scores on three of the GHCS sub-scales were predictive of resident's quality of life outcomes. High scores on the subscales of Effective Team Leadership and Alignment of Staff with Organisational Values significantly predicted levels of engagement in meaningful activities and relationships. High scores on the Supporting Well-Being subscale significantly predicted residents' community involvement.

The aim of this study was to explore culture in group homes and supported living settings in the UK to identify the dimensions of culture present in this context. The term 'resident' is used in the paper as a shorthand to refer to the individuals who live in these settings. However, we acknowledge that in some countries this would not typically be used to refer to those living in their own home, as in supported living arrangements.

2 | METHOD

2.1 | Design

Within a sequential qualitative mixed-method design (Morse, 2010) we drew on complementary ethnographic and qualitative methods including in-depth participant observations followed by supplementary semi-structured interviews with frontline staff and managers of group homes. Taking a constructionist perspective, we sought to reveal the structural conditions and the cultural context underlying observed behaviour and individual accounts as these create the conditions under which meanings are socially produced and re-produced Given that we are seeking 'latent' (as opposed to explicit) themes, comparison of the two methods allowed consistencies and inconsistencies to be discovered.

2.2 | Sampling and settings

The original intention was to recruit services that fulfilled the following criteria:

- Supported people with severe or profound intellectual disabilities
- Located in the South East of England
- Were either a residential group home (i.e., where the accommodation and support were provided by the same organisation) or a supported living environment (where people rented or owned their home and support was provided separately). In both cases, six or fewer people shared the home and received 24 h support.
- Were considered high performing (see supplementary material for definition and selection process)

High performing was defined as providing support that was rated as consistently good, that is, reflecting good Active Support. Active Support is when staff support people to spend a high proportion of their time engaged in meaningful activities and relationships and residents are supported to have opportunities to experience a better quality of life – for example, social inclusion, positive relationships and choice and control over their lives. High performing homes are ones where no resident is scored less than 66.67% from observations using the Active Support Measure – ASM (Mansell et al., 2005).

Only six services from the four organisations initially contacted met the inclusion criteria related to supporting people with more severe intellectual disabilities. Subsequent, structured observations in these six services found that only two services managed by two organisations met or almost met (e.g., the average score on ASM was just below 66.67%) the inclusion criteria (See supplementary information for further detail). However, over the course of the data collection period, the quality of support deteriorated slightly as measured by structured observations undertaken after 3 months from initial selection visits. Therefore, we have described the sample as being 'better' rather than 'high performing' group homes.

Service 1 (S1) is situated in a residential area in a town in the South East of England. It is a registered care setting for six individuals with a range of needs, managed by a charitable provider. The people supported ranged from 46 to 52 years of age and all had intellectual disabilities with Adaptive Behaviour Scores (ABS) (calculated using the Short Adaptive Behaviour Scale, Hatton et al., 2001) ranging from 55 to 163 (mean 101). Only one person had an ABS score of over 151, the cut off usually used to denote more severe levels of intellectual disability (Mansell & Beadle-Brown, 2012). Most were reported by staff to be autistic and had complex health needs. One person had a physical disability. The organisation had adopted Active Support as its practice model over 20 years ago.

Service 2 (S2) was situated in a residential area in a town in the South East of England, within walking distance of the town centre. It is a local authority managed registered care setting for 6 people, although one person lived in a self-contained flat within the setting. The service had been specifically developed to support people who were described as having challenging behaviour and used positive behaviour support as a practice framework. The people supported ranged from 19 to 30 years (mean 24 years) and all had intellectual disabilities, with ABS scores ranging from 88 to 153 (mean 116). Those in S2 where therefore more similar to one another in terms of adaptive behaviour scores than the people in S1. Almost all were reported by staff to be autistic; none had a severe physical disability.

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2.3 | Ethics

Ethical approval was from the UK Social Care Research Ethics Committee (REC) reference: 15/IEC08/0054 and research governance through local authority research approval. None of the residents were assessed by the organisations as having capacity to consent to this research (Mental Capacity Act, 2005), therefore consultee advice for their participation was sought from family members or legal guardians. Personal or nominated consultees for all 12 people who lived at both services advised that the individual could be involved in the research.

All staff, frontline managers and senior managers were invited to consent before observations commenced or in advance of interviews. In service 1, all but one member of permanent staff agreed to participate plus consent was gained from one regular agency worker. Fifteen staff in total participated (including the service manager and deputy manager). In addition, two senior managers (the service manager's manager and the CEO of the organisation) participated. In service 2, all permanent staff agreed to participate plus 6 agency staff. This gave a total of 24 staff including the service manager and two deputy managers, senior manager (the service manager's manager).

During observation fieldwork, the researcher observed examples of concerning practice in interactions between staff and residents. Where appropriate the research team brought these to the attention of the staff team through feedback or to the service's senior management team. Staff were made aware of the procedure for reporting concerning practice as part of the consent process.

2.4 | Procedure

2.4.1 | Participant observations

Participant observations were conducted by the 5th author who has Masters-level training in working with people with intellectual disabilities, is an experienced support worker and has worked as a deputy manager in an intellectual disability service.

During the initial intensive phase, participant observations were conducted for 3 days within 1 week, thereafter on a monthly basis for 3 months – typically around 9 h per month. After a break of a month, in the second phase, participant observations were conducted twice a month – typically 6 h per month. For S1, the second phase was over a 6-month period, for S2, a 3-month period. In total the researcher undertook 19 visits over a 10 month period in S1 (with at least one observation conducted in nine of those months) and in S2 undertook 15 visits over an 8-month period (with at least one observation conducted in six of those months).

During service visits, the researcher supported people as a supernumerary member of staff, taking part in activities and going out with people, but did not support or observe people during personal care nor administer medication or other medical interventions. The researcher also attended staff training and team meetings, reviewed documentation including policy documents, practice guidance, induction procedures, and observed staff undertaking record-keeping processes including completing quality documentation and staff feedback documentation. Detailed field-notes were written immediately after each visit and included the researcher's reflections on all elements of the visit including organisational policies and process documentation viewed during the visit.

2.4.2 | Staff and manager interviews

Towards the end of the observation period, semi-structured interviews were conducted (by the second and fifth author) with 15 staff across the two services including, 9 support workers, two deputy managers, two service managers and two senior managers. Interviews focused on the perceived purpose of the setting, the person's role, key focus and challenges of their job and the culture of the setting, including what had influenced the culture and the ways in which this had evolved over time. Interviews were audio-recorded and researchers took additional notes if necessary. Interviews were transcribed verbatim (by the fifth author).

2.5 | Data processing and analysis

Field-notes, interview notes, audio-recordings and transcripts were labelled with numerical codes to prevent identification of participants. Anonymised field-notes, interview notes and interview transcripts were loaded into Nvivo 11 to manage the corpus of data more easily. A general inductive thematic analysis approach was used initially (Thomas, 2006). In order to avoid prior knowledge biasing the analytical process, a researcher naïve to the project and literature on group home culture conducted the initial data analysis. The first author, a researcher in health and social care, with a background in care-work read the interview transcripts (n = 15), interview notes (n = 4) and field notes (n = 33) and listened to audio-recordings to check for accuracy and become familiar with the data. In line with our exploratory research aim, initial coding was inductive to ensure the codes were data (rather than theory) driven. The data was viewed through the lens of Schein's three-level model of organisational culture, paying attention to the degree of congruence between observable artefacts, espoused values and what this suggested about the basic underlying assumptions staff held (Schein, 2017) (see Table 1).

Codes were systematically applied across the corpus before being collated into initial themes and subthemes. Within-case analysis was undertaken to examine patterns in the themes for each service, before cross-case analysis being undertaken to illustrate variation across services and across data collection methods (triangulation).

As part of the inductive thematic analysis process, the first author presented the initial themes and subthemes to the first four co-authors for review and discussion, and notes of the discussion were produced.

Initial discussions indicated a high degree of alignment between the 'blind-coding' and the conceptual models of Bigby et al. (2012/14) and Humphreys et al. (2019).That evening, the

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TABLE 1 Three-level model of organisational culture from Schein (2017).

Levels of culture	1. Artefacts	2. Espoused beliefs and values	3. Basic underlying assumptions
Empirical level	Visible and feelable structures and processes Observed behaviour	Ideals, goals, values, aspirations, ideologies, rationalisations	Unconscious, taken-for-granted beliefs and values
Characteristics	Difficult to decipher	May or may not be congruent with behaviour and other artefacts	Determines behaviour, perception, thought and feeling.

Source: Adapted from Schein (2017) p. 18.

first author read the literature on group home culture making notes on similarities and differences to their initial coding structure and then coded the data for a second time, using their knowledge of Bigby et al.'s five dimensions of culture and Humphreys et al.'s seven subscales of group home culture (see Figures 1 and 2).

The revised coding structure and themes were discussed again among the co-authors to determine the scope and definition of each theme and how parsimoniously the data reflected the conceptual frameworks in the previous literature. The discussion also identified which conceptual framework offered the best hermeneutic 'fit'. The seven dimensions represented by the subscales of the GHCS – described by Humphreys et al. (2020) were considered the best hermeneutic fit for the data. Finally, the first four authors rated the two services along a five-point scale for each of Humphreys et al.'s seven subscales as illustrated in Table 2. The five-point rating scale was derived from the description of each dimension provided by Humphreys et al. (2019).

2.6 | Findings

In the following sections, excerpts from interview transcripts, interview notes and field notes show how the culture in these two groups homes map onto the dimensions reflected by the seven subscales in the GHCS. Staff and residents' names are changed to preserve anonymity.

2.7 | Alignment of staff with organisational values

The Chief Executive Officer (CEO) of S1 was clear about the ethos of the organisation describing the key aims as supporting choice, promoting independence and supporting engagement with the wider community through Active Support.

> …why can't the staff make the cup of tea, cause it's not, that's not the point, we are not caring for somebody, these people are perfectly, not only are they perfectly capable of making a cup of tea or contributing to it, but also they should, cause the whole point is to engage people as much as possible.
>
> …we deliberately try to make it simple about, better lives is about engagement, having mates and going out, that is really, it not dressed up, it's not that complicated.
>
> CEO, S1

Contrary to the ethos of the organisation espoused by the CEO, some staff continued to do things for residents rather than with residents. They failed to provide the support people needed to have control over their own lives.

> Andrew [resident] has a drink and is sat on the sofa, when he finishes Nancy [support worker] prompts him to take his cup to the kitchen, he pushes the cup away, she [Nancy] looks at me then and says 'we really spoil him' and takes the cup off to the kitchen.
>
> Fieldnote, S1

There was also evidence of misalignment with the organisational values and ethos – the CEO of SI was very clear that the services should be focusing on supporting people to have the best quality of life more broadly, of which health and safety is an important element. However, at the level of the senior and middle managers the focus was primarily reported as being the health and safety of the people supported, with little attention paid to other elements of quality of life.

> the most important aspect is to make sure they are safe, make sure they are safe and everything that happens, happens for a safe reason.
> I mean my main objective for [S1] would be to make sure that people are safe, safe friendly environment, healthy lifestyle …
>
> Senior manager, S1

In S2, the service organisation's espoused values were that resident goals should be 'meaningful, person-centred and generated by the individual where possible'. The service manager and deputy managers modelled a respectful and inclusive culture and alignment with these values was evident in staff attitudes.

> for Frankie and Billy its opening up their world in that making them actually capable of … doing more and

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TABLE 2 Ratings for each service indicating position on each of the 7 dimensions from the GHCS.

Position on the dimension				
1 low	2	3	4	5 high
Supporting well-being (1 = Staff do everything for people, no support for choice, no participation, no opportunities or support for community inclusion, staff activity appears to be based on staff agenda; 5 = People are being supported to participate in a range of activities around the home, to make choices, to get out and about and participate in the community. People at the centre of staff activity)				
	S1 – involving people in tasks but it was mechanical, lack of choice and control. Substantial variability and inconsistency.	S2 – more individualised. Staff want to help people have control (although not always well done). Going out is important. People are less involved in the home. Having a good day is important but is seen as one where no behaviours that challenge occur. Mostly consistent across staff but not time.		
Social Distance (1 = Strong examples of 'othering'. They are 'not like us' or people are treated as children. At extreme this equates to dehumanisation; 5 = People are seen as 'just like us' by staff. Treated as adults)				
	S1 – Some examples of othering. People as children, paternal approach. Some staff better but overall sense of not being equal		S2 – People seen as generally 'like us' and deserving of a good life, equality, but not completely consistent across all staff	
Valuing Residents and Relationships (1 = People not valued as people, not a source of positive relationship for staff; 5 = Staff value people as individuals. Staff care about people and want the best for them and want to be with them. The people they support are seen as good company and fun is had)				
	S1 – inconsistent, some staff better but most staff controlling and do not see people as valued company or as equal partners.			S2 – Much more equal partners in communication. Staff wanted to be there so people had better lives. Fun was had.
Alignment with organisational values (1 = Misalignment – staff in services actively opposing the espoused values of the organisation; 5 = Complete alignment between staff/service and organisational values)				
	S2 – at odds with the big/distant organisation. No real sense of the mission of the overall organisation. Some examples of where the service manager had to oppose something suggested by the organisation that was not in the interest of the service users	S1- more in alignment. Clear organisational mission statement and values. Staff knew what they were supposed to do. But in practice alignment more with senior manager focus on health and safety.		
Factional/team cohesion (1 = Staff team is fragmented; cliques apparent. Different views and ways of working which are detrimental to staff dynamics; 5 = Alignment between staff. No cliques or informal groupings, staff are all working in the same direction)				
		S1 – At least two groups identified, one closely aligned with the deputy manager and the others less so. Manifests in how staff provide support than with in team conflict or disagreements.	S2 – generally this is a strong dimension. Some inconsistencies between staff mean that it is rated as a 4, not a 5.	
Effective leadership (1 = No leadership – staff are essentially autonomous, ad with little direction, co-ordination; 5 = Clear leader who role models, provides positive influence, feedback, and so forth (practice leadership). Clear sense of direction provided and staff organised and know what they need to do)				
	S2 –Little leadership. Staff quite autonomous and not co-ordinated. Little planning, want to be 'flexible', 'respond to the needs of people'. But		S1 – Strong leadership including modelling, coaching, and so forth but controlling style. Leadership not necessarily in the right direction – that is, Not	

(Continues)

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self-directing more and you know and at some point in the future maybe actually, both of them, I could see them living on their own at some point

Support worker, S2

2.8 | Effective team leadership

Despite some misunderstanding of Active Support (the approach to support used by organisation 1), the deputy manager in S1 offered strong team leadership in *trying* to implement Active Support and seemed to take the majority of responsibility for this on themselves. Their leadership style was characterised by directive instructions and, to a lesser extent, role modelling.

> Dexter [resident] is retrieving items from the fridge and Eny [deputy manager] is trying to get him to locate the cabbage. At times Eny intervenes with Magda [support worker] and tells her what people can do themselves or what she should be supporting them to do. However, Magda seems to be overall responsible for the soup.
>
> Fieldnote, S1

The deputy manager's attitude towards the staff implied she viewed them as requiring a lot of ongoing supervision.

> Deputy manager mentions her family, her husband and two daughters, she talks about getting them to tidy up after themselves, this leads on to a comment about staff being like her babies too, implying they need a lot of direction and taking care of.
>
> Field-note, service 1

In contrast, staff in S2 were genuinely encouraged to express themselves and contribute their ideas.

> I hope staff feel that they can have input and change things and things could change when I am not around and you know that is positive I think, cause I think you need to empower the staff to have an input.
>
> Deputy manager, S2

Team leadership was more diffuse in S2, as there were several deputy managers, who together, fostered a respectful and inclusive culture among staff with strong role-modelling. This is described by one of the deputy managers in the quote below.

> I think there is a culture of respecting each other as individuals and having a kind of diverse sort of team and celebrating that, we don't expect to just have one type of person working here.
>
> Deputy manager, S2

TABLE 2 (Continued)

Position on the dimension				
1 low	2	3	4	5 high
	'flexible' approach leads to chaos. Passive modelling and opportunities for development by experience, provided but no coaching.		reflected in other dimensions so not necessarily a 'positive influence'.	
Collaboration with the organisations (1 = Staff don't feel supported by the organisation and are resistant to change; 5 = Staff are open to new ideas and feel supported by managers and senior managers.			S2 – very open to new ideas and willing to try new things (although not clear if they would differentiate good ideas from bad ideas). Front line mangers feel supported by senior managers at least some times but not by wider organisation. S1 – slightly less open to new ideas and change but willing to have researchers in and expressed desire to improve. Felt reasonably well supported especially by one senior manager.	

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2.9 | Collaboration within the organisation

For some staff working in S2, the wider organisation was seen as unsupportive during times of organisational change.

> Obviously we have had a few managers, different managers, I think we have been through phases where there has been a bit more moaning and groaning, because like I say the way I saw it the manager wasn't visible enough. I think that led to lot more, it's 'them and us' culture.
>
> Service manager, S2

Nevertheless, staff were open to new ideas and furthermore, were encouraged by their managers to contribute their own ideas which fostered ownership and empowerment.

> new ideas are welcomed from everybody … they welcome the new ideas, and there is a sense of staff being able to … take the initiative as long as they are working within their guidelines and their training
>
> Senior manager interview, service 2

> … the best bits of our team days, can feel like everyone has an input and everyone is listening and I think that is really important, no matter whether you have been here 6 months or 12 years…
>
> Deputy manager interview, service 2

Staff (and sometimes residents) in S1 were also resistant to changes instigated by the organisation.

> when Active Support was introduced it also brought a lot of negativity as well from the staff in the beginning, even the people we support because all of a sudden you are asking them to do something that [they're not used to], 'no you do it', I have seen people throw the bin at me, [and say] 'no you go and empty the bin'…
>
> Senior manager, S1

2.10 | Factional

In both services, there were accounts given of teamwork, particularly indicated by staff's willingness to work overtime to cover staff shortages or sickness. In both services, managers and deputy managers worked alongside staff indicated a willingness to do the same tasks that staff do.

> I hate the hierarchy of manager, deputy whatever it's like, the way I see it we are all equal, we are all doing a job that needs doing and I should muck in help out and I think people appreciate that and see that.
>
> Service manager, S2

In S2, roles were seen as negotiated, and responsibilities shared, with a staff rota indicating who would plan and lead the shift (artefact). More experienced staff were key-workers for particular residents, and they could also take on extra roles such as communication or health and safety champion.

> … I think that is part of the culture we have created and I think maybe not intentionally and I don't think anyone sat down and thought that is how we are going to do, it kind of seems to have emerged like that…
>
> Deputy manager 1, S2

In both services, however, there was some reports of resistance from some staff to the approaches that managers were trying to embed.

> He [manager] tells me some staff don't think it [PECS] will work and is concerned about introducing it if people won't support her [resident] to use the approach in the long term. He tells me her keyworkers think it's a good idea and they will start off just a small team using the system with her.
>
> Field-note, S1

2.11 | Valuing residents and relationships

Instances of staff respecting and valuing the people they supported were observed in both services,

> Peter [resident] is hoisted by Christopher [staff]. Christopher seems to be very attentive, watching to how he responds and not shushing (Peter is verbalising), he tells him 'getting in your chair now Peter'.
>
> Fieldnote, S1

However, this level of care was not consistent among the staff in S1. Some interactions indicated a substantial lack of respect for individuals and in some cases were examples of very poor and restrictive practices.

> She [deputy manager] was unsuccessful in engaging him [Neil, a resident] in making the tea and then commented, 'I am not going to drink it for you as well', as she moved away Neil tipped the teacup over …
>
> Fieldnote, S1

> Dexter [resident] says out loud about Andrew's Mum in hospital and that Andrew [resident] is not coming/going home. Eny [staff] responds in a stern tone 'you

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> want to go to your side?' (meaning the lounge on the other side). 'Do not say that,' she [Eny] then suggests she will 'scrub out your name' for the trip to the office the next day. Dexter immediately goes quiet and says nothing more.
>
> Fieldnote: S1

In S2, treating people with care and ensuring their dignity and comfort was embedded consistently enough across staff at all levels to be considered a group norm, that is, 'implicit standards and values that evolve in working groups' (Schein, 2017, p. 4). When asked about how they would describe the culture of the staff team in S2, the senior manager, responded,

> I think that they [staff team] have respect and dignity [it] is a really key thing for them, and they have a caring culture and a culture of good communication.
>
> Senior manager, S2

This group norm was evident in the behaviour of staff described in the fieldnotes,

> Toni [support worker] tells us we can put a light on and that she will not open blinds until Ruby [resident] is dressed. The flat has large sash windows to the front and would be overlooked by the houses opposite …
>
> Fieldnote, S2

2.12 | Social distance from residents

Some staff in both services took a parental attitude towards residents, regarding them to be 'like children' rather than adults.

> Both Nancy and Micha make comments in the car to Dexter 'are you going to be good?' and 'good boy'.
>
> Fieldnote, S1 visit 12

> Timothy was already starting to bang his head on the window of the car, she referred to him as 'cheeky chops' and asked him to 'be good for [staff members own name]'.
>
> Fieldnote, S2 visit 2

Furthermore, subtle forms of 'othering' were observed, such as using a different toilet from the residents and not accepting drinks, they made.

> She [staff] had said that she wanted a drink too and Dexter [resident] got a cup out or her, she moved the cup to one side and said, 'I will make my drink'.
>
> Fieldnote, S1

In S2, staff perceived residents to be socially closer to themselves, possibly due to effective training.

> I think autism awareness training was really amazing, eh because, that's when you realise that the people you are supporting are not suffering autism but are actually on the autistic spectrum… which means they are normal as us.
>
> Support worker interview, S2

2.13 | Supporting wellbeing

In both services, organisational values became, to some extent, distorted during operationalisation. For example, in S1 resident's choice was de-coupled from the activities residents were being encouraged to participate in, which is a distortion of the CEO's espoused values of 'supporting people to do the things that *they choose* to do'.

> Dexter [resident] wants to prepare the carrots, we start peeling them and I support him to do this, it is slow going, after peeling one we chop it, Dexter wants to do another, but Magda [support worker] is keen to get rid of us, saying he has to go to help with the recycling. Dexter is very reluctant to leave the carrots and I find this very frustrating on his behalf.
>
> Fieldnote, S1

There were also examples of staff making decisions for their own reasons, without involving people they're supporting in those decisions.

> Nancy and Micha [support workers] discuss where to go to pick up the plants and eventually settle on going into town, as they are cheaper at the market there, the residents are not consulted.
>
> Fieldnote, S1

Opportunities to engage with the community outside the home were evident in S1 with residents going to the shops, bank or café, visiting family, going bowling or horse-riding, attending day services, art classes and doctor's appointments. There was a tendency for staff to leave people with higher support needs out of activities or not provide sufficient support for participation. The three residents being engaged in the excerpt below are verbal and mobile, whereas the two residents not being engaged were non-verbal and their mobility was restricted.

> As I arrive, Dexter, Sally and Sian [residents] are all having a hot drink and some crackers, Andrew and Neil [residents] are not and they are sat in their usual positions in the lounge area within the dining room.
>
> Fieldnote, S1

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In S2, the support provided was somewhat more enabling and person-centred in many respects, with substantial efforts made to meet the differing needs of each individual.

> I kind of see, I see this job as being, you know spending time with the most unusual people you could ever hope to meet and with the intention of having the best day you can every day, making sure they have the best day they can every day.
>
> Support worker, S2

Compared to S1, residents in S2 were less engaged in household chores inside the home and activities outside the home. Residents attended to some personal care tasks (e.g., putting shoes on), meal preparation and laundry, but their involvement in other household tasks was limited. However, compared to S1, there was more equity between residents in terms of opportunities for engagement within the home. More attention was given to the inclusion of non-verbal residents using a range of techniques such as intensive interaction and Makaton.

Going out into the community with residents was seen as important, but it was not always obvious whether this was based on resident's interests and choices. Behaviour support plans were the mechanism staff used to operationalise positive behaviour support (PBS). Staff were encouraged to adhere to each resident's behaviour support plan and daily and weekly routines, designed in partnership with an external team of occupational therapists and psychologists. Perhaps related to this, staff repeatedly avoided making demands that they anticipated may lead to behaviours that challenge and this was consistent enough throughout the data corpus to be considered an 'observed behavioural regularity' (Schein, 2017).

> Sometimes there is genuine reasons, time management and staffing levels impacts. Lots is done for people, sometimes this is a response to reducing demands on people, which impacts mood.
>
> Interview note, S2

2.14 | Positioning services on each dimension

Table 2 below illustrates each 'end' of the dimensions and where the researchers rated each of the services.

There are number of key points to note from Table 2. First, there is variability between the two services and variability across the dimensions. These two services both supported individuals with similar levels of need and characteristics and both were nominated by their organisations as 'good' at supporting individuals with severe and complex needs and met the criteria for inclusion at the outset of the study. However, neither service was rated consistently at the top end for each the dimensions, although S2 did score at the top end of the scale on 'valuing residents and relationships'.

Second, Table 2 also illustrates that the two services differ in position on each dimension for the most part, and also that their relative position also varies – so for example, the services are rated at the same position on only one dimension, S2 is rated closer to the top end for four dimensions but lower than S1 on two dimensions.

Finally, the variability within each service represents differences across staff, service users and time. On a number of dimensions especially for S1, ratings are lower because inconsistencies were observed. For example, on 'social distance', S1 was rated lower on the scale due to inconsistency between staff and S2 was rated slightly better because staff were more consistently respectful and treated people as adults and 'like them'.

3 | DISCUSSION

3.1 | Limitations

Although the original aim of the study was to describe culture in good (high performing) settings, we were not able to recruit these settings and, similar to Bigby et al (2015; 2016a), have instead described 'better' rather than 'good' services. This study has highlighted the difficulty of finding good services and of providing good services consistently across time. The length of time needed to identify services had subsequent consequences for other aspects of the study such as the length of time available for participant observations. Intensity of data collection was also not as originally planned due to occasional difficulties accessing the services – for example, in one setting the researcher could only visit when the service manager or deputy manager was present.

3.2 | Key findings

However, despite the limitations above, the in-depth nature of the research combined with the methodological triangulation achieved by conducting participant observation, that included review of policy and process documentation alongside interviews, has allowed further exploration of the dimensions of culture in a different setting (i.e., in the UK and not just group homes). The study has affirmed the variability in culture both between and within settings as previously identified by Humphreys et al. (2019, 2020). There was variability across different members of staff, even when supporting the same individual and variability in how staff thought about, and worked with, the various individuals they supported, even though they worked in the same setting.

Even in these 'better' services, there was variability across the different dimensions within the same settings. For instance, it was possible for the deputy manager in S1 to be providing coaching and other aspects of 'effective leadership' but for the focus of leadership not to be in line with organisational values or with the dimensions of 'supporting well-being', 'valuing residents and relationships' and 'social distance'. Such variation across dimensions may be an indicator

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that a service is not performing well in terms of quality and outcomes, as there are likely to be correlations between at least some of the dimensions if services are to be 'good' overall. For example, a culture that supports well-being will also be one that values residents and relationships. This concurs with the work of Humphreys and colleagues, who suggested that culture may be more heterogeneous than has been previously considered and that a binary differentiation (e.g., simply at one end of a scale or the other) is not likely to be effective or accurate as a way of summarising where a service sits, in terms of its culture.

In addition, this study has highlighted that the dimensions of culture may be even more complex than initially conceptualised in the descriptions in the GHCS and potentially more nuanced than the items of the GHCS would capture. For example, on 'alignment of staff with organisational values', in S1, the senior manager was not in alignment with organisational values, but the deputy manager's practice was in line with the views and values of the senior manager. Support workers were in alignment with the senior and deputy manager's *misinterpretation* of the organisational values. The GHCS, lack of alignment between staff and senior managers would be identified but would not capture the more complex situation where the organisational espoused values were being misinterpreted by senior or middle managers as in S1.

3.3 | Implications

This study indicates that the framework offered by the seven dimensions of the GHCS may be a useful starting point for an observational measure of service culture. Whilst the perspectives of staff working in such settings has to be a key element of any measure on service culture, this study suggests that combining staff perspectives with observations, interviews and documentation review may provide a more complete picture, especially in services where culture may be more mixed. A more complex scoring algorithm is also likely to be advantageous to capture variability between staff and across dimensions. Further research could develop the rating scale used in this study, with guidance for making the ratings on each dimension and then test its validity and reliability in different settings. A potential model for doing this would be the Observational Measure of Practice leadership (Bigby et al., 2015).

Although more research on the culture in services for people with intellectual and developmental disabilities is needed to allow definitive conclusions and recommendations, this study indicates that understanding and tackling issues of service culture is likely to be an important element of management in these settings. This is particularly important to ensure that those supported experience consistently good outcomes. These findings have potential implications for new staff inductions, for example, how staff are integrated into an existing team, what information they receive about organisational values and what support they receive to stay aligned with organisational goals.

AUTHOR CONTRIBUTIONS

Diane Fox made substantial contributions to the analysis and interpretation of data. Julie Beadle-Brown, Jill Bradshaw and Christine Bigby made substantial contributions conception and design and to the analysis and interpretation of data. Julie Beadle-Brown and Lisa Richardson made substantial contributions to the acquisition of data. All authors have been involved in drafting or critically revising the paper.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The anonymised data that support the findings of this study are available from the corresponding author upon reasonable request.

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