Exploring the impact of ward climate and the development of a tool to measure staff culture in forensic community homes.

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Abstract

Background: Secure settings have a distinct environment. They are intended to manage risk whilst balancing a therapeutic approach. This thesis provides an investigation into organisational factors that impact on staff and patient outcomes in secure and community settings; specifically ward climate and staff culture. Ward climate is a multifactorial construct comprised of the material, social and emotional conditions of a ward and the interaction between these. Culture can be summarised as jointly held views, beliefs, and behaviour across a workplace. Staff culture is multidimensional, ranging from broad organisational levels to within-team facets. Research studies evidence the influence of organisational factors on patient rehabilitation and staff burnout.

Aims: Healthcare staff in forensic settings experience some of the highest levels of violence compared to other healthcare professionals. Research has evidenced patient violence has significant impact on rehabilitation, other patients, and staff. The first aim of the thesis was to explore published literature of ward climate, focusing on the impact on patient aggression and staff burnout in secure hospitals.

There is a paucity of research on organisational factors that can impact rehabilitation in forensic community homes. To enable future research to explore the impact of organisational factors, the thesis aimed to develop a tool that can measure staff culture in community settings.

Method: A review of key concepts, definitions and models was first carried out to provide an overview of the thesis and the background for the research (chapter one). It followed by a systematic review that explored the impact ward

climate has on two important issues in secure hospitals; patient aggression and staff burnout.

Chapter three provides an overview of the methods considered within the development of the tool to measure staff culture. Chapter four explores staff experiences of working in or supporting forensic community homes. Thematic analysis was used to identify themes and sub-themes relating to culture from interviews undertaken with members of a multidisciplinary team. Findings were used to inform the development of the Cultural Assessment of Staff Teams (CAST), a psychometric tool measuring staff culture. Chapter five describes further development and validation of the CAST tool. It outlines the processes to ascertain face and content validity of items. Item reduction and re-wording were completed following the scoring of the expert feedback. Following cognitive interviews with a sample of the target population (support workers) final amendments were made to the tool.

Results: The thesis contributes to the research regarding organisational factors in forensic settings. The systematic review found mixed results. There was an overall finding that the higher the security of the ward the greater the impact ward climate had on patient aggression. Staff burnout and sickness were associated with ward climate.

Regarding the tool development, the domains identified to measure staff culture in community settings were 'The Organisation', 'Home Manager', 'Care Team', and 'Risk Management'. The first version of the tool had 129 items. Once the face and content validity were scored and cognitive interviews were facilitated, the numbers of items decreased to 86.

Discussion: This thesis emphasises the importance of forensic settings measuring and responding to organisational factors. The thesis provides an insight into the concepts of staff culture in forensic community homes and has informed the development of the CAST. Compared to inpatient settings there is a lack of published work on the impact of organisational factors in forensic community settings. The CAST will enable further research to be undertaken to identify relationships between staff culture and resident outcomes.

Authorship declaration

Chapter four research project one was presented at the following two conferences:

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Glossary of Terms

CASP	Critical Appraisal Skills Programme
CAST	Cultural Assessment of Staff Teams
CBI	Copenhagen Burnout Inventory
CQC	Care Quality Commission
CVI	Content Validity Index
EssenCes	Essen Climate Evaluation Schema
GHCS	Group Home Culture Scale
HCR20	Historical and Clinical Risk Management - 20
MBI	Maslach Burnout Inventory
MDT	Multi-disciplinary Team
PBS	Positive Behaviour Support
WAS	Ward Atmosphere Scale

Chapter One: Introduction

The thesis explores organisational factors that influence staff and patient outcomes in forensic settings. It is widely acknowledged that psychiatric settings have a distinct atmosphere (Tonkin, 2015). Aggression is high in secure hospitals and management of risk is a key focus. Research has suggested between 30% - 76% of psychiatric care staff have been assaulted by a patient at least once in their workplace (Hallett et al., 2014; Campbell et al., 2011). This can result in staff injury, trauma and illness, subsequently incurring financial cost to the organisation (Hallett et al., 2014). Given the high levels of aggression displayed in secure settings the systematic review that will be presented in chapter two explored whether ward climate impacted on aggression displayed in secure hospitals. The systematic review incorporated a focus on staff burnout due to the consequences patient aggression can have on staff, as evidenced by the staff injury and illness rates (Hallett et al., 2014).

Defining aggression and violence has shown to be problematic due to the heterogeneous behaviours (Dickens et al., 2012), which can range from verbal abuse to fatal assaults (Dublin & Lion, 1992). Aggression can be defined as verbal, nonverbal or physical behaviour that is threatening to self, others, or the environment (Dickens et al, 2012). Violence refers to behaviour that causes tangible harm and includes physical force, threats against self, others or a community, that results in or has a high likelihood of injury, death, psychological harm or deprivation (World Health Organisation, 2002). Challenging behaviours in secure settings refer to actions that staff find difficult to manage, they include

behaviour of such an intensity, frequency or duration that the physical safety of the individual or others is placed in jeopardy (Emerson, 2001).

Research has for a significant time tended to focus on patient characteristics and demographics that can underlie aggression. Stewart and Bowers (2012) found a history of drug use was consistently associated with verbal aggression. Psychopathological symptoms such as delusions, hallucinations, boundaries, limiting patient freedom, staff attitude and overcrowding have been shown to escalate levels of aggression (Taylor-Watt et al., 2017). Studies that have explored staff understanding of patient aggression have often found that staff attitudes will influence their care and management of aggressive behaviours (Bilgin & Buzlu, 2006; Dickens et al., 2012). As well as the use of seclusion, restraint, and involuntary medication for the management of risk (Husum et al., 2010).

More recently research has been conducted to explore environmental factors that can influence patient rehabilitation. It has been evidenced that social climate is a fundamental factor within the treatment of psychiatric patients (Tonkin et al., 2012). The Royal College of Psychiatrists (2008) has recommended that, as standard practice in secure settings, there should be routine monitoring of social climate.

Ward climate and staff culture

Ward climate has been avidly researched in mental health due to its pervasive role (Laker et al., 2020). Definitions of this phenomenon and the construct continue to generate debate. Some published research of mental health settings

incorporate both aspects of climate and culture into one construct (Laker et al., 2020). Some research studies intertwine aspects of the separate constructs into one, this has included factors such as values, social cultures, and environmental qualities (Dickens et al., 2014; Laker et al., 2020; Abdi et al., 2015). There is an acknowledgement amongst research that the concepts are closely linked and can impact one another. What is also acknowledged is that both climate and culture profoundly affect staff and patient outcomes.

This thesis discusses ward climate and staff culture as two separate constructs, a definition of both has been discussed. It is recognised that there are close links between the two concepts, however there are also clear differences. A Venn diagram (Figure 1.1) is displayed below to give an overview of the constructs, how they are separate and a recognition of factors in which they overlap. Both constructs greatly impact on patient and staff outcomes. Climate as a concept has been researched more than culture in forensic settings. This has led on to the development of psychometrics to measure climate, resulting in studies exploring how climate influences patient rehabilitation and staff experience.

Culture as a concept in forensic settings has been researched less. This thesis aims to develop a tool that will provide a quantitative measure of the construct in forensic community homes.

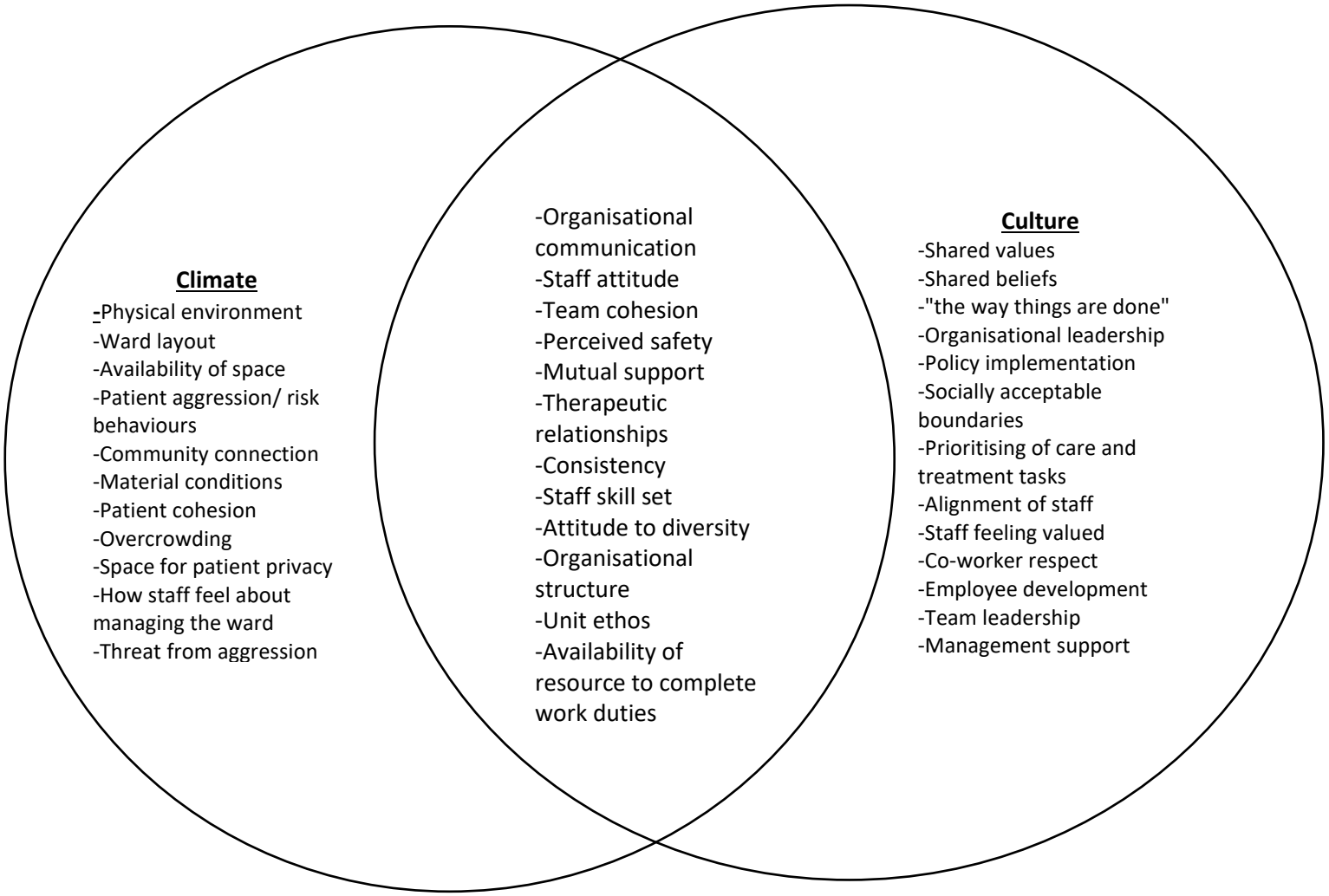


Figure 1.1 A Venn diagram to display the relationship between ward climate and staff culture.

The diagram displays how the two concepts are different, it stipulates the factors relevant to each concept. The diagram also displays how there is overlap between the concepts. Factors such as organisational communication and therapeutic relationships have been evidenced to be related to both climate and culture. The purpose of the diagram is to acknowledge that whilst climate and culture are two distinct concepts there are factors related to both.

Defining ward climate

It has long been acknowledged that climate is an ”intangible“ phenomenon (WHO, 1953 p. 17). There is a range of theoretical perspectives that have led to a lack of one definition. Social climate is identified as a multidimensional construct comprised of the material, social, emotional conditions of the ward and the interactions between these components (Bressington et al., 2011; Puzzo et al., 2018). Social climate can be viewed as a dynamic characteristic of inpatient settings that influence or impact staff and patients (Milsom et al., 2014). Social climate incorporates how safe the environment is, including threat from aggression and violence and how staff feel about managing this (Robinson et al., 2016). The external model of violence (Nijman et al., 1999) emphasises the role of environmental factors. The model suggests that, in psychiatric care, environmental components such as management, treatment of patients, and ward layout could contribute towards challenging behaviours patients display (Dickens et al., 2012). Issues such as overcrowding, limited space or lack of privacy are identified as environmental factors that can impact on patient aggression (Duxbury, 2002).

Nijman et al. (1999) also found that temperature, ward space, overcrowding, limited privacy and shift patterns influenced aggression. Studies have found staff experience and use of agency staff influence aggression, as well as patient need not being met (Carmel & Hunter, 1993; Turnbull & Patterson, 1999).

Measures of Climate

Multiple measures have been designed to quantify and assess climate. A review by Tonkin (2015) found 12 separate measures across 85 articles. The two most

commonly used measures in the review are the Ward Atmosphere Scale (Moos, 1989) and the Essen Climate Evaluation Schema (EssenCES) (Schalast et al., 2008).

The Ward Atmosphere Scale (Moos, 1989)

The WAS (Moos, 1989) was developed to assess social climate in correctional settings and is the oldest measure. It is a psychosocial measure comprised of 86 items with 10 scales and can be administered to both staff and patients. The domains are Relationship Dimensions (involvement, support and spontaneity), Personal Growth Development (autonomy, practical orientation, anger and aggression, personal problem orientation) and System Maintenance Orientation (order and organization, program clarity, and staff control). There are ten items in each sub-scale.

The work on which the measure is based on was conducted around 50 years ago, since which time the manner of providing care has greatly changed. Researchers have therefore questioned whether it is still relevant to current forensic and mental health settings (Schalast et al., 2008; Doyle et al., 2017). A revision of the measure has been suggested (Røssberg & Friis, 2003). There is an acknowledgement that cultures have changed since the 1960's, when the items were developed. Items such as "it is a good idea to let the doctor know that he is boss" (Staff Control Domain) are not necessarily a measure of that construct today (Røssberg & Friis, 2003). However, the WAS (Moos, 1989) is a longer measure compared to the EssenCES and, therefore, may provide a deeper insight into social climate, although it could be questioned whether this would be an accurate insight. In the 1960's and 70's only a few subscales were

measured as satisfactory (Røssberg & Friis, 2003), it is possible that, in the current service culture some items may have become even less relevant. A systematic review by Tonkin (2016) concluded that the WAS had less empirical support compared to the EssenCES.

The EssenCES (Schalast et al., 2008)

The EssenCES (Schalast et al., 2008) is a 15 item measure of social climate across three dimensions; Therapeutic Hold (perception of the ward as supportive of patients' needs and the quality of the therapeutic relationships), Experienced Safety (perceived safety from aggression and violence), and Patients' Cohesion and Mutual Support (extent that community members offer positive support and are cohesive in each other's rehabilitation and recovery). It is a measure used by secure services in the National Health Service and other private health care organisations in the UK. The EssenCES has good convergent and divergent validity, support for the proposed structure and good internal consistency (Tonkin, 2016). Studies have reported internal consistency of the EssenCES. Cronbach's alpha across studies were 0.82 (resident cohesion), 0.77 (experienced safety) and 0.91 (therapeutic hold) (Tonkin, 2016). In a review by Tonkin (2015) it was reported that the mean Cronbach's alpha values across ten studies indicated good empirical internal consistency of the EssenCES.

Model of Climate

Doyle et al. (2017) conducted a qualitative systematic review and developed a conceptual model of social climate in secure settings. Themes were identified across 22 studies to inform the model of social climate. The studies involved psychiatric hospitals and prisons. 13 studies had sought the patient experiences

in forensic settings to encapsulate their views within the model, whilst nine studies incorporated staff views. In total seven factors were identified. Figure 1.2 displays the model.

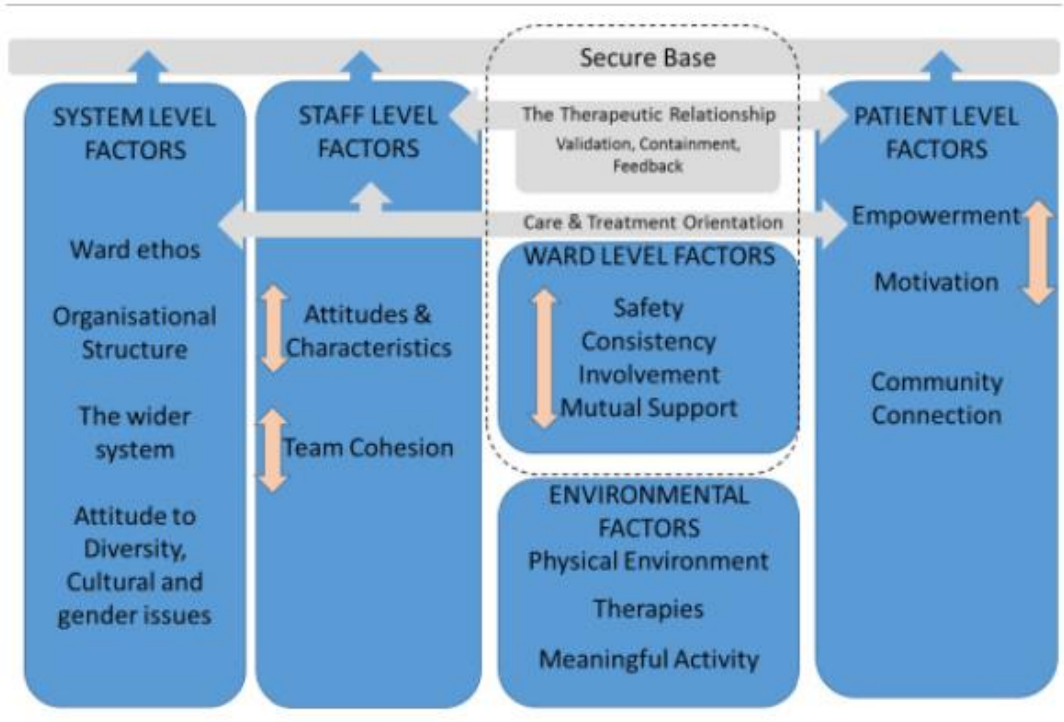


Figure 1.2. Conceptual model of social climate (Doyle et al., 2017).

This model offers a framework of social climate in psychiatric hospitals that sought to include patient and staff perceptions. The model contains five areas that are relevant to social climate: the system, staff, patients, the ward (shared space) and the physical environment. Within each of the five areas key influential factors that are relevant in influencing that area are listed.

When reviewing the model in relation to the WAS (Moos, 1989) and the EssenCES (Schalast et al., 2008) the measures appear to lack domains of some of the system factor levels such as Attitude to Diversity, Cultural and Gender

issues. However, they do cover other areas the model identifies, such as the ward level factors, patient level factors and environmental factors.

It is noted that the study involved both psychiatric hospitals and prisons. It is questionable as to whether one model should be developed in relation to both settings. Psychiatric hospitals have a focus of rehabilitation and risk management. Prisons have a focus of detention and risk management. It could be suggested two separate models for the settings would be more representative of their culture.

Defining culture

Organisational and staff team culture have been evidenced to impact on client rehabilitation and quality of life (Gillet & Stenfert-Kroese, 2003). Culture is defined as multidimensional rather than unidimensional (Humphreys et al., 2019). There are multiple definitions of culture, it is not synonymous with social climate. A broad definition from literature defines it as ”the way we do things around here“ (Deal & Kennedy, 1982, p.4). Key components of culture include shared values and beliefs that can influence an individual’s behaviour and emotions (Alvesson, 2013; Ehrhart et al., 2014; Robinson et al., 2016; Schalast et al., 2008). Within organisations, culture can influence how staff act, the way they think, and how they make decisions and determine priorities (Lok & Crawford, 2004; Hansen & Wernerfelt, 1989). The culture within a staff team will define who the team are as a collective and informs boundaries of socially acceptable behaviour (Matsumoto, Yoo & Chung, 2010). Culture has also been conceptualised as existing on multiple levels, for example the wider organisational level and within team levels, thus potentially resulting in

numerous subcultures present within organisations (Martin, 2002; Humphreys et al., 2019). Furthermore, cultural factors may be divided into those that are general to all work settings and those that are specific to a particular setting, in this case forensic. These factors are summarised in Table 1.

Culture in general work settings	**Culture in forensic settings**
Shared values and beliefs	Prioritising of care and treatment tasks
"The way things are done round here"	Therapeutic relationships between staff and patients
Socially acceptable boundaries	Consistency in care practice
Alignment of staff	Ward ethos
Staff feeling valued	Staff and patient safety
Co-worker respect	Risk management
Employee development	Person centred care
Team leadership	Staff understanding of patient need
Management support	
Team cohesion	
Organisational structure, visible leadership	
Availability of resource to complete duties	
Attitude to diversity, cultural and gender issues	
Influence of determining priorities	
Organisational communication	

Table 1.1 A comparison of general and forensic cultural factors.

As staff culture refers to shared attitudes and beliefs amongst a team, it influences how employees think and make decisions. Within secure settings these factors will impact on patient care and the treatment they receive. Studies have empirically evidenced that the quality of a therapeutic patient and staff relationship can directly contribute to the emotional stability of patients (Fluttert, 2010). It is therefore important to have a tool that can assess culture in these settings.

Published literature has highlighted a distinction between formal and informal organisational culture (Mansell & Beadle-Brown, 2012; Humphreys et al., 2019). Formal culture refers to job descriptions, policies, training, mechanisms in place to monitor staff performance and organisational planning approaches (Felce et al., 2002). These factors are implemented and overseen by management. They are designed to shape the behaviour of staff through providing clear expectations and guidance (Humphreys et al., 2019). In comparison, informal culture refers to the relationships of staff, the approaches in their working, staff and client interactions, and the reasons staff work in the setting (Felce et al., 2002; Hastings et al., 1995). Researchers have suggested that congruence between informal and formal cultures contributes to a higher quality service, on the contrary incongruence contributes to lower quality services (Emerson et al., 1994); however, there is no empirical evidence that can underpin this currently. Table 1.2 has been developed to show concepts of formal and informal culture in forensic settings.

Concepts of culture in forensic settings	
Formal culture	**Informal culture**
Policy implementation	Staff relationships
Prioritising of tasks	Staff approaches to their working
Job descriptions	Staff and patient interactions
Organisational planning approaches	Staff reasoning for working in forensic settings
Mechanisms to monitor staff culture	Ward ethos
Organisational expectations	Staff understanding of patient need
Staff skill set	
Risk management	

Table 1.2 A table to distinguish between formal and informal culture in forensic settings.

A framework for understanding factors that influence staff who support individuals with challenging behaviour was developed by Hastings and colleagues (Hastings, 1997, 2002; Hastings & Remington, 1994; Hastings & Brown, 2000). Several variables were identified that include: a lack of staff behavioural knowledge and skill, negative emotional responses, beliefs/ attitudes, and informal and formal service culture. Positive staff values and attitudes relating to service users with a learning disability have been found to be related to well-being in staff (Hastings & Horne, 2004). Culture has been associated with staff outcomes such as reported stress, work satisfaction and staff retention (Gillett & Stenfert-Kroese, 2003). It has been suggested that organisational culture can act as a buffer against workplace stress, or it can exacerbate it (Hatton et al, 1997; Stenfert-Kroese, 2003).

Measure of Culture

The Group Home Culture Scale (Humphreys et al., 2019) was developed as a tool to measure staff culture in shared homes for individuals with an intellectual disability. It included domains that were relevant to the population that focused on the residents' functional skills, the measure did not include domains focused on a forensic population. Humphreys et al. (2019) identified that organisational culture in such homes influences staff behaviour and impacts the resident's quality of life (Humphreys et al., 2019).

The tool was developed through a mixed-methods sequential research design (Creswell & Plano Clark, 2011; Humphreys et al., 2019). An initial construct of

items was developed that was informed by research. Items were reviewed by a panel of experts. Cognitive interviews were facilitated with a sample of the population. Following tool amendments, seven domains are present on the tool. Domains include: Supporting Well-Being, Factional, Effective Team Leadership, Collaboration within the Organization, Social Distance from Residents, Valuing Residents and Relationships, and Alignment of Staff.

It is noted that the tool was developed based on ”underperforming homes“ and ”better performing homes“ (Bigby & Beadle-Brown, 2016). The research did not draw upon high achieving homes, this could potentially result in aspects of culture not being conceptualised or overlooked from well-performing settings.

What does optimal culture look like?

Within general health settings there is an emphasis on developing a culture that maintains patient safety. Individuals are encouraged to raise concerns about patient experience and care. The aim is to reduce risk and achieve optimal standards for patients, staff and organisations (Department of Health, 2015). Specific to nurses, the National Compassion Strategy was launched in 2012 with a focus on the 6Cs. These included care, compassion, competence, communication, courage and commitment. The aim was to shape culture and provide patients and professionals with a high-quality consistent experience.

Within general healthcare there is a plethora of instruments for measuring organisational culture and patient safety cultures (Mannion et al., 2009). However, it was found these measures lacked a focus on the quality of culture.

There was more of a focus on patients' experiences of safety and care (Mannion et al., 2009).

The 'culture of care' barometer was developed as a tool that included a focus on developing cultures where staff feel cared for, supported, valued and respected; this is equally as important for providing high quality care (Rafferty et al., 2017). From an organisational development perspective, the 'culture of care barometer' is for healthcare providers to measure their culture of care and to raise awareness to signs of deteriorating standards (Wood, 2021). The domains include a focus on 'organisational values' that incorporates employees feeling valued, good communication within the organisation and visible leadership at the higher levels. A second domain focused on 'team support' that included supportive team relationships, and management and development of employees. The final domain focuses on 'everyday work' and incorporate co-workers support and respect to each other, and ability for employees to complete their job in relation to resources available and time (Rafferty et al., 2017).

Influence of culture in care settings

There is a government focus to care for people in the community where possible. There is a recognition that secure hospital settings can have a negative impact on people's mental and physical health (Joyce, 2020). There are many factors that can influence this, including reduced contact with social supports, restrictive interventions, limited hospital resources, and human factors relating to staff skill and experience (Joyce, 2020). Research has identified organisational culture impacts on service outcomes and care (Barney, 1986).

Recent inspections of care companies have highlighted the importance of ensuring organisations are transparent. They encourage individuals to raise concerns regarding care. Inspectorate reports have documented the negative impact that can be caused by a closed culture, which in turn can impact on the level of care staff provide to residents. The Care Quality Commission (CQC) (2021) describe a closed culture as a culture that can lead to harm, in which human rights are breached, for example abusive practice occurring.

There have been many scandals of abusive practice such as Winterbourne View (CQC, 2011) and Whorlton Hall (Murphy, 2018). The CQC requested an independent review into each of the settings. The report on Whorlton Hall (Murphy, 2018) highlighted the impact of culture on staff practice. Recommendations from the review included the need for urgent consideration of additional safeguards to identify closed and punitive cultures of care or identifying settings which may be at risk of developing such a culture. Within the report it stressed the need for organisations to have well-led leadership that provide high-quality care, that is based on individual client need and promotes an open culture. The Whorlton Hall report (Murphy, 2018) described how staff did whistle-blow as they were concerned about the patient safety. The staff reported a deterioration of culture and inappropriate use of restraint. The report highlighted the importance of ensuring disclosures are monitored and responded to. There is an urgent need to be able to identify 'toxic cultures' and prevent such abusive practice occurring again.

The CQC has produced a paper for inspectors called the Quality of Life tool for inspecting services for people with a learning disability (CQC, 2021). This

included proposed factors that are red flags alerting inspectors to the potential development of a toxic staff culture. The CQC (2021) identified the red flags to include clients who reside in a service that are vulnerable and highly dependent on staff. It also included the service lacking permanent staff, or lacking staff with adequate skill and training. In addition, a lack of leadership, lack of staff supervision and poor response to complaints. Additional red flags include having poor managerial oversight of the service. Particular concerns were raised by families or staff, which included a lack of managerial awareness regarding concerns about culture, or care; the use of clients being restricted without consideration of their human rights; a lack of external visitors for example commissioners not monitoring the service; and finally little contact with advocacy or safeguarding services. Although much of the CQC guidance is aimed at settings for learning disabled and autistic individuals, the regulator is clear that the same principles apply to mental health and adult care settings where the settings are closed environments (Frankova, 2020).

Organisational culture has been consistently identified as a factor that influences the service quality. This is based on the premise that culture influences staff attitudes and behaviour which impacts the residents' care and quality of life (Lincoln et al., 2019; Mansell & Beadle-Brown, 2012).

In response to such cultures being unearthed there have been a number of legislations and guidelines written that aim to increase the safeguarding of vulnerable individuals in care. The Independent Review of the Mental Health Act (Department of Health and Social Care, 2018) recommended that a new criterion is developed for measuring the social environments of settings. When the

aforementioned red flags are present, inspectors are advised to plan a visit that focuses on care and human rights. This further highlights the need to have a tool that can be used in services to provide a measure of the staffing culture.

Culture, climate and outcomes

Research was conducted by Bigby and Brown (2016) and Bigby et al. (2014) on group homes that supported individuals with severe intellectual disability. This included homes that were performing well and group homes that were underperforming. Comparisons of culture across the underperforming and better performing homes showed residents had a higher quality of life in the better performing homes. Comparisons of culture highlighted differences in staff practice. Within the underperforming homes interactions by staff with the residents were characterised as being self-centred. When this was compared to staff practice in well performing homes the care was person-centred, staff interactions towards residents were warm and included moments of fun and enjoyment. This study again highlights the direct impact staff cultures have on client care and client experiences.

Gillett and Stenfert-Kroese (2003) explored organisational culture and residents' quality of life in two residential homes from the same organisation in a pilot study. The tool that was used to measure culture was the Organizational Culture Inventory (OCI; Cooke & Lafferty, 1989 as cited in Gillett & Stenfert-Kroese, 2003). They found residents who lived in a more positive culture had a higher quality of life. They also found the higher performing home scored statistically significantly lower scores on the three negatively influential cultural styles; oppositional, competitive and perfectionistic. The tool was not specifically developed for a care setting. The authors of the measure stated it is appropriate

for all types of organisations. However, it could be suggested items such as staff members 'turn the job into a contest' may not be relevant for a care setting in comparison to a corporate setting, even though the results do highlight the impact of team culture on residents' quality of life.

A significant quantity of research has focused upon the quality of care delivered in homes for individuals with learning disabilities, physical health and complex needs (Bigby & Beadle-Brown, 2016). Research looking at residential settings for individuals with a learning disability has identified that, subsequent to the complexity and severity of the person's disability, delivery of care that is enabling and empowering to the resident correlates with the residents' quality of life (Bigby & Beadle-Brown, 2016). Within the forensic community settings there is a paucity of research identifying factors regarding culture that correlate to an individual's recovery or quality of life. There is a lack of research based in forensic community settings.

Defining forensic community home

This thesis refers to "forensic community homes". These are settings that provide a supported living environment for individuals with complex needs. This may include individuals with an offending risk and mental health difficulties. The residents typically have stepped down from secure hospital or prison and require additional support to continue their rehabilitation and integrate into the wider community.

The homes involved in this research were based within a private organisation in Wales. The organisation operates multiple community homes, and secure

hospital settings. The community homes are continually staffed by support workers and senior support workers. They are overseen by a house manager and receive clinical input from a psychiatrist and psychologist, alongside any other appropriate allied health professional. Clients live in single sex occupancy house. Each client has their own bedroom, and they share communal spaces.

Rationale for tool development

Over the course of the last decades mental health care has undergone major changes. This has included development of therapies, care settings, and new legal frameworks (Novella, 2010). Following many instances of ill-treatment of mental health patients, it has been a government priority to transform mental health care. This includes a focus to move suitable patients from hospital to appropriate community orientated settings (Novella, 2010). There is recognition that secure hospitals can institutionalise people and detention can be harmful to patients. In Holley et al's. (2020) study, patients reported their routines were monotonous and repetitive, with some having undertaken the same routine for years. The current recognition in mental health care is that clients should be actively treated and supported to live in the community.

As discussed, research has evidenced the impact culture has on shaping staff attitudes that can influence care practice. To date there is no psychometric tool available to measure staffing culture in forensic community homes. Such a tool could be useful in three ways. Firstly, it will provide additional insight into staffing behaviour and attitudes within a team. Secondly, it could be used to compare staff team culture across an organisation. Thirdly, it could be utilised to

assist in the development of a new service, to shape the ideal staff culture. This thesis describes the research to develop a tool to fill this identified gap.

Overview of Thesis Structure

The thesis contains six chapters, of which the first chapter is a general introduction to the thesis and the sixth chapter is an overall discussion of the thesis.

Chapter two

Chapter two presents a systematic review that explores the impact of ward climate on patient outcomes and staff burnout in psychiatric hospitals. The chapter outlines the methodological approaches that were followed. Initially, 116 studies were identified and, following the pre-determined inclusion and exclusion criteria, seven studies were included. The chapter discusses the mixed findings and provides suggestions for future research.

Chapter three

Chapter three provides an overall outline of the methodological approaches undertaken in study one and study two (chapters four and five). These studies focused on the development of a tool that measures staff culture in forensic community homes. Chapter three aims to provide insight into methodological approaches that were considered throughout the tool development. The chapter provides reasoning behind the chosen approaches. A discussion of future research is provided.

Chapter four

Chapter four presents study one. This is a qualitative piece of research focusing on exploring multi-disciplinary team (MDT) members' experiences of working in forensic community homes. The chapter describes how the semi-structured interview was developed. It provides an exploration of the interview themes and sub-themes that were identified through thematic analysis. The focus of this piece of work was to identify key concepts of culture in forensic community homes. The findings from study one were used to develop items for inclusion in the tool.

Chapter five

Chapter five discusses the process of utilising the results from chapter four to inform the development of items on the tool. Domains and sub-domains were based on the themes and sub-themes identified in the thematic analysis. Items were developed to measure each of these constructs, incorporating both positive and negative aspects. The first version of the tool was distributed to a panel of experts who were asked to rate the face and content validity for each item. This chapter discusses amendments that were made following expert feedback. The second version of the tool was then administered to a sample of the target population (support workers and senior support workers). Cognitive interviews were facilitated to identify any ambiguities within the tool. The findings resulted in final adjustments to items, which included providing definitions of terms and examples of phrases.

Chapter Two: Systematic Review

Does ward climate have on an impact on patient aggression and staff burnout in psychiatric hospitals?

Summary

Secure psychiatric hospitals serve an important function of rehabilitating patients who have serious mental health needs and present a risk to themselves or others. They have a need to balance rehabilitation and risk. Research has identified several factors that can influence the effectiveness of rehabilitation and treatment outcomes (De Vries et al., 2016). One of these factors is ward climate. Ward climate is a multifactorial construct comprised of the material, social and emotional conditions of a ward and the interaction between these (Tonkin, 2016; De Vries et al., 2016). It describes the environment or atmosphere of a setting (Schalast et al., 2008). Ward climate has been suggested as an important factor that can influence treatment drop-out, re-admission rates and therapeutic alliance (Bressington et al., 2011).

To further explore the impact of ward climate on patient aggression and staff burnout a systematic review was conducted. One hundred and sixteen studies were identified and, after applying the inclusion and exclusion criteria, seven studies were included in the review. Overall, the studies reported mixed results. One possible reason could be due to the different levels of secure hospitals as, from the studies, it appears that the higher the level of ward security the stronger the correlation between climate and aggression. Only two studies were found to focus on climate and staff outcomes. One study found a correlation between burnout and climate, the second found a correlation between climate and staff sickness.

Introduction

The model of mental health care has undergone many changes over the last decades. There has been a shift in legislation. Where possible individuals with mental health needs should transition from psychiatric hospitals into the community. There is a drive to ensure individuals are living in the least restrictive conditions. There is also a recognition that secure hospitals can have a detrimental impact on individuals who do not require that level of security (Loch, 2014). The environment by nature is restrictive, such restrictions are only necessary when an individual requires external factors to maintain their own and others' safety. Legislation is currently focused on ensuring patients are not detained unnecessarily for prolonged periods of time (Saxena et al., 2006).

Inpatient care

In the UK individuals are admitted to psychiatric hospitals if they pose a risk to themselves or others (Holley et al., 2020). The aim of hospitalisation is to provide care and treatment to the individual and provide protection to the public by reducing the risk the patient poses (Holley et al., 2020). Within forensic hospitals the continual assessment of risk reduction to others, the self, and the environment dominates service provision (Maden, 2007). Risk informs decisions made about patient's lives and their freedom, this reduces their own level of control (Brown et al., 2014).

Research has shown patients can experience trauma whilst they are detained in hospital, this can have a significant impact on their quality of life. There can be strict rules on patient movement between wards, restricted access to mobile phones and limited access to outdoor spaces (Roberts et al., 2008; Reavey et

al., 2019). Patients have described inpatient experiences in which they were too scared to leave their rooms from fear of other patients (Brown et al., 2014). Whilst other patients have reflected on the discrepancy between being sedated through medication and then being informed by staff to wake up early and be productive (Brown et al., 2014). The role of an inpatient setting is to manage risk and provide rehabilitation; however, it is recognised these factors can be opposing.

Patient aggression

Secure settings support individuals who can present with challenging and violent behaviour. The reality of violence and aggression for professionals in these settings is such that training is offered to help them manage and prevent this (Anderson & West, 2011). There is no single definition for aggression. For this study aggression will be defined to include threatening behaviour, verbal abuse, physical aggression and property damage (Anderson & West, 2011).

Research that has focused on violence in the workplace found healthcare staff in forensic, acute, and general mental healthcare settings experience some of the highest levels of violence compared to professionals in other healthcare settings (Bowers et al., 2011). Nurses within the psychiatric profession have been identified to be at risk of being victim to physical and emotional abuse perpetrated by patients (Delaney et al., 2001). Research has evidenced within psychiatric hospitals episodes of violence from patients has significant impacts on other patients, staff and treatment (Woods and Ashley, 2007).

Aggression is overrepresented in individuals affected by severe mental illness such as bipolar disorder, schizophrenia, autism, and attention deficit hyperactivity disorder (Manchia & Fanos, 2017), compared to unaffected populations (Pulay et al., 2008). Mental illnesses are diseases that affect emotion, cognition, and behaviour control; subsequently they impact on an individual's ability to function (American Psychiatric Association, 2020). A study from Sweden found individuals with a diagnosed mental illness were three to four times more likely to have been convicted of a violent crime after the onset of their illness compared to their siblings without mental illness (Sariaslan et al., 2020).

The perpetration of aggression is multifactorial and can be due to factors such as genetics, attachment difficulties, trauma, substance misuse, lack of emotional regulation skills and personality traits (Butchart et al., 2006; Manchia & Fanos, 2017). Studies that have focused on exploring the impact of childhood trauma have found individuals may develop post-traumatic stress reactions, and there have been strong links between childhood trauma and aggression (Goh et al., 2021; Widom, 1989). Psychiatric patients often have a past history of trauma. The aggressive presentation by patients can impact on how safe staff and patients feel on the ward.

Research has also shown interpersonal factors can be associated to high patient aggression. Factors such as negative staff attitudes (Evans, 2000; Duxbury, 2002) and staff using controlling or coercive behaviour (Ray & Subich, 1998). Staff who lack clinical skills and interpersonal skills have also been shown to negatively impact the risk of patient aggression (Spokes et al., 2002). Research

that has explored patient perception of why aggression occurs has found patients attributed it to controlling attitudes by staff and environmental factors (Duxbury & Whittington, 2005) all of which are identified as components attributing to ward climate.

Staff burnout

Burnout is a prolonged response to chronic emotional and interpersonal stressors (Maslach et al., 2001). The experience of burnout is a manifestation of distress. It is characterised by exhaustion, cynicism, and inefficacy (Maslach, Schaufeli, & Leiter, 2001).

Maslach et al. (2001) suggest that the exhaustion element of burnout represents the individual stress of burnout, occurring when the individual is overextended and depleted of emotional and physical resource. Cynicism refers to the interpersonal effect of burnout, so that an individual presents as callous, or extremely detached to aspects of their job. The component of inefficacy represents the self-evaluation dimension of burnout. The individual experiences feelings of incompetence and a lack of productivity and sense of achievement.

Frontline psychiatric staff are exposed to directly challenging behaviour. They work in teams where there are often high levels of staff vacancies resulting in dependency on agency staff (Totman et al., 2011). Such experiences lead to high levels of sickness among staff, at a cost to the NHS of around £1.1 billion per year (NHS, 2017).

Professionals who are found to be most at risk of burnout are those directly delivering psychiatric care, especially nurses (Caldwell et al., 2006).
When staff within healthcare reach burn out, they can experience emotional depletion, detachment from patients, lack of compassion, and a perception that the organisation does not value them (Berry & Robinson, 2019). Burnout can impact on the quality of care staff deliver to patients. Within inpatient mental health, research has found a significant correlation between staff well-being and patient outcomes (Department of Health, 2009). Staff have been shown to greatly influence ward climate. Factors that are known to contribute to a positive ward climate are staff interactions with patients, trusting staff relationships and staff interactions with patients (Nesset et al., 2009; Fish & Culshaw, 2005; Meehan et al., 2006). If staff are experiencing burnout this may impact on their interactions with patients and their ability to develop therapeutic relationships. Staff with poor interpersonal and clinical skills have been found to increase the risk of patient aggression (Spokes et al., 2002). Papadopoulos et al. (2012) suggested reducing staff stress and burnout may decrease the frequency of incidents and conflict.

The Job Demands Resource Model (Bakker & Demerouti, 2007) specifies how job strain (burnout) and betterment (work engagement) may result from two specific sets of working conditions: job demand and job resource. Job demands refers to job duties that require physical and psychological resource. Job resource refers to amount of support on offer to complete demands. Job demands are not necessarily negative; however, they may turn negative when job demand is high and job resource is low (Schaufeli et al., 2009). Job strain (burnout) was explored as a variable in the systematic review.

Systematic Review

Whilst undertaking the research there was one existing systematic review by Robinson et al. (2016) that was focused on exploring perceptions of social climate and aggressive behaviour in Forensic Services. Their review focused on the years 1990 to 2015. It included a variety of different measures of climate for both hospitals and prisons. Ward climate can influence the daily experiences of both staff and patients. They found factors which were associated to aggression were patients' perceptions of safety, the level of cohesion between patients, the atmosphere of the environment, and an open group climate.

This systematic review explored whether ward climate impacts on patient aggression and staff burnout. It aimed to bring individual studies together to explore the relationship between ward climate, staff burnout and patient aggression. Each individual study was brought together to synthesise and evaluate the findings, uncovering consistency; this approach far extends what a single study can accomplish (Cumming, 2014; Siddaway et al., 2019).

The current review focused on patient behaviour including aggressive behaviour measured by incidents and data reporting. It included studies that measure staff burnout. The current search strategy included recent studies beyond 2015, it also only focused on secure hospitals and excluded studies that did not use the EssenCES measure. This was to increase the likelihood that the studies are measuring the same concept. The EssenCES has three clear dimensions to it, whilst other measures like the Ward Atmosphere Scale (Moos, 1989) or the Prison Environment Inventory (Wright, 1985) include eight domains; it is difficult

then to be confident that the authors in the individual studies are effectively measuring the same concept. This is especially difficult when it has already been identified that climate is multidimensional and there are various definitions of the concept. Including studies that have used the same psychometric measure in the environmental setting increases the likelihood that the authors of each individual study are measuring the same concept.

Measuring Ward Climate

As discussed in chapter one, the WAS (Moos, 1989) and EssenCES (Schalast et al, 2008) are the two predominant measures of climate. It was identified that climate has changed since the development of the WAS (Moos, 1989); therefore this systematic review will only focus on the EssenCES (Schalast et al, 2008) as it is a more recently developed measure with good internal consistency and convergent validity with other measures (Robinson et al., 2016).

Social climate is recognised as a multifactorial construct that is comprised of components that describe how a setting is perceived by residents or staff (Tonkin, 2016). Components can include feelings of safety, physical and psychological needs of residents, the extent the setting provides opportunity for residents to learn prosocial behaviour and skills and therapeutic support (Tonkin, 2016). The model in chapter one (figure 1.1) provided insight into the components of social climate.

Aims & Objectives

The aim of the systematic review was to assess the impact of ward climate on patients and staff. The following review questions were explored:

Does ward climate impact on patient aggression?

Does ward climate impact on staff burnout?

Method

Search Strategy

The criterion for the study selection was guided by the Population, Intervention, Comparison and Outcome (PICO) (Frandsen et al., 2020) approach. These parameters were used to formulate a focused and well-articulated research question. A scoping search was conducted prior to identifying studies for inclusion. This was to assess the volume of published work and type of publications in the area.

Review objectives

The object of this review was to assess the impact of ward climate on patient aggression and staff burnout.

Participants

Patients in secure hospitals; all levels of secure wards were included.

Staff working in secure hospitals, this includes support staff, nursing and all members of the MDT.

Intervention

A measurement of climate with the ESSEN Climate Evaluation Schema tool.

Comparing

Comparing the scores of the climate measure with patient and staff outcomes.

Outcomes

Patient aggression measured for example using incident reporting data or risk management tools. Staff burnout measured using an appropriate psychometric tool.

Study characteristics

Quantitative data provided for the climate and outcomes.

Information Sources

Literature searches were conducted through the University of Nottingham's online library, Scopus, PsychINFO, PubMed, Web of knowledge, MEDLINE and EMBASE. In text citations and article reference lists were searched by hand.

- Nottingham University online library search date 14.08.2021 completed 30.01.2022, published from 1997 to 2022
- Scopus search date 14.08.2021 completed 30.01.2022, published from 1960 to 2022
- PsycINFO search date 14.08.2021 completed 30.01.2022, published 1990 to 2022
- PubMed search date 14.08.2021 completed 30.01.2022, published 1883 to 2022
- Web of knowledge search date 14.08.2021 completed 30.01.2022, Published 1990 to 2022
- MEDLINE search date 1.05.2022, completed 14.05.2022 published 1990 to 2022
- EMBASE search date 1.05.2022, completed 14.05.2022 published 1990 to 2022
- Additional studies were searched by hand through in text citations or article reference lists, completed on 02.02.2022.

Search Terms

Table 2.1 outlines the search strategy. Truncation marks (*) were used so words with the same word stem would be identified, for example Violen* was used to search for both violence and violent. Boolean operators 'AND' and 'OR' were used to maximise the sensitivity and specificity.

The ESSEN climate evaluation schema was specifically searched for as discussed in the inclusion criteria this was on the only tool chosen to measure climate. A search combination of "psychiatric ward'' OR "secure hospital'' OR "Psychiatric hospital'' OR secure unit OR low, medium, high secur*, hosp* was made for the setting. This was due to the inclusion strategy focusing on secure hositpals and wards. Lastly, Violen* OR Aggress* OR behaviour OR Staff burnout was searched to explore patient and staff outcomes relevant to the inclusion criteria.

Search strategy

Constructs	Search terms
Organisational climate/ ward climate	"The ESSEN climate evaluation schema''
AND	
Setting	"psychiatric ward'' OR "secure hospital'' OR "Psychiatric hospital'' OR secure unit OR low, medium, high secur*, hosp*
AND	

Impact: Patient / staff	Violen* OR Aggress* OR behaviour OR Staff burnout

Table 2.1. Systematic Review Search Strategy

All search terms were mapped to databases and searched as text in the title and abstract. Searches were not limited to specific years or dates. They were limited to the English language.

Study selection

The following selection criteria was followed to decide whether studies would be included into the review.

Inclusion criteria

Studies were included if the setting had been focused on secure hospitals. All levels of secure hospital were included. Studies were required to use the EssenCES to measure ward climate. Studies were also required to use a measure or provide quantitative data on patient aggression, violence, behaviour or staff burnout.

Exclusion criteria

Studies were excluded if they focused on secure hospitals for learning disabled patients. It is recognised that models of social climate for forensic settings for individuals with learning disabilities are different from models used in non-learning disabled secure hospitals (Doyle et al., 2017; Tonkin, 2016). The tool was originally designed for non-learning-disabled hospitals, it is recognised that adaptions to tools are required to increase validity. A study by Barker et al.

(2021) suggested there was preliminary evidence for the tool to be used in low-secure learning disabled hospitals. Clinicians that had administered the tool to learning disabled patients noted a number of concerns including patients experiencing difficulty understanding the language, use of abstract concepts, mentalising which is difficult for patients with autism and a learning disability to consider what someone else is thinking, as well as difficulties understanding the Likert Scale amongst other issues noted (Chester et al., 2015). Robinson and Craig (2019) also found patients experienced difficulties with the wording, and the five-point Likert Scale. Robinson and Craig (2019) reported their findings could not be compared to the findings of other studies as they were not gathered from a learning disabled population. It appears this research area continues to be explored, therefore, this area was excluded.

Studies were also excluded if they were focused on the prison population. It is noted that prison and hospitals have a different climate, hospitals are associated more to a therapeutic environment whilst prisons have an additional deterrent factor (Gunn, 2000). Although there are some therapeutic communities within prisons, forensic hospitals and prisons do operate differently.

Studies were excluded if they administered a different climate measure other than the EssenCES or if they did not provide data for patient behaviour/ staff burnout. Unpublished studies were also excluded as they had not been subject to the peer review process (Robinson et al., 2016).

The combined strategy resulted in 116 publications being retrieved (see Figure 2.1). The selection criterion was applied to the studies. This resulted in 81

studies being excluded on title or abstract as they were duplicates or because they were conducted in a non-secure hospital setting. After full-text reading, 25 studies were excluded as they did not use the EssenCES tool to measure culture or on further reading it became evident that the studies were not based in a secure hospital. Through searching article citations and references one further study was included. This resulted in a total of seven studies included in the review.

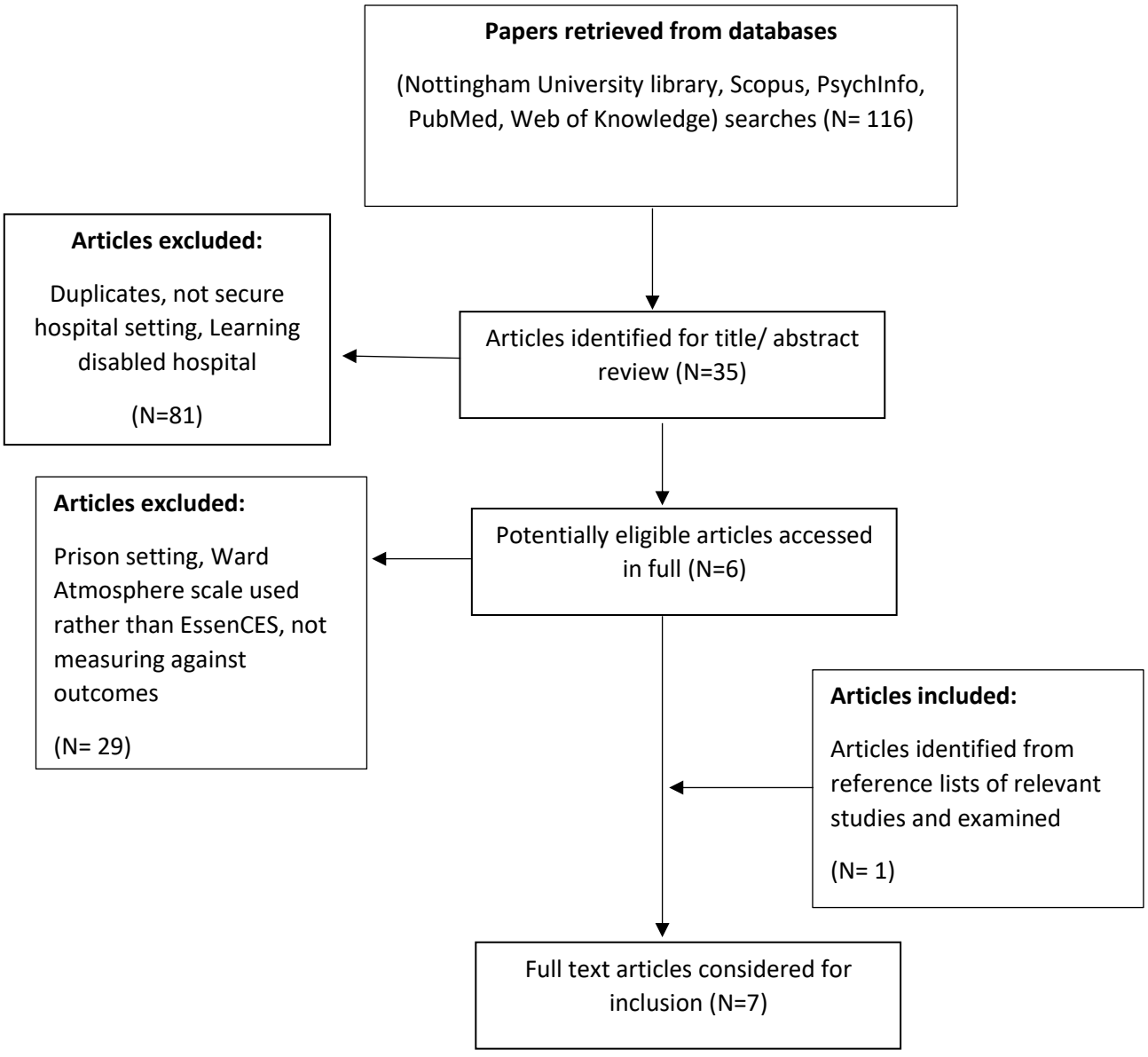


Figure 2.1 Flow Chart of Publication Selection Process.

Quality assessment

A crucial aspect of a systematic review is assessing the quality of the studies' methodological approaches. This is important to reduce the susceptibility of bias within the results. There are multiple tools that have been developed for the purpose to assess study quality, however, there are no appraisal tools for cross-sectional designs. The Critical Appraisal Skills Programme (CASP) was used with irrelevant sections removed, Robinson et al. (2016) used this approach in their study. The tool that can be seen in appendix A.

The stage of quality assessment is important within a systematic review as it focuses on the appropriateness of the methods used in each study (Von Elm et al., 2007). Areas such as inadequate reporting of methodology or weak statistical analysis amongst other study flaws should be identified in the quality assessment. If weaknesses are identified the researcher must decide whether the study should be incorporated or excluded. If the quality assessment identifies that key aspects were not included, such as the measures of variables, then each weak study identified will be considered on an individual basis (Juni et al., 1999).

The quality assessment process is used to ascertain to what extent the criteria are met in each included study. If the criterion is fully met it scores 2, partially met it scores 1, not met or unsure score 0.

Each article was awarded a score expressed as a percentage of how well the criteria were met. This was calculated by the criteria scores for each article were totalled together and divided by the maximum possibility (18) and multiplied by 100. Studies were retained if they scored 75% or above (Robinson et al., 2016) as they were deemed of appropriate quality.

Seven papers achieved 75% or above in the quality assessment. Thus, all of the papers identified from the inclusion criteria were retained. The scores can be seen within the summary table 2.2.

Data extraction

A data extraction table was developed to highlight the salient information from each study, see appendix B. Information regarding the authors, aims, measures administered, study design, findings and limitations was tabulated.

Description of Studies

As the studies identified included a range of aims, methodologies and participants it was deemed appropriate to conduct a qualitative data synthesis. The key findings from each study were extracted. This section will outline the findings relating to climate, patient behaviour and staff burnout.

Five out of seven studies reported on patient and staff views. One study reported only patient perspectives and one study reported only nursing staff perspectives. In total 3,183 participants' views are reflected in this review (patients= 1,279; staff= 1,904).

Participants were recruited from secure settings across four different countries, the UK, Germany, Canada and USA. The security levels of the ward from the UK included one open, eleven low, six medium, six high. Seventeen wards were based in German hospitals and were reported to be the equivalent of medium and high secure UK wards. One study was based in Colorado, USA, and included intermediate, minimum, medium, and maximum security wards. The study conducted in Canada was based in a high secure hospital.

Some of the studies that included patient views offered patients incentives such as monetary rewards. Regarding patient recruitment some studies reported patients met with staff who explained the study, others reported measures were left on the ward for patients to complete. Some studies stated patients that were not deemed to have capacity or were extremely unwell at the time were excluded from taking part. One study provided staff with incentives to participate that included a free hot drink reward. There was a range of disciplines involved across the studies, this included nurses, psychologist, occupational therapist and support staff.

Studies reported on a combination of psychometrics and quantitative behavioural data. Every study used the EssenCES to measure ward climate, as discussed this was a factor of the inclusion criteria. A range of quantitative analysis methods were utilised including, but not limited to, t-tests, correlations, regressions, and factor analysis.

Aims of the studies

Two studies that were identified were focused on measuring whether a new purpose-built hospital influences how safe staff and patients felt on the ward (Bridekirk et al., 2021; Eggert et al., 2014). The studies compared the EssenCES scores in the old and new hospitals alongside patient incident frequency, staff sickness, and job satisfaction.

One study focused on burnout in relation to the ward environment and perceived effectiveness of clinical supervision (Berry & Robertson, 2019), nurses and support staff were included. Three studies explored the relationship between patient demographics, clinical characteristics, level of ward security and ward climate (Dickens et al., 2014; Long et al., 2011; Puzzo et al.., 2019). Lastly, one study focused on the validation of the EssenCES and patient aggression (Schalast et al., 2008). A table summary of the studies is displayed below.

Author(s), year &	Aims and objectives	Study design	Ward setting & country	Participants	Measures used	Findings	Quality assessment
Berry, & Robertson (2019)	Explored burnout, the perceived effectiveness of clinical supervision and ward environment	Cross-sectional	Medium secure ward UK	Nursing staff (137)	Supervision: Manchester clinical supervision scale Climate: EssenCES Burnout: Maslach burnout inventory	10% approximately staff were experiencing burnout. Main predictors were age and ward environment. Clinical supervision had minimal association with burnout.	83%
Dickens et al. (2014)	Explored if patient demographic and clinical characteristics are	Cross-sectional	1 open, 9 low, 3 medium secure wards, UK.	Inpatients (63)	Aggression: HCR20, Overt Aggression Scale	PC: gender, security level, HCR20 total score explained	89%

	associated with ward climate.				Treatment engagement Climate: EssenCES Patient S17 leave status	variance in PC. ES: gender + security level significantly related to ES. Pd & psychosis explained variance. TH: level of security predictor. Lower session attendance more positive climate.	
Eggert et al. (2014)	Explored relationship between person and environmental variables as means of explaining changes in ward climate, safety, job satisfaction, treatment outcomes in new high secure unit.	Comparison group	Intermediate, minimum, medium and maximum security USA	879 participants 353 staff 526 patients	Climate: EssenCES Copenhagen Burnout Inventory Patient grievances, assaults, seclusion, restraint, staff sickness Patient progression and discharge	Experimental group compared to control group reported lower levels of experienced safety at time period 1 than 2 and 3. Restraint and seclusion periods didn't alter over time. EssenCES no significant correlations with assaults, seclusion or restraint. Significance between EssenCES factors and treatment outcomes-	83%

						experienced safety increased, discharges increase.	
Long et al. (2011)	Assessed climate in female secure wards and variation by level of security and ward type, therapeutic alliance, patient motivation, treatment engagement and disturbed behaviour.	Cross-sectional	2 medium secure wards (admission + treatment) 2 low secure wards (1 specialist PD & 1 rehabilitation LS) UK	80 staff 65 patients	Climate: EssenCES Patient motivation inventory Treatment engagement through mean number of programmed sessions attended. California Psychotherpay alliance scale Behavioural disturbance: number of behaviours classified by Overt Aggression Scale + Incidents recorded	Social climate varied according to ward type and level of security. EssenCES ratings indicative of positive social climate were associated with lower levels of security; such ratings were associated with lower behavioural disturbance and with higher levels of motivation, treatment engagement and therapeutic alliance	88%
Puzzo et al. (2019)	Explored association between social climate, sense of community scores and disruptive behaviour.	Cross sectional	6 wards high secure hospital wards split 3 high dependency wards + 3 assertive rehabilitation.UK	111 participants (69 staff & 42 patients)	Climate: EssenCES SOC Index Incident report & seclusion data as measures of disruptive behaviour Across 6 months	SOC and climate are relative concepts. Relationships between SOC and incidents remained high when controlling for social climate. Climate didn't predict	83%

						incident targets when controlling for SOC. EssenCES score significant predictor in incidents.	
Schalast et al. (2008)	Validated the EssenCES and explore patient aggression.	Cross sectional	17 mental health hospitals ; 46 wards. Medium to high level. Germany	333 staff and 327 patients	Climate: EssenCES 'Job Satisfaction Questionnaire' Patients behaviour measured over a 3 week period of 'problematic occurrences' Good Lives Milieu Index- measures general patient satisfaction Experiences on the Ward Questionnaire	Items on EssenCES appear to show internal consistency. Staff safety scale strongly associated with the number of problematic occurrences on the ward. 3 domains on EssenCES low correlation with job satisfaction questionnaire. Staff climate assessments correlate more strongly with patients' climate assessments than job satisfaction.	78%
Bridekirk et al. (2021)	Explored perceived and objective safety indicators among staff and patients.	Longitudinal	5- year cross sectional design consisting of six waves of	256 patients 932 staff 1, 188 total	Climate: EssenCES Person-In-Recovery and the Recovery	Patients rated perceived safety higher then staff. Rates of	89%

			data collection. Canada		Self-Assessment Scale-Revised, number of aggressive incidents, number of times staff needed additional support in incidents, restraint frequency	perceived safety didn't improve for patients following a change of unit. Following the change staff reported improvement in perceived safety, patient cohesion and implementation of recovery orientated principles.	

Table 2.2 Summary of studies exploring climate, patient aggression and staff burnout.

Is there a relationship between perceptions of ward climate and patient aggression?

To measure violence and aggression of patients a combination of methods was used across five studies. These included the HCR-20 (Douglas et al., 2013) score, Overt Aggression Scale (Yudofsky et al., 1986), number of patient assaults and incidents recorded across a period and seclusion use. All studies used quantitative measures.

Long et al.'s (2011) and Puzzo et al. (2018) reported that the level of ward security was positively linked to incidents of patient verbal aggression. They found EssenCES ratings indicative of a positive climate were associated with

lower levels of security on the ward. They found such ratings were also linked with lower behavioural disturbances (measured on the Overt Aggression Scale, number of recorded incidents and seclusion episodes) and patients presented with higher levels of motivation, treatment engagement and therapeutic alliance. This study reported the mean EssenCES score of each domain for staff and patients for each individual ward. Dickens et al (2014) also found the level of security was a predictor for the Therapeutic Hold scale.

Eggert et al.'s (2014) study and Bridekirk et al.'s (2021) studies focused on whether ward climate and patient aggression was altered following patients and staff moving to new modern hospitals. Eggert et al. (2014) hypothesised that the EssenCES domains would correlate negatively with assaults and episodes of seclusion and restraint. A significant result was found for the Experienced Safety domain (for the experimental group who moved into a new state of the art facility). This was also correlated to patient discharge. The new environment provided staff and patients with a larger space. The quality of the living conditions had been improved, this may in turn have increased patients' perceptions of experienced safety. The new facility had additional courtyards, more natural light, larger rooms and more space for patients to separate themselves. However, Eggert et al. (2014) noted that patient discharge may have occurred earlier due to the pressure to admit new patients into the facility. Interestingly, Bridekirk et al. (2021) found that just before the move took place patient restraints were at their highest, patients may have experienced high levels of anxiety knowing they were moving hospital sites to a new unfamiliar environment. Following the move incidents that required additional staff support, violence and restraints also increased. Both staff and patients would have spent

a period of time being in a setting they were unfamiliar with. This may have contributed to the dramatic increase in incidents. Within the study the authors noted the setting experienced a high turnover rate of staff. The study collected data across a 5-year period, this is a limitation of the study as different staff and patients were completing the psychometrics. It is difficult to determine whether the change in buildings did impact on safety and climate when it was not the same participants completing the measure at each stage.

Puzzo et al. (2018) measured the ward climate across six high secure wards in the UK. They also measured the Sense of Community as research suggests Sense of Community is related to behavioural incidents in secure settings. They measured incident reports across a six-month period as well as short term seclusion. This study reported on the overall EssenCES score and found it predicted overall incident reports, but that climate did not predict non-physical incidents. When Sense of Community scores were controlled for climate, they did not predict incidents. Puzzo et al. also found climate did not predict seclusion use. They suggested the removal of a highly volatile patient may actually increase the ward safety and therapeutic environment.

Schalast et al. (2008) found lower rates of Experienced Safety on the EssenCES were linked to higher 'problematic occurrences', for example 'drug relapses' or 'severe verbal aggression'. Bridekirk et al. (2021) found male staff rated Experienced Safety lower than female staff, this may be due to males being called upon in more situations of responding to violent incidents. Interestingly Schalast et al. (2014), Dickens et al. (2014) and Bridekirk et al. (2021) found staff rated Therapeutic Hold higher than the patients did; meaning that staff

made more positive assessments of this aspect of climate. This may be due to the items focusing on various aspects of staffs' work which patients don't have the awareness of.

However, Dickens et al. (2014) did not find any significant predictors between Experienced Safety and the patient scores on the Overt Aggression Scale or the overall HCR-20 score or clinical HCR-20 score. The Overt Aggression Scale measures verbal aggression, aggression against objects, aggression against others and aggression against the self, as recorded across a two-week period. Dickens et al. (2014) did find the patient's HCR-20 score was a significant predictor in Patient Cohesion on the EssenCES scale. This result suggests poor ratings of Patient Cohesion from patients who have a higher risk of being violent may lead to increased levels of aggression. It is noted that this study had only 63 participants across 13 wards of three different levels of security: open (3 patients), low (39 patients) and medium (21 patients). Due to the small sample size, it could be difficult to ascertain significant results, especially as the samples were collected from varying levels of ward security. The study did not report when the HCR-20 had been updated and how much of a current reflection the risk assessment was of the patient.

The studies indicate ward climate can impact on patients' aggressive behaviours. It is noted there are different factors that are likely to influence on another this has shown to include the level of ward security, patient characteristics and ward design.

Is there a relationship between perceptions of ward climate and staff burnout?

Only two included studies (Berry & Robertson, 2019; Eggert et al., 2014) explored the relationship between staff burnout and ward climate.

The studies used different measures for burnout including the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005) and the Maslach Burnout inventory (MBI) (Maslach et al., 1996). The MBI measures three aspects of burnout in healthcare, emotional exhaustion, depersonalisation, and personal accomplishment. The CBI has three scales measuring personal burnout, work-related burnout, and client-related burnout.

Eggert et al. (2014) found no significant effects between the EssenCES on any of the CBI scales (personal burnout, work-related burnout, and client related burnout). They did find a significant correlation between the experienced safety scored on the EssenCES and a positive correlation with staff sickness. As Experienced Safety increased, the unscheduled staff sickness increased. They also found a significant negative correlation between Therapeutic Hold and unscheduled staff sickness: as the Therapeutic Hold increased staff sickness decreased. Staff sickness has been shown to correlate to burnout, Schauefeli et al. (2009) found that burnout predicted staff sickness duration and frequency.

Berry & Robinson (2019) recruited a sample of support workers, senior support workers, nurses, and clinical lead nurses. They found approximately 10% of staff had burnout. Among the staff with burnout, 29.2% indicated they were emotionally exhausted, 29.9% perceived low levels of personal accomplishment

and 29.9% experienced high levels of depersonalization. More positive ward environments were found to be significantly associated with lower levels of burnout on all subscales. They found age was correlated to burnout, younger nurses were found to be more emotionally exhausted. They also found nursing staff who scored low experienced safety and perceived the patients to be less supportive of each other (patient cohesion) were more likely to be emotionally and psychological drained. However, these findings need to be interpreted with caution as the scores for the clinical supervision and staff burnout were skewed. All data underwent Winsorizing (Field, 2013), this improved the data set for the burnout however clinical supervision continued to be skewed. Therefore, only the total score for clinical supervision was used which has not been validated. This study collected EssenCES scores across 7 different medium secure wards. Each ward has its own distinct purpose, the Cronbach's alpha for the therapeutic hold was of questionable validity, the authors suggest this may because of the sample mix and staff being drawn from different wards with a different purpose.

Discussion

The aim of the systematic review was to assess the impact of ward climate on patients and staff. The following review questions were explored: Does social climate impact on patient aggression and behaviour? And, does social climate impact on staff burnout?

Whilst undertaking the research there was one existing systematic review that was focused on exploring perceptions of social climate and aggressive behaviour in Forensic Services (Robinson et al., 2016). Their review focused on the years 1990 to 2015 and purely focused on the relationship with aggression. It included

a variety of different measures of climate for both hospitals and prisons. Ward climate can influence the daily experiences of both staff and patients. They found that the factors associated with aggression were patients' perceptions of safety, the level of cohesion between patients, the atmosphere of the environment, and an open group climate.

The results of the studies included in this review indicated mixed results. Within the studies a correlation was found between the level of ward security and climate and aggression. The higher the security the more likely a relationship was found between aggression and climate. This could be because patients experienced more frustration due to more restrictions and less independence. Creating an optimal therapeutic climate within high secure settings is difficult due to the complexity of patients and their involuntary detainment (de Vries et al., 2016). Patients in high secure are often more mentally unwell, and more of a risk to themselves or others compared to lower secure settings. Therefore, it may be that the real relationship is between mental health risk and climate, rather than with the level of security per se.

Long et al. (2011) found EssenCES total score significantly correlated with patient motivation, treatment engagement and therapeutic alliance. This highlights the influence of ward climate on treatment outcomes. It is noted ratings were higher in lower secure wards in comparison to medium. Again, this may be due to the patients being more mentally unwell in medium which could impact on their ability to engage in treatment and develop therapeutic alliances. Patients may also be on higher doses of antipsychotic medication which impact levels of energy and sedation; again this could bear an effect on their scores.

Interestingly two studies (Schalast et al., 2014; Dickens et al., 2014) found staff rated Therapeutic Hold in a more positive regard than patients did. This aspect of climate is influenced by the staff as it is their care practice that mediates the therapeutic hold on the ward. These findings are in accordance with previous research (Howells et al., 2009; de Dries et al., 2016). The difference in perception could be due to staff and patients having different roles in the setting (Røssenberg & Friis, 2004) and the restrictions patients experience on their freedom (de Vries et al., 2016).

Puzzo et al. (2018) identified that the Sense of Community scale was more related to incidents than to climate. They also noted that the wording on the EssenCES and Sense of Community scale could have influenced these scores. The Sense of Community is written in the first person and uses emotive language such as 'I get important needs of mine met because I am part of this community', 'being a member of this community makes me feel good'. Whereas the EssenCES is written in the third person: for example, 'staff members take a lot of time to deal with patients', and 'really threatening situations can occur here'; these require an external perspective. Individuals who are mentally unwell may find it more difficult to process and connect with information in the third person. They might find emotive statements in the first person easier to process which would then result in a higher score.

Limitations

It is acknowledged that the studies included were across four different countries, this included various levels of secure wards, different methodological

approaches, different cultures and different populations of patient. There is a wide number of variables that are being compared within the same research question. It is also noted within studies some included a range of levels of secure wards. To include all the results in one may impact on the overall significance. Different wards have a different focus, which will differ more in-between levels of ward security.

A weakness in some of the studies is that the incident data was captured across a 2-3 week period, unlike Puzzo et al. (2018) who captured it across six months and Bridekirk et al. (2021) who captured data across a 5-year time span. A longer period would provide a more representative understanding of disruptive behaviour in the setting. Secure settings go through periods of being settled and factors such as new admissions, staff change, and patient dynamics can impact the ward. Studies that were longitudinal and collect data across a longer time span capture a more representative nature of the wards. Within the studies found there was only one longitudinal study. A cross-sectional study provides data at a specific time point, whilst a longitudinal study provides insight into data across time periods. Longitudinal studies are able to show changes over time and therefore may be more useful for examining culture in forensic settings and looking for possible causes and effects.

There was a weakness regarding the exploration of climate and staff burnout. Firstly, this area has not been well researched, only two articles could be identified. It is difficult to draw strong conclusions from a small sample of research. Secondly, the findings of the two studies were mixed, there was not a clear direction in the findings. Berry and Robinson (2019) included nurses,

support workers and senior support workers into the sample. Staff have different roles, duties and responsibilities. It would be beneficial for future studies to separate the job roles when exploring burnout, this may provide a clearer insight into the relationship with climate.

Lastly, during the search process synonyms of burnout were not searched. Such synonyms could have included 'staff stress', 'staff mental health', 'staff well-being', 'staff morale'. On reflection, this is likely to have impacted on the number of studies identified, therefore impacting on the results. The current systematic review only found two articles on staff burnout, it is likely if further synonyms had been searched a larger number of studies may have been identified. The use of relevant search terms is one of six elements that highly impact the precision of the search and number of results retrieved (Sampson et al., 2009). Salvador-Oliván, et al. (2019) conducted a PubMed search to review systematic review articles published in January 2018. Data was extracted related to various types of errors. From the 137 studies included, they found 92.7% of articles contained various errors, specifically 54% of studies had missing synonyms. The objective of the search is to retrieve all publications that are relevant to the area of study, to minimise bias in forming conclusions (Salvador-Oliván, et al. 2019). It is most likely this current systematic review will be prone to bias in forming conclusions due to the lack of synonyms relating to 'burn-out', resulting in relevant papers being missed.

Future directions

It is noted that the studies were correlational. It could be suggested that aggression and incidents of disruptive behaviour influence the ward climate. The nature of correlational research makes it impossible to infer causation (Puzzo et al., 2018). Future research should be undertaken to clarify the direction of the relationship.

Future research could incorporate a focus on job roles. Support workers and healthcare assistants spend their shift on the ground floor with patients, they will be more exposed to incidents of aggression compared to other professionals that are not solely ward based. Future studies could differentiate between job roles, burnout and ward climate.

Some of the studies incorporated in the systematic review included incident data for patient aggression across a two-week period. It could be suggested a 6-month period would be more representative. The nature of the wards can be highly influenced by factors such as new admissions of patients or staff changes a longer time period would offer a more representative overview of incidents.

The review found mixed results regarding climate and staff burnout, though there were only two relevant studies identified. 353 staff and 157 nursing staff were the total number of participants across the studies. Eggert et al. (2014), who did not find a relationship between burnout and climate, acknowledged that there could have been variables that were not accounted for in the tool to represent burnout, for example autonomy, workload, and staffing levels. Berry and Robinson (2019), using the MBI, did find a correlation. Although Eggert et

al. (2014) acknowledged that the MBI is the optimal tool to measure burnout; however, they chose the CBI for ease of administration. This could have impacted on the results obtained. It would be beneficial for future research to explore this area more so as only two studies were identified in the search.

The results from the systematic review highlight the clinical implications for secure settings. It is important that organisations are measuring the social climate on their wards. Once they have insight into how staff and patients perceive the climate, appropriate interventions can be actioned to ensure all members feel secure on the ward. The measure could be of value in assessing the impact of ward changes and interventions established to support a more positive climate (Long et al., 2010).

Chapter Three: Methodology

A chapter to present methodological considerations during the development of the CAST

Summary

This chapter presents an overview of the methodological considerations and approaches undertaken across two research studies that are focused on the development of the Cultural Assessment of Staff Teams (CAST). The first study explored staff experiences of working in forensic community homes, this was in relation to the executive manager, their line manager, support received, team working, amongst other areas. Through thematic analysis themes and sub-themes relevant to culture were identified. The themes were used to inform the construction of domains on the tool. The second research study presents the items were developed to measure each domain. A mixed methods approach was used, firstly to attain face and content validity of items through expert scoring. The tool was amended following expert feedback. Lastly, cognitive interviews were facilitated with a sample of the target population. The aim was to mitigate ambiguity within the tool. The cognitive interviews resulted in wording amendments and examples of situations added to items. This methodology chapter will explore the research considerations throughout the whole project.

Introduction

The CAST was developed with the aim to expand the resources that can be used to inform organisational development in forensic community homes. As discussed in the systematic review there are a range of tools to measure organisational development within inpatient settings. Measures such as the WAS and the EssenCES have been used to explore relationships between organisational factors and staff and patient outcomes. There is a lack of tools that have been developed specifically for community settings.

The purpose of the CAST is to measure culture among staff teams working in forensic community homes. The aim of the homes is to facilitate rehabilitation for individuals who have mental health difficulties and/ or offending risk. The homes are staffed continuously with support workers and senior support workers, who are overseen by a house manager. The house manager is a middle manager who provides leadership and support to their team and residents. The home managers are required to have applied experience in the care field in which they can demonstrate their leadership skills. Their typical level of qualification is diploma level. The community homes that were involved in the research receive input from a multidisciplinary team that was comprised of psychology, psychiatry and, if required, occupational therapy, speech and language or dietetics.

This methodology chapter will discuss the approaches used across the whole research projects for the development of the CAST. A mixed methods research approach was used as combining both qualitative and quantitative methods can enhance the richness of the research, compared to the use of just a single

method (Creswell & Plano Clark, 2011). The concept of culture was explored through published research and semi-structured interviews. The process of using the themes and sub-themes identified from interviews to generate tool domains and subdomain and item generation. This chapter will also discuss the processes involved in ascertaining item content and face validity and population testing of the tool; all of which are crucial aspects of establishing a sound measure (Germain, 2006).

Impact of Covid-19

This research was undertaken during the Covid-19 pandemic. Adjustments were made to aspects of the project to ensure it complied with restrictions, for example some participant interviews were facilitated through video call rather than in-person. The research discussed in chapter four was presented at a conference that was held online rather than in-person, again to comply with Covid-19 restrictions.

At the time that interviews were facilitated with participants across the project, they were working under increased pressure and in a high degree of uncertainty. All staff in the organisation were asked to visit only one site during the pandemic. This impacted on the daily working of staff. For example, the house managers were visited in person frequently by the area manager, they would offer support and oversight of the functioning of the home. During a time in which home managers were facing increased pressure and demands it is therefore likely that they had less support available to them. During this time, patient contact with professionals such as psychologists and psychiatrists was reduced to video calls, and face to face contact was stopped. This impacted

negatively on patient well-being, patients reported it increased their levels of anxiety and uncertainty. The impact on the patients would have also been experienced by the staff. It is recognised that the pandemic had a significant impact on personal lives as well as professional working. During this time the pandemic may have impacted staff well-being, functioning, ability to cope and feel resilient. During the research it was important to be mindful of the extreme pressure and uncertainty individuals were facing, this could have impacted the responses given throughout the research.

Rationale for tool development

Care settings are designed to provide residents with high quality care. Organisational development is key to ensure residents reside in an optimal culture that supports them to rehabilitate.

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Developing the CAST will provide organisations with a tool to measure their staff culture, thus helping them to identify the strengths and weaknesses of a team's culture. They will be able to obtain data on the behavioural norms of a team. The findings from the respondents will provide the organisation with the opportunity to respond these and target specific areas where change needs to occur. It could also prevent a closed culture from developing by increasing transparency between the ground floor staff and senior managers. The CQC (2021) explains common features of a closed culture include poor quality care, poor quality reporting, a lack of staff competence and training. Closed cultures are defined as poor culture that can lead to harm, and breaches of human rights (CQC, 2021). The challenge faced in such settings is to prevent abuse from occurring, rather than acting after it has. The tool could support organisations to

develop a vision for cultural change and inform action plans. The tool could be readministered post-intervention to evaluate the effectiveness of organisational action plans and measure whether it has been effective in shaping cultural change. Lastly, the tool would also highlight the homes' relative strengths, and the practice in high-performing homes could be modelled to help lesser performing homes.

This chapter will only focus on the methodological approaches used across the research projects, and the research findings are reported in chapters four and five.

Aims

The aim of this chapter is to discuss the methodological approaches that were considered during the development of the Cultural Assessment of Staff Teams (CAST) measure.

Scale development

Since the early 2000's researchers have discussed the value of developing scales through a mixed methods approach. This is referring to the application of both qualitative and quantitative methods. The combination of approaches is suggested to increase the overall instrument reliability (Zhou, 2019). Mixed method approaches have also been shown to increase the comprehensiveness of item generation and the validation of items (Bryman, 2006). Using both qualitative and quantitative methods, enables the research to capitalise on the strengths of both approaches (Durham et al., 2011).

Numerous published studies have described the processes involved in developing a new tool, these are summarised in Figure 3.1. This model is based on the work of Zhou (2019) and it is in turn adapted from Creswell's (2011) exploratory instrument design.

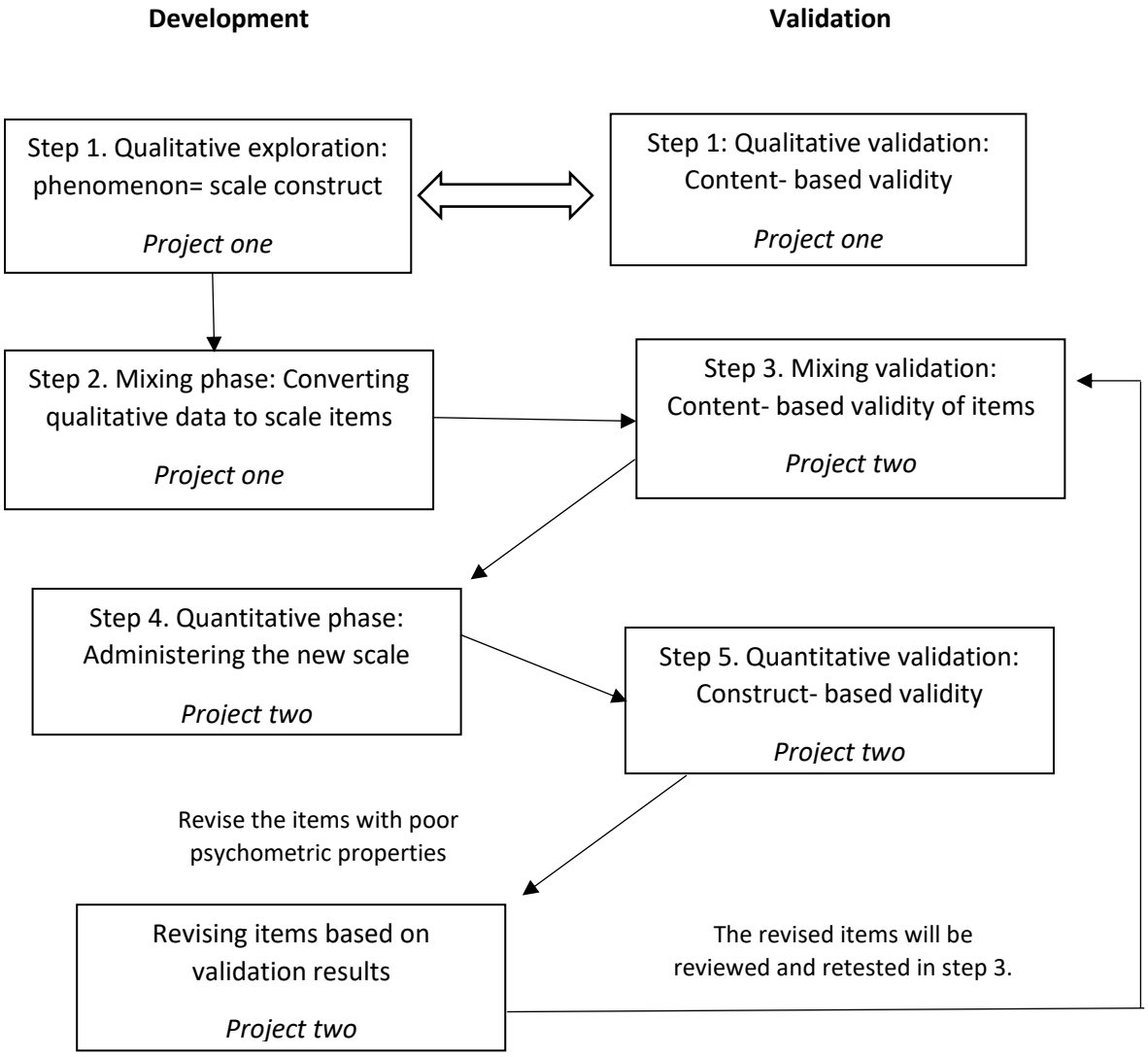


Figure 3.1 Mixed Methods Model of Scale Development and Validation Analysis (Zhou, 2019).

The model proposes five stages (1) qualitatively investigating the scale construct, (2) converting the qualitative data into scale items which is an integration strategy within mixed methods, (3) conducting mixed validation to

review each item's content-based validity, (4) administering the items and collecting responses, (5) conducting quantitative validation to analyse item properties and examine construct validity. The items are then reviewed and revised in an iterative manner, as shown.

The approaches undertaken for the development of the CAST followed the process of stages 1 to 4 and are discussed in detail in chapter four and five. Once stage 5 is reached, the scale is potentially ready for use or for further research directions.

Project one

Scale construct

Research was undertaken that focused on organisational and staff culture to inform the scale construct. Despite differing definitions of culture found in literature, key concepts of it include shared beliefs, values, and, attitudes that can shape staff practice, decision making and behaviour (Alvesson, 2013; Humphreys et al., 2019).

The Group Home Culture Scale (Humphreys et al., 2019) was used to inform the process of question development as this is focused on culture, with a different health care setting as the focus. The domains on this tool included; supporting well-being, factional (the extent to which there are detrimental divisions in the team), effective team leadership, collaboration with the organisation, valuing residents and relationships, social distance from residents, and alignment of staff with organizational values.

The concept of culture specifically in forensic homes was explored further. A qualitative research approach was chosen as it enables more in-depth data to be gathered. Guided by the published literature, all of the study one interview questions were aimed at exploring the central phenomenon (Zhou, 2019) which in this case was staff team culture. This is important as the scale items are based on the findings of the interviews. It will increase the content validity if the interview questions are based on the central phenomenon (Zhou, 2019). Zhou (2019) explains that only when the qualitative study is designed to explore the scale construct as the central point, do the findings provide the most relevant and rich data for the item wording and construct.

Constructs are higher level concepts that are not directly observable (Agarwal, 2011). The constructs developed in the CAST have been constructed by the researcher who also acts as the observer. The Nobel prize-winning physicist Heisenberg (1958) stated 'we have to remember that what we observe is not nature itself, but nature exposed to our method of questioning'. This clearly refers to the potential limitations that can occur due to the approach and methods of the researcher. Therefore, using a combination of research approaches may help to increase the construct validity.

Both the studies discussed in chapter four and five recruited participants who had different roles and experiences of working in or supporting community homes; this was designed to include a wide range of perspectives.

Sampling techniques

Purposive sampling was crucial in this research as the data that was gathered contributed to a better understanding of the theoretical concepts of culture (Etikan et al., 2015). Purposive sampling is commonly used in qualitative methods to identify the information-rich participants for the most effective use of available resources (Patton, 2002). Qualitative methods are intended to achieve depth of understanding (Patton, 2002). Selecting participants needs to be done with sound judgment. The process involves identifying and selecting individuals that are knowledgeable or experienced with the phenomenon of interest (Cresswell & Plano Clark, 2011). The researcher identified potential participants in the organisation who as individuals and as a collective could provide in-depth rich responses during the interview. The researcher contacted the potential participants from a university email account and not the organisation's email account to reduce any perceived pressure participants may have felt to contribute to the research. They were assured that they did not need to respond if they were not interested in partaking.

However, there are some weaknesses with this recruitment approach. Purposive sampling is a technique that may be prone to researcher bias compared to random sampling (Sharma, 2017). Furthermore, the judgemental component of purposive sampling is a disadvantage when the participant selection is poorly considered and there are no clear criteria for selection (Sharma, 2017). To alleviate these issues, the researcher considered the range of job roles required for the interviews. They considered the need for participants to be based within different community homes and a clear criterion was established. There were concerns that if this approach was not applied the participant sample could lack

heterogeneity. For example, if a random sampling approach was followed and all staff across the organisation were included it could result in only one job role being recruited, as the organisation has a larger ratio of support workers to other professions. The sample could have lacked input from a range of disciplines and variety of homes. This could result in aspects of culture not being conceptualised, ultimately resulting in a weaker tool being produced.

Initial version of the CAST

The Group Home Culture Scale (GHCS) (Humphreys et al., 2019) was an important source as this tool measures staff culture. However, the GHCS is focused on settings that provide care to learning disabled individuals. Several items within the GHCS are not relevant to residents in forensic community homes, such as "staff mimic what some residents say or the sounds they make''. In contrast, the CAST is intended for use in forensic community homes where residents may have mental health needs as well as have a forensic risk, so there was a need for this new tool to incorporate these aspects which are not present or not relevant to the GHCS.

As further research was explored the concept of culture developed. As discussed in the introduction research on the 'care of culture barometer' and the 6Cs further expanded understanding of the core concepts within culture. Research on culture was accumulated through published literature on a range of healthcare settings and client populations, such as learning-disabled population, nursing, midwifery, general healthcare (Wood, 2021; Hastings & Horne, 2004; Humphries et al., 2019; Department of Health, 2019). The concept of culture was explored further as many research studies reflected on the link between 'toxic cultures'

and malpractice. Reports such as Winterbourne View (Care Quality Commission, 2011) and Whorlton Hall (Murphy, 2018) identified 'red flags' that were associated to staff and organisational culture.

From the research undertaken on staff culture, the findings were used to inform the interview schedule. This was developed to explore staff experiences of working in such homes. The aim was to provide insight into factors that influence culture in community homes. The interview schedule can be found in Appendix C. Semi-structured interviews were chosen, as questions could be developed that were focused on the topic being explored, which provided a framework for the interviews and provided prompts to encourage further responses. Semi-structured interviews enable participants to answer freely, they provide the researcher with the opportunity to respond with relevant follow-up questions; enabling rich data to be gathered (Kallio et al., 2016). Interviews were used as an inductive method to inform the construct of staff culture in forensic community homes by seeking the opinions of the target population. This methodological approach has been widely utilised in psychometric tool development and it is regarded as the most effective method of information gathering to inform the development of a construct (Morgado et al., 2018).

Thematic analysis of the interview data in the first study identified themes and sub-themes, which were used to inform the development of the initial version of the CAST. The themes identified resulted in four domains: The Organisation, Forensic Risk Management, Home Manager and Team.

Item development

The findings from study one informed the study construct. Themes from thematic analysis were converted to scale domains, sub-themes were converted to sub-domains (Zhou, 2019). The codes in the data set and quotes were used to inform the wording of items.

A combination of both team and individual practices were included in the measure. This enables the tool to focus on the culture of the person as well as the staff team culture. The first version of the tool was comprised of 129 items. The generation of items is a crucial element in developing a sound measure (Germain, 2006). Items were written to cover the continuum of a domain, resulting in both positive and negative aspects being accounted for. To adhere to the guidelines of item writing, simple and clear language was used. Each item focused on one idea only (Gideon, 2012). This is important as items that contain two ideas cannot be scored clearly by participants.

There was a focus to ensure items were written clearly and succinctly, as published research advises keeping items under 20 words (Kyiazos & Stalikas, 2018). Each item only referred to one point of interest (Price, 2017) for example "we support clients to reintegrate into the community''. Items did not contain two points; for example, "we support clients to reintegrate into the community and it feels rewarding to see them make progress''. The wording of the items was intended to be personal as it is likely to feel more relevant to the participants (Kyiazos & Stalikas, 2018). Double negatives were avoided as there was an emphasis on ensuring items were clear. Lastly, the tense of the items

was in the present, as it is advised that past tense items are avoided (Price 2017; Kyiazos & Stalikas, 2018).

The initial pool of items was relatively large (129). Writing more items than is required enables the researcher and expert panel to identify the items with the highest validity and clarity (Saville & Maclver, 2017). It was expected that items would be made redundant following expert review.

Response options

There were several considerations regarding response options, including for example, whether there would be a mid-point and whether responses would be numbered or labelled.

It was decided a four-point Likert scale would be most appropriate for users to score. Scoring systems with more options were considered as they can allow finer gradation (Furr, 2011); however, it also increases the chances of random error and could potentially reduce the participant's ability to discriminate among many options (Kyiazos & Stalikas, 2018). Research has found participants seem to be more satisfied when scale points are labelled rather than numbered (Streiner et al., 2015). As the tool was aimed at measuring a sensitive topic that would reflect on a team's culture it was thought four options that were labelled 'strongly agree', 'agree', 'disagree', 'strongly disagree' would be deemed more effective (Furr, 2011). Labelling Likert options appears to be the most popular design for psychological measures (Dimitrov, 2012). Words clearly indicate what the response option is referring to. It was also decided there would be no mid-point in the scale, as research has shown participants who have less intense

attitudes or with limited interest tend to identify with the mid-point (Krosnick & Presser, 2010; Kyiazos & Stalikas, 2018). As the tool is exploring culture, a topic that has been linked to abusive practice and patient outcomes, it is important that respondents are encouraged to identify with a response in one direction of the other.

Project two

Attaining Validity

Once the first version of the tool had been developed, it was assessed on its validity. Chapter five outlines the second research project in detail. The project had two distinct stages to it. The tool was again amended following feedback; using quantitative and qualitative approaches, a cultural measure was developed through phases, each phase informing the next. The first phase was to attain face and content validity of items, which was scored by experts. Following the expert feedback, the tool was amended to produce the second version. The second version of the tool was administered to a sample of the target population and cognitive interviews were undertaken to mitigate ambiguous and problematic items and to clarify the instructions.

Attaining validity on the items is fundamental to tool development. The purpose of the expert review process is to maximise the content validity (Kyiazos & Stalikas, 2018). Content validity has been defined as 'the degree to which an instrument has an appropriate sample of items for the construct being measured' (Polit & Beck, 2004, p. 423).

Common quantitative methods include sorting and calculation (Zhou, 2019). There is common acknowledgement in published literature that content validity is achieved through two distinct research phases. Firstly, the a priori efforts that are made by the researcher to enhance content validity. This is through conceptualisation and domain analysis prior to the item generation. This is followed by an a posteriori effort to analyse the significance of the scale content through expert critique (Lynn, 1986; Polit & Beck, 2006).

Within study two (see chapter five), item Content Validity Index (CVI) scores were calculated to ascertain whether they met the cut-off to remain in the tool. The content validity was scored by a panel of experts who know the construct well (Svedbo et al., 2018). They were applied professionals supporting community homes, such as clinical and forensic psychologists or academics who had literature published in the field of psychology. Feedback from a panel of experts is invaluable when developing a new tool.

Five experts provided CVI scores for each of the items. This included one jointly trained in forensic and clinical psychology, three clinical psychologists and one professor in psychology. To eliminate chance factors of expert agreement, Lynn (1986) advised that, if a panel has five or fewer experts, the CVI for an item to be retained should be 1.0. The CVI score is calculated by counting the number of experts who scored the item as 3 or 4 (3=item needs minor revision, 4= item is representative) and dividing that by the total number of experts (Lynn, 1986). This provides information on the proportion of experts who perceive the item to be content valid. Experts were also asked to score the face validity and offer suggestions of alternative wording or phrasing. This was to ensure that the

items were worded clearly without ambiguity. The expert feedback enhances the process of ensuring that items can be understood when administered.

It was decided that once the tool had been amended following expert feedback, there would be a second round to improve validity. Undertaking cognitive interviews with a sample of the target population is a common qualitative approach to test the items (Willis, 2005). Their purpose is to identify ambiguous wording with a sample of the target population. They help to ensure that each item measures what was intended, increasing accurate answers, and enabling participants to respond thoughtfully (Willis, 2005).

Cognitive interviews

Researchers working on tool development increasingly use cognitive interviews to enhance the validity and reliability of the items (Knafl et al., 2007). The approach is based on cognitive theory and incorporates a range of techniques to provide insight on how future respondents will interpret the tool instructions, items and how respondents formulate a response (Knafl et al., 2007). The purpose is to pre-test questions and determine whether they should be modified prior to wider use.

The process of the cognitive interview was considered as there are multiple available formats. This includes following either a think-aloud interview technique or a probing style. Both approaches were considered, and a probing style was chosen.

The think-aloud method requires participants to discuss all of the thought processes they are experiencing when they form their answer. There were concerns that this process may impact on the participant's task performance (Willis, 2005). There was also a recognition that participants may require training to be able to answer questions in such a manner, which may then take time away from the actual interview process. Even when participants have received training, because it is an unnatural manner to answer, they may struggle to follow the desired process; which impacts on the quality of responses (Von Thurn & Moore, 1994). Bickart and Felcher (1996) found the ability to engage in a think-aloud process has a positive relationship with educational levels. The target population is working in a job role that does not require high educational standards and the participants' full cognitive ability would not be known prior to interview.

Verbal probing was chosen as an alternative method and applied to the interviews. The interviews were conducted in a pragmatic approach with specific aims (Hareendran et al., 2018). Once the participant answered the initial question, the researcher followed it up with probing questions relevant to the interview (Willis, 2005). This included asking participants to define what a certain phrase or word meant to them. It also involved asking the participant to recall what they have been asked in their own words. It also included general probes, such as asking participants to explain how they came to their answer by explaining what they thought about. Despite the growing literature that supports the value of cognitive interviews in tool development (Dillman, 2000), there is a lack of guidance regarding the analysis and interpretation of data (Knafl et al., 2007). Published literature on tool development that used cognitive interviews

informed the analysis of the tool (Knafl et al., 2007; Tilden et al., 2015). Each item was individually reviewed, and respondents' comments were written verbatim. Comments across all items were compared and explored. Interpretations of phrases and wording was compared to ensure there were not varying understandings that would indicate ambiguity.

The probing method was chosen as Willis (2005) suggests it does not interfere with a participant's processing of a question and does not bias results. The method enables the researcher to control the interview and ensure the participant is responding with relevant information, avoiding irrelevant discussion. If an item is found to be ambiguous, it enables the researcher to focus on this more to explore the source of the problem (Willis, 2005). Von Thurn and Moore (1994) found that participants did not require any training, and the process was easy for participants to understand and follow; this increases the quality of data gathered. There is, however, a potential bias that can be associated to probing interviews. The misuse of probes, or a lack of depth in exploring problematic areas could bias the data gathered. This would be a disadvantage to the researcher as it would impact on the validity of the items.

The data from the cognitive interviews informed further changes in the tool. In the event, all items were retained but some items or phrases were identified as requiring definitions or examples. Within the interviews, when a participant identified the need for additional clarification, suggestions were sought on wording and example definitions were given to gain participant feedback. Definitions and examples were added into the tool in brackets to increase the clarity of participant understanding.

Conclusion

This methodology chapter explains the processes that have been followed to develop the CAST. The purpose of these projects was to construct a scale with specific measurement characteristics of staff culture in teams working in forensic community homes.

Across the two projects a mixed methods approach has been used. The research was informed by published literature; this was used to develop the questions for the semi-structured interviews. Semi-structured interviews were undertaken with members of the multidisciplinary team who worked in or supported community homes. The interviews were transcribed verbatim and analysed. Through thematic analysis the transcripts were coded, themes and sub-themes were identified. Rich data was collected from the participant interviews and the researcher believed no further recruitment of participants was required. The domains and sub-domains were used to inform the domains on the tool. Items were developed to measure the construct, this included both negative and positive aspects.

The initial tool was distributed to a panel of experts to review the content and face validity of items. The experts' scores were analysed, and this resulted in items being omitted. Items were also re-worded to decrease ambiguity. Phrases that had been identified as requiring definitions were given them. There was a reduction in sub-domains. The second version of the tool was administered to a sample population and cognitive interviews were undertaken to explore their opinions. This resulted in further amendments to item wording to increase the

clarity of items and phrases through added definitions and examples. This resulted in the final version of the tool.

The tool has gone through rigorous stages of amendments following reviews by different participant samples. The CAST provides a means to measure many of the key characteristics of forensic community home culture. The refining of the tool throughout each stage of research has progressively increased the validity of items. The number of items was reduced from 129 to 86.

Methodology limitations

The participants who have taken part in this project have predominantly been from the same private organisation. It could be suggested that this may impact on the generalisability of the findings from the interviews. However, it is noted that many of the participants had worked in different organisations before. Some participants drew upon their experiences in different settings to inform some of their answers, making specific reference to the NHS. It is also acknowledged that the organisation works in line with best practice principles and public health policies. As community homes from other organisations must legally follow the same guidance, this should provide some generalisability into how homes are managed.

During the expert validation stage one expert commented on the difficulty of rating the relevance of an item as ”on the surface all the items seem broadly relevant“. However, it was noted that some items were more relevant than others or encapsulated concepts without the loss of key information. The purpose of the expert review panel was to have a group of experts critique the

items, which helped to identify overlapping items and opportunities for grouping them together. The CVI scoring methods provided a framework for items to be retained or omitted.

The initial draft version of the tool sent to experts contained a lot of items (n=129). Part of the process of asking experts to critique the tool is to reduce the number of items. However, due to the length of the tool, the experts reviewed they may have become fatigued through the process. This could have impacted on the quality of their responses and the items retained.

A reflection on the data analysis is of the researcher's active role throughout the project. They developed the research idea, decided on the methodological approaches, conducted interviews, analysed the data and completed the write up. It is possible their research into the topic and subsequent workings have influenced the findings. It is possible that research into the field of staff culture has influenced aspects of the study analysis and findings. The researcher consciously analysed data looking for positive and negative components. Whilst undertaking interviews the responses given to participants were neutral, and they did not influence participants' responses. The researcher was sponsored by the organisation to complete their doctoral training. As some of the participants were familiar with the researcher they may have been able to relate to the researcher more, this may have increased the amount of information disclosed in interview compared to an unknown researcher. However, it could have also had the opposite effect, participants may have been concerned about disclosing aspects of information knowing that the trainee would continue to work in the organisation.

Methodology strengths

There was a substantial amount of research undertaken in the planning of developing a new measure. Each stage of the tool development was informed by published literature to optimize the quality of the research. Decisions were informed by the literature regarding tool development, organisational culture, and group home literature. The semi- structured interview conducted with MDT members is a methodological approach that has been widely utilised in psychometric tool development and it is regarded as the most effective method of information gathering to inform the development of a construct (Morgado et al., 2018). The questions were informed by published literature on the concepts to further the phenomenon being explored.

The tool underwent several stages to attain validity. Throughout the whole process of tool development there were professionals, academics and staff from community home involved in the validation. Drawing on a breadth of knowledge aims to further increase the validity of tool items which is a crucial aspect of establishing a sound measure (Germain, 2006).

There has been an interest from Public Health Wales regarding the use of the tool. Meetings have been undertaken to discuss how the methodological approaches can be applied to the development of a tool to measure culture in various dementia settings. This suggests again that the methodological approaches undertaken are considered as a strength within the research. Professionals recognise the impact that staff culture and practice have on resident's care and quality of life. Reports such as the Whorlton Hall Review

(Murphy, 2018) highlight the devastating impact that closed and abusive cultures can have on residents' lives. By developing a tool that can actively measure a staff team culture it may highlight where interventions are required to mould a care team's culture.

Future directions

It is acknowledged that this is a new tool and further research would be advised. Large scale validation would be a subsequent stage in the tool development. This would require a significant number of measures to be administered to the target population; support workers based in forensic community homes. Large quantities of data would inform appropriate norms. It would provide further information on the reliability, consistency, and replicability of the measure. As more information is gathered, the tool may require further amendments to be made on items and scoring.

Chapter Four: Research Project One

Exploring staff perspective of culture within forensic community homes.

Summary

This research project was the first stage in developing the Cultural Assessment of Staff Teams (CAST), a psychometric tool that will measure staff culture in forensic community homes.

Forensic community homes support individuals with mental illness and offending risk. Typically, the individuals may have transitioned from secure hospital to a community home. They are supported continuously by staff who work within a multidisciplinary team. This research focused on exploring staff experiences through open-ended interviews. Six members of a multi-disciplinary team who work in or support forensic community homes were interviewed. Questions were focused on exploring staff experience, with the aim to identify components of culture in the setting.

Through thematic analysis four main themes were identified. Firstly, 'The organisation' which incorporated a focus of leadership, values and awareness of need. Secondly, 'Forensic risk' referring to staff practice, clinical input and client risk management. Thirdly, 'House Manager' centring on applied practice and qualities of management. Lastly, 'The Care Team' which included the approach of the team, roles of staff and factors that impact on team dynamics. The themes identified will be used to inform the development of items on the psychometric tool.

Introduction

Culture has a direct impact upon all individuals within the setting. It can influence people's behaviour and emotions (Schalast et al., 2008). Organisational culture impacts upon staff's conscious and subconscious thinking, their decisions, and perceptions of situations (Lok & Crawford, 2004; Hansen & Wernerfelt, 1989). Organisational culture impacts upon how staff set professional goals, undertake tasks, and determine priorities (Lok & Crawford, 2004). Culture defines who the staff team are as a collective and maintains boundaries of socially acceptable behaviour (Matsumoto et al., 2010). Having consensus amongst staff members creates a consistent approach, whilst reducing uncertainty and friction, this improves relationships and cohesiveness (Zander, 1994; Melnick et al.,2009); factors that account for effective team working. A lack of consensus results in a weaker staff culture, in which core beliefs are less widely accepted and upheld, this can lead to inconsistent actions, differing interpretations, conflict between staff, and the development of cliques (Martin, 2002; Melnick et al., 2009).

Within forensic settings a poor, closed staff culture negatively impacts upon the service users and their rehabilitation. In such settings a poor culture refers to a perception that staff have power, residents are made to feel vulnerable and uncared for, as well as breaches of human rights (CQC, 2021). Studies have empirically evidenced that the quality of a therapeutic patient and staff relationship can directly contribute to the emotional stability of patients (Fluttert, 2010). Research studies evidence the influence of organisational culture on the outcomes of patient rehabilitation (Day et al., 2012).

Forensic community homes are designed to provide supported residence to adults who have mental health needs and offending risk. Individuals may have stepped down from secure settings; such as hospital or prison. Studies have shown those who reside in community homes are living in settings, in which they can experience a lack of control or autonomy (Mansell et al., 2007). This can have a detrimental impact on the residents' quality of life and mental health (Mansell et al., 2007). Research has identified factors relating to staff characteristics that impact on residents' experiences. These include staff experience, skill set and availability of resources in the home (Bigby & Beadle-Brown, 2018).

As discussed in chapter one, research within learning disabled care homes has found that organisational culture accounted for differences in residents' quality of life (Gillett & Stenfert-Kroese, 2003). Residents who resided in more optimal cultures experienced a higher quality of life (Bigby et al., 2014). A significant quantity of research has focused upon the quality of care delivered in homes for individuals with learning disabilities, physical health and complex needs (Bigby & Beadle-Brown, 2016). However, there is a lack of research in forensic community settings. To date there is not a psychometric tool that can be utilised to measure staff culture in forensic community homes. Such a tool could enhance the organisation's knowledge regarding each home's culture. It could also be used to assist within the development of a service.

The current research project was the initial stage of developing a tool to measure staff culture in forensic community homes. The aim was to explore staff working experience. Interview questions were based on themes derived from the

literature that focus on factors relating to staffing culture within residential settings (Tonkin, 2015; Robinson et al., 2016; Humphreys et al., 2019). Semi-structured interviews were undertaken to explore staff experiences of working in the homes.

Research aim/question

Research aim: To undertake open-ended interviews to explore staff experiences of working in forensic community homes.

Research question: What factors can be identified as components of culture of forensic community homes?

Method

Design

A qualitative semi-structured interview design was adopted. Interviews were conducted with multidisciplinary team members exploring their views and experiences of culture in forensic community homes. Interviews were undertaken either in person or through video call in line with Covid-19 restrictions.

Participants

All participants were recruited from the same private organisation within Wales. The organisation has several in-patient hospitals and community homes. A purposive sampling approach was undertaken to ensure a range of multidisciplinary team members were incorporated. The researcher identified many potential participants. They were contacted directly with the participant

information sheet (Appendix D). The following considerations were required to be met; participants work within or support forensic community homes and had been employed in the organisation for at least one year. All participants were required to be over the age of 18 years.

Six participants were recruited, none of them withdrew from the study. The participants were members of the multidisciplinary team and included: support worker, two senior support workers, a house manager, a psychiatrist and a psychologist. A range of professional roles were included to provide a holistic perspective of factors associated with staff culture. This is important as each profession will contribute to and influence cultural dynamics. Participants who worked within the homes such as support workers, house manager and senior support workers were based in different community homes to increase the generalisability of the findings. The psychiatrist and psychologist provided input into several community homes across the organisation.

Thematic analysis

There are several qualitative approaches to analyse data. As Braun and Clarke (2020) reflect it is tempting to imagine a perfect qualitative analytic approach to do excellent qualitative research, however they refer to this as a 'hallowed method' quest (Braun & Clarke, 2020). This study was not focused on testing a theory or a hypothesis. It was exploratory in nature, it was inductive and driven by the data. It was centred on the exploration of participants' subjective experiences and sense making (Braun & Clarke, 2020, 2013; Willig, 2013).

Thematic analysis was the most appropriate approach (Braun & Clarke, 2006). Unlike other qualitative approaches, it does not assess in isolation subjective human experiences, it is broader and can draw together social and cultural aspects of the phenomena (Guest, MacQueen & Namey, 2012); which were relevant to this study. Thematic analysis is a flexible approach that is not bound to one specific theoretical or epistemological position (Braun & Clarke, 2006; Braun & Clarke, 2019). Thematic analysis was chosen because the study was focused on a need for the research to have actionable outcomes with implications for practice (Sandelowski & Leeman, 2012) and required organising the analysis into shared meaning- based themes to develop the CAST. It had an analytic interest on how personal experiences are located within wider socio-cultural contexts and the sample was heterogenous as participants were recruited from different disciplines (Braun & Clarke, 2020). The data source involved in the CAST included wider reviews of published studies to inform the concept of culture, rather than the research just focusing on personal experience and sense- making (Braun & Clarke, 2020).

Validity

Within qualitative research the importance of ensuring reliability and validity has long been advocated (Stiles, 1993). Within this research study several strategies were followed to ensure a good standard of validity.

Reflexivity

All interviews were conducted by the same trainee forensic psychologist who had previous experience of undertaking qualitative research. A reflexive diary was written throughout the data collection period. This enabled the researcher's

experiences and values to be recognised and acknowledge the impact this may have on the research (Howitt, 2016). The researcher created the interview questions, undertook the interviews and analysed the data. It was important that the researcher's assumptions and preconceptions were consciously acknowledged, as these could have shaped the outcome of the data. Reflexivity can ensure the researcher is continuously reflecting on themselves and ensuring the process of conducting the research is a consideration of analysis. This aims to reduce the potential risk of the researcher's own experiences and interpretation to influence the results (Mruck & Breuer, 2003).

Understanding interpretation

To ensure the researcher was interpreting the participants correctly, within interviews the researcher clarified understanding. This allowed participants to confirm or clarify what was said. To achieve this the researcher would reflect through a summary what the participant had stated.

Themes and sub-themes

The themes and sub-themes were developed through analysis of what the participants had said. This included using direct quotes.

Transcripts

A member of the research team reviewed the transcripts and codes produced. Thematic maps were developed that were also reviewed by the research team.

Data Collection

The trainee forensic psychologist developed the interview questions, which were reviewed by the research co-authors. The interview schedule explored staff experiences of working in forensic community homes in relation to culture. There were 16 questions in total and participants were interviewed individually. All participants consented to the interviews being audio recorded. On average interviews lasted 40 minutes (timing range 19:17- 60:02 minutes).

The interviews were undertaken either in person or through video call in line with Covid-19 restrictions. Although facilitating the interview online enabled the research to continue, there were some disadvantages. The interview undertaken through online video call seemed more problematic to navigate. It is difficult to become attuned to someone's body language through a virtual call and at times there were practical difficulties such as a loss of internet connection or a lag. Sansom-Daly & Bradford (2020) used the term a 'loss of humanness' to reflect the computer dynamic. This was acknowledged at the start of the call and the participant was encouraged to inform the researcher if they wanted a break to increase comfort. The participant may have also found it difficult to engage online with the researcher, they may have found it difficult to build a rapport with the researcher. Regarding the research it may have impacted on what the participant was willing to discuss and it could have negatively impacted on the quality of the data collected. However, due to the pandemic restrictions online interviews were a method that enabled the research to continue.

Data analysis

Transcription and analysis

Interviews were audio recorded and transcribed verbatim. As mentioned in the previous section, thematic analysis was used to interpret the data. Themes were data driven rather than theory driven as the study explored participant experiences that were used to inform a specific concept. Interviews were conducted, transcribed and analysed by the same researcher; enabling the researcher to be fully immersed in the data. Interview transcripts were read several times so the researcher was familiar with the data. Each transcript was coded to identify points of interest. The codes were examined further with the purpose of ascertaining overlaps which generated initial theme ideas. Initial themes were then reviewed alongside collated themes and uncoded data, with the purpose to identify final themes and sub-themes (Braun & Clarke, 2006). These were analysed and interpreted in detail.

Ethics

A proposal of the research was submitted to the University of Nottingham's Faculty of Medicine & Health Sciences Research Ethics Committee and the organisation's ethics board where the research was being undertaken. Ethical approval was granted by both (Ethics Reference No: FMHS 42-0620) and no advisory amendments were given (see appendix E).

To enable informed consent, participants were provided with a participant information sheet. They were provided with the opportunity to ask questions before signing the consent form (Appendix F) prior to engaging with the study. Participants were informed of their right to withdraw at any point during the interview and up to one week after interview. They were made aware that there

would be no consequences if they decided to withdraw. As the researcher was on placement in the organisation, they did not directly discuss the research with the staff members prior to them returning the consent form this was to mitigate explicit coercion staff may have felt. Contact with staff was made through the researcher's university email account rather than the organisation's email to mitigate implicit coercion.

Participant anonymity and confidentiality were maintained. During an interview if an identifier was mentioned, it was not transcribed to protect identities being revealed. Participants were not deceived during the study. Following interview participants were given a debrief form (Appendix G) that again outlined the study aims and procedure undertaken.

Results and discussion

In total six interviews were completed. From these, four themes were identified: 'The Organisation', 'Forensic Risk Management', 'House Manager' and 'Care Team'. Within each theme several sub-themes were identified. See Table 4.1 for a display of the themes and subthemes. Due to the nature of the qualitative study, discussion of results will be presented alongside theme findings.

As discussed in chapter one and specified in table 1.2 concepts of culture can be comprised by formal and informal type. The sub-themes identified are a mixture of informal and formal concepts of culture. Some of the sub-themes are more practice focused, procedural concepts these are referred to as informal types of culture. They may influence culture or be influenced by culture. Please refer to

the column 'type of culture' in table 4.1 for the concept of culture for each sub-theme.

Theme	Sub-themes	Explanation	Type of culture
The Organisation	Leadership	The organisation needs a clear managerial structure that has efficient communication between levels.	Formal
	Management's awareness	The organisation should understand the needs of its homes and the challenges they face.	Formal
	Values	The organisation should promote diversity, equality and protect human rights.	Formal
Forensic Risk Management	Client Risk Management	Forensic risk should be managed through appropriate risk assessments which are reviewed in a timely manner. There should be clear communication between the MDT.	Informal
	Clinical input	Clients should have treatment plans. There should be formulations of client presentation.	Informal

		Clinicians should offer training that informs staff practice.	
	Staff practice	Staff should be positive role models. They should manage challenging behaviour, be consistent with boundaries and be attuned to client behaviour.	Informal
House Manager	Qualities	The house manager should be knowledgeable, supportive, and approachable.	Formal
	Applied practice	The house manager should be physically present. They should engage staff in reflections. They should have awareness of staff strengths and developmental needs.	Informal
	Home functioning	The home should have appropriate staffing levels, they should be able to retain staff and ensure appropriate mix of clientele.	Informal
Care Team	Care Team Role	The care team should support client rehabilitation, work closely with the multidisciplinary team, support community reintegration and set client goals.	Informal

	Team approach	The care team should treat the environment like a home, be positive, caring and motivating. The team should be responsive to need and work from a person centred approach.	Formal
	Practice concerns	Negative cultural factors include team splitting, lack of training, informal leaders and not feeling valued.	Formal

Table 4.1 Code Book of Themes and Sub-Themes.

The Organisation

The first theme 'The Organisation' captures the effects the organisation has on staff experiences. The sub-themes that characterised this were leadership, values, and awareness of need.

Leadership

Participants discussed the need for the organisation to have a clear leadership structure. This involves the organisation providing a clear outline of responsibility for each level of management.

''I think from staff point of view knowing that there is that leadership there which is there to support you. I think that that kind of gives the staff confidence to know that if something was wrong or you weren't sure of something you've

got someone they can go and ask, they've got that support network in place for them…". (L)

Participant L discussed working in an organisation that has a clear leadership structure and how this appears to increase staff confidence. Due to the challenges staff encounter from the clients, feeling confident is a vital component of the quality of care they deliver (Cunningham & Kitson, 2000).

Participants also discussed the importance of senior management being approachable.

"certainly, that the managers are more approachable and for example in the NHS if you need to speak to an executive or at the board level you probably have to make an appointment and wait for weeks to get their attention but certainly that's not the case here; it's a phone call away, or an email…'' (B)

"the management style of some of these service level managers are quite inclusive and in some ways sort of informal as well. Again it's not that hierarchy I was talking about. Staff feel that they can approach and they don't normally hesitate if they don't understand…" (B)

Such findings are in-line with existing literature, it is found that approachable management who respond to concerns in a timely manner are essential elements of effective leadership (Swani & Isherwood, 2019). A central component in many leadership theories identifies the importance of

approachable leaders who have the ability to create an open culture that enables others to discuss observations, concerns and ask questions (NHS, 2010).

Management's awareness of need

The second sub-theme identified was management's awareness of need. This was in reference to management being aware of what is happening on the ground floor, and that they have an understanding of the challenges the staff teams experience on a daily basis. Some discussed the inconsistent responses to situations:

"sometimes things are taken out of context sometimes things are whipped up to a drama that don't need to be. But by the other token, some things aren't taken seriously enough when they need to be… " (V)

It appeared that participants experienced frustration when they perceived that management lacked an understanding of the priorities of the challenges they faced. There seemed to be a dissidence between management's priorities and ground floor staff priorities. One participant discussed their experience in the NHS, where the management was comprised of several layers in which constant change occurred:

"like the NHS is constant change, too many people getting involved, trying to fix something, fix a problem that isn't there. And this constant turnover of staff who then try and change things and that really affects the staff team who, in terms of keeping up with those changes… " (B)

"And sometimes the staff team are not skilled enough to implement changes that is recommended higher up. So for example the board would, the board would probably forward some sort of policy or latest guidelines for guidance and then they would say well you have got to implement this an which at local level they don't really understand what about and they wouldn't know how to actually implement those…" (B)

This highlights the importance of having a consistent management team who are approachable and are working towards the same shared goals (Al-Sawai, 2013). Changes amongst organisations can be positive and can drive teams forward to develop. However, regular changes can bring about uncertainty for the teams. It may also result in the teams feeling disconnected from managers and sensing a lack of support. Participants reflected on the communication received from senior management regarding policy changes. There is a focus on management having an awareness of priorities and an awareness of staff understanding, it is crucial management disseminate information that is understandable to their staff team. Participant B highlighted staff struggle to understand and therefore implement change, which can result in a culture that resents the senior management team.

Values

The third sub-theme identified was the importance of 'organisational values'. Participants discussed that core organisational values underpin an ethos that can promote good quality care. It is important that clients receive care that is dignified and supports their integration into community living. Participants

discussed the importance of the staff values being aligned to the organisations and to their team.

''An effective staff team would first need to understand the organisation's core values and what we stand for. Because there are certain expectations from the organisations of what the staff team should have their own core values system and how that aligns with the organisation's values… " (B)

This participant discusses the importance of teams aligning their values with one another and the organisation. This is consistent with existing literature that suggests if this does not occur cliques and factions can develop within teams that negatively impact on culture (Martin, 2002; Melnick et al, 2009).

Participants also reflected on values in consideration with the forensic aspects of client's history.

"In a liberal society we do give people a second chance and those values are really important…'' (T)

"obviously the whole point of community homes is treating them with dignity and helping to integrate them into the community as well…'' (L)

This is an important consideration as the staff teams support offenders who have committed various crimes with a range of victims; participants highlighted the importance of ensuring their care practice is not compromised by this.

Forensic Risk Management

Forensic risk management was identified as the second theme. This was comprised of three sub-themes: client risk management, clinical input, and staff practice. Participants discussed how clients' forensic risk can impact on staff culture and similarly how staff culture can impact on client risk.

Client Risk Management

Participants discussed some of the resources they use to manage risk. This included Positive Behaviour Support (PBS) plans, working together as a MDT and having effective communication with professionals to manage risk. However, it was noted by participant B that some staff may not feel confident in using the measures in place.

"they were struggling in implementing changes to PBS, they really didn't know what we were talking about. It is not that they were reluctant or resistant to making those changes, they, they don't really have the skills to do it…'' (B)

"I think it comes to communication as well I mean if you're going to have someone coming in who's having input with the clients then obviously, they need to communicate to staff as well. Because for example it's no good a psychologist coming in having a session and then leaving without saying what's been discussed in the session because how are we meant to follow anything through that's been discussed…" (L)

Participant B and L identify several areas that are related to risk management. Not only does the staff team need the appropriate frameworks and plans to

manage risk they also need to understand the plans, and the confidence to ask for help if they do not understand them. There needs to be clear communication between the different disciplines in the MDT to ensure risk and care practice is consistently managed.

Clinical input

Participants discussed the impact of clinical input on managing forensic risk. The importance of a clinician having experience in making public protection decisions was identified, as well as a clinician who has a clear understanding of legal frameworks of managing forensic patients with mental health difficulties. When considering how clinicians can support a community team, it is important that they can support the team to understand why a client may have committed their crimes, what their current risk is and how this risk can be appropriately managed.

"I think an effective clinician working in a forensic community home is a clinician who has got a lot of experience in making decisions about public protection, who knows very, very clearly the overall legal framework of management of forensic mental health patients… " (T)

"I think clinicians really need to understand the client group. They need to have appropriate knowledge, knowledge base skills, the values and the attitudes to carry out their job effectively…" (B)

Participants also discussed how they would value more clinical input:

"it would be nice if someone give us advice on how to do it properly sometimes yeah. Yeah and not just only during MDT just have a little chat…'' (Z)

Participant Z made reference to wanting more clinical input indirectly on an informal basis. This may have a positive impact on staff culture as the more clinical support they are offered the more equipped they may feel to work confidently with the client. Research has shown the importance of healthcare workers having support to discuss stressful events and how this can promote feelings of being understood, emotional relief and supporting staff to think rationally (Zech & Rime, 2005).

Participant B and L discuss the approach of clinicians in the community home:

"be a good sort of listener and a leader. Management and leadership skills are also part of an effective clinician. To be able to listen to the staff to work with them collaboratively, even if you know you try and pitch your communication to the level they would understand…'' (B)

"if you're coming in and you've got the type of approach of oh well I'm qualified I know what I'm doing, you're only a support worker you haven't got a clue what you're talking about then obviously that would impact the staff. If you've got someone comes in who is offering input and advice and is saying right okay situations like this right okay this is how we can work in a different way and try and support that client in that situation then obviously that can be a good thing because it's a different approach and it might be a case of it could be none of

the staff have actually thought about going through things that way and it's a different more effective way to manage it…" (L)

Participant B discusses the effective attributes of a clinician; this requires a clinician to display leadership, which is appropriate when thinking of the legal responsibility clinicians have regarding clients on their case load. Participant B identified the importance of a clinician pitching communication at a level that all staff can understand. Participant L explains if a clinician develops a collaborative relationship with the team, then the team will feel more confident in asking for additional support or clarification on how to implement strategies and they may be more likely to follow the advice given.

Staff practice

The importance of staff being able to manage highly challenging behaviours and risk was discussed throughout the interviews.

"I'm just trying to think of the right word for this, tolerant, I would say tolerance for you know behaviours that perhaps are hard to tolerate..." (T)

"quite high tolerance threshold to risk and uncertainty… " (T)

"at the moment we are quite lucky with the incidents. But in the past we literally had them day by day… it is a stressful situation and not everyone will deal with stress, so some of the staff need to go home, some of the staff literally will be like so stressed they can't work because of the day…" (Z)

"they (clients) smashing the house yeah, they throwing the items yeah, there is some days literally they will just argue with you for no reasons…" (Z)

Participant T acknowledges that staff in forensic community homes are required to support clients who can present with challenging behaviours. It is well recognised in published literature that staff who support clients with mental illness or offending risk are exposed to multiple challenges including aggression and managing risk, so they often experience higher levels of anxiety and stress due to the nature of their profession (Husted & Dalton, 2021). This has the potential to impact on staff decision making and care practice. Participant Z reflected that after some incidents staff have had to go home due to the level of stress they are experiencing.

House Manager

Throughout the interviews, the role of the house manager was highlighted as a pivotal influence for staff teams. The house manager's qualities, applied practice and factors that impact on the functioning of the home were identified as sub-themes.

House manager qualities

Participants discussed the importance of house managers having specific qualities. One of these was the house manager having the leadership skills to shape the staff team and facilitate change.

"and they (house manager) seem to be driving down the changes that are proposed by the board, which is quite good. It makes it easier for the staff team

who are working in the community homes that they can go to the house manager for advice…" (B)

"it is about being honest and creating a nurturing environment and also inspiring the new staff. Maintaining that clear line of communication, prompting sort of the qualities of taking responsibility and being accountable and then trusting each other… "(B)

"she (house manager) is pretty amazing, she has shaped this house, you can see like her leadership skills she's just so good like she didn't just support the boys she supported us…" (O)

"a very strong understanding of practice leadership and you know not just task based understandings either, so you know an understanding of quality. So it's not just did we do that? But how did we do it? How do we know we did it well? And for that that person would have to be committed to asking people and getting feedback. So getting feedback from their staff, and getting feedback from service users, careers, commissioners and also a leader that seeks feedback from people elsewhere in the leadership hierarchy… " (T)

Participant B made reference to the house manager being a key factor in facilitating change, as well as having a significant role in supporting their team to working alongside 'the board' which refers to the organisation's executive leadership. The participant highlighted the house manager is a crucial aspect in communicating from 'the board' to the ground floor staff.

Participants also discussed the importance of the manager having supportive qualities:

"needs to be honest, approachable, obviously knowledgeable in situations. From my point of view if I have got an issue whether it be work wise or personal I know I can go to my manager and speak about it because if it was a personal issue that could potentially affect my job role or my ability to carry on with the role then having that chat having that support put in place even for an issue outside of work. Obviously as a staff team then it boosts staff morale because you know that that support is there for you"… (L)

"doing the supervision sessions just to reflect on how things are also supporting those staff. Like you know, there have been situations where the staff have been in tears like they've, they've either had like personal issues, family issues they can't maintain that balance. And it's about being flexible about managers being really flexible and accommodating…" (B)

Participant L made the direct link between staff feeling supported and this boosting staff morale. If a team has a manager who is supportive and approachable, the staff are more likely to ask for help when they require it. Participant B reflected on the wider difficulties staff may be experiencing on their personal life, it is important that managers accommodate personal issues as these may impact on staffs ability to undertake their job.

"*We've had situations where this staff had to leave because they simply couldn't work with the managers…" (B)*

"It's also about, I think the managers really promoting those skills and making sure they are providing adequate supervision, training..." (B)

Participant B highlighted the consequences of house managers not being supportive, the managers have a direct impact on their staff team. If a member of staff does not feel supported by their manager, this could impact on their decision to seek out new employment.

Applied practice

Within interviews participants discussed the importance of the house manager having leadership skills. Within the realm of leadership skills, an important aspect was the house manager's ability to recognise each member's strengths, and to allocate them duties that complement the staff member's and team's skills.

" I think it's having the right mix of people. I think it's about having the right type of people as well. I mean with most homes, what I tend to do is I tend to allocate people to the skills that they have…"(V)

"They need to be picking up when people are struggling, they need to be responsive if people ask for help and they need to understand what the metrics are that they are looking at that tell them one what the quality is like…" (T)

In addition to utilising the strengths of each staff member, participants referred to the importance of identifying and supporting the developmental needs of the

team. This may come in the form of training, reflection or discussion in supervision sessions.

The house manager's approach to the team was identified as having an impact on staff culture. Participants discussed the value of having a manager who is supportive and approachable. For example, having a manager who takes the time to discuss the reasoning behind decisions or having a culture in which staff can ask why something occurs was attributed to a positive working culture.

"If I have a question like oh why's this? Whether it is to do with like a certain framework or something she answers straight away like even though she's busy she always makes time for the service users and and the staff…" (O)

Alternatively, participants discussed the impact when this does not happen. They discussed if a manager is not approachable and is condescending this impacts negatively on the team morale, it makes staff feel that they are not able to ask questions and prohibits learning and development. It was also acknowledged that this had a secondary impact on the service users:

"I mean we had a battering, the atmosphere was like oh my god you would never believe it. The staff were depressed, the clients were depressed, those who were like on an informal unsupported basis were out all day…" (O)

Participants also commented that if the house manager has a negative attitude it can filter down to the rest of the staff team.

”it got to the point where we were all turning against each other as well, because we were so frustrated we were just like arguing with each other…'' (O)

”if the management's attitude is going to be negative as we've seen towards some of the clients, then that heavily influences the staff team who work under…'' (B)

“I think if you've got a manager that you can't approach or if you've got a manger who is undermining you on a consistent basis then staff morale is going to be at an all time low…” (L)

The quotes above indicate that impact the house manager can have on their team. Not only can this be a positive impact when practice leadership is modelled but it can be a negative impact:

”if it is not coming from the management then staff lose their sense of identity and then that leads to like a fragmented approach…'' (B)

This indicates the importance of having a house manager with leadership qualities. The staff team is reliant on them to provide direction. If the team is aware of the leader's expectations this can increase consistency amongst the team as they have clarity of what they are working towards. As discussed by participant B if the team lacks that quality of leadership, they are not provided with direction then each team member will be working towards their own perceived goals and priorities leading to a loss of consistency amongst the team.

In-turn this can produce informal leaders in the group which can impact on patient safety and culture.

Home functioning

Within interviews participants also discussed factors that are external to the team that can impact on the culture. This included the team having the appropriate level of staff and staff retention and also the importance of the client dynamics and the impact these can have on the home.

Appropriate staffing level and retention

Staff retention was discussed as a challenge that occurs amongst community homes. The participants identified this causes concerns to ensure the vacancies in the team are filled, though this often results in the employment of agency staff. Participants identified secondary problems that can occur such as the agency member not being aligned to the organisation's values. This is natural as their employed identity is with the agency and not so much with the organisation they are working for on that day.

" Once you've recruited, once you've got through all these recruitment and retention issues which is a big problem…" (B)

" They were really struggling to retain staff and that means they'll have to fill in those gaps. So then there's an over reliance on agency staff who in some ways, I don't want to generalise it, but in some ways they don't have those core values and their sense of identity is different…" (B)

This can have an impact on the staff team in regards to their sense of identity. The team could be split in regards to permanent and temporary staff who may have different values. The agency staff member could be working across several organisations so they do not have the opportunity to develop loyalty to an individual home. In addition, participants discussed how a high turnover of staff negatively impacts on the team. In addition, this will also impact on the quality of care that residents receive. The more familiar staff are with the clients and their care plans the higher the quality of care can be delivered.

There were also discussions regarding the correct staff skill set and mix to meet the needs of the clients.

"the forensic care home too, there are issues about sort of staff mix as well. Like you know the ratio of male and female which, which became an issue in terms of managing those clients. And there was, there's a real sense of frustration from the manager that you know we don't have permission to have a higher male staffing ratio…" (B)

Participant B highlighted the importance of ensuring ratio of staff gender were adequate to client risk and need. The participant identified that when this was not met a sense of frustration developed in the staff team that was aimed at management who were perceived to be a barrier to obtaining the staffing mix.

Client mix/ dynamics

The client mix and dynamics was discussed throughout interviews in relation to their impact on home functioning. Participants expressed the importance of

having clients in the home who do not impact negatively on each other's rehabilitation.

" It is important what kind of service users we've got, it's not the best mixture now we have mental health, the learning disability, a little autism and they are clashing…'' (Z)

"if you have like mix of clients with varying needs then they get lost in knowing what the service is about. So I find that some other staff do struggle with that. An example would be like one of the projects in XXX you would have a mix of clients with autism then you've got clients with learning disability. But then at the same time we have clients with just mental health issues and then it's about, the staff get a bit lost in that… " (B)

"it is difficult to then drive those values. Not about values, it is difficult to drive that knowledge and the skills that they will need as they would need to have a broad range of skills which may not be possible to achieve in our setup…" (B)

"suppose different approaches would depend on who it is you're speaking to. I mean for example like with mild learning difficulty you might need to take a different approach and communication style to what you would with someone who is paranoid schizophrenic obviously it's going to be person centred as well because obviously they're all individuals I mean some of them you're going to be able to have a bit of a laugh and be a bit more upfront with them during situations where as other ones you may need to take a more subtle approach…" (L)

If the care team are supporting residents with varying needs and diagnoses who 'clash', as participant Z discussed, this could have a negative impact on the staff team. They will be required to use different therapeutic approaches for example those treated for Emotional Unstable Personality Disorder would require a different therapeutic approach compared to clients with Autism, participant L reflects on this in their comments. Participants identified the need to ensure client dynamics are well matched and do not negatively impact on each other's rehabilitation and care. Careful consideration should be taken when admitting new clients into the home. Participant B reflected that when there is such a range in client need, this will impact on the clarity of home values. Within culture values have been identified as informing the staff culture, if there are a lack of values it could negatively impact on the staff culture.

The Care Team

The care team typically comprises of support workers and senior support workers. The care team's role, team approach and practice concerns were identified as sub-themes.

Care Team's Role

Participants discussed the breadth of their roles within the care team. There was a shared purpose and some overlap so that all roles contribute to supporting clients to reintegrate back into the community. There was also an agreement that staff are there to support client rehabilitation; this could include developing daily living skills, utilising care plans to inform practice and support clients to work towards their goals.

Team Approach

Many participants discussed the importance of being part of a team that was consistent in its approach. Consistency is important in client rehabilitation so they have an understanding of how staff will respond and expectations.

"Giving the same training so there is a consistent approach as well. Because although it's always good to have different views and different visions you need to have a consistent approach with the client group you're working with…" (L)

"he will sometimes just sit and observe the staff, how they communicate to each other, how we talk, and they play sometimes the staff against each other…" (Z)

Participant Z reflected that clients may try to split the staff team and test the staff responses. This is further reasoning as to why it is important for consistency amongst the team.

An aspect within team approach was the approach staff take with clients and the staff members personality. Participant O discussed the relevance of being honest with clients, which may help to reduce the clients anxiety. Participant L reflected on importance of participants having a personality type that enables them to be adaptable due to the challenging nature of situations that can occur.

"being honest with them about something, not like pussy footing around them, it's literally like how it is, so they know what page they're on and their anxiety doesn't bubble"… (O)

"I think support workers need to obviously be knowledgeable whether that's pre-existing knowledge or whether that's going through training and getting some sort of knowledge prior to working with the clients. I think they need to have the type of personality whether they are able to adapt to situations because unfortunately it's not always black and white in this type of job…" (L)

"no matter what they tell you in training that this is what you do in that situation, yeah that's not always going to work for every single individual client. So they have got to be adaptable…" (L)

In addition, the importance of staff being able to develop relational security with service users was discussed; this refers to the care and understanding staff have of clients and of the environment, and the translation of this into the most appropriate care responses (Department of Health, 2010). Relational security includes safe and effective relationships that are professional, therapeutic, and purposeful (Department of Health, 2010).

"I think security is probably one of the most important. Relational security, not so much physically security although that can factor in you know it depends on the section you know or what legal framework they are on. So security, building therapeutic relationships with staff is incredibly important…" (V)

"they've also obviously got to be deep down they have got to be caring I mean it's pointless coming into this job if you don't actually care about people and if you don't actually want to make an impact on someone's life I mean it's not

really the job to get into if you don't actually want to have a positive effect on people…" (L)

"if you take the approach of you're coming into work and you act like you can't be bothered, you don't want to be here you'd rather be somewhere else then obviously the client group is going to pick that up. It's going to make them less, well more reluctant to work with you whereas if you come in and act like you actually want to be here you actually want to make a difference you do want to support and help them then obviously then they will be more inclined to speak to you when they're struggling, they'll be more prepared to work with you on a daily basis…" (L)

Participants reflected on the impact a caring approach can have on staff's ability to develop therapeutic relationships with clients. It was identified that relational security can help staff become more aware of changes in service users' presentations and being alert to subtleties and enable staff to challenge clients when appropriate. Participant L reflected on the impact of staff not being caring, identifying that clients are less inclined to work with the staff which will impact on the client rehabilitation.

Practice concerns

Throughout the interviews, several factors were identified that appear to impact negatively on the staff team culture. An example was of teams having 'informal leaders' who then appear to split the team into smaller cliques.

”if you’ve got support workers who like to try and team split or like to gossip then obviously that can have a massive impact on the morale of the team because you can end up with a team that’s divided which is really not going to help with a consistent approach…’’ (L)

“you only need one or two or a few staff to start using that negative metric, the, the whole project, then there’s that group conformity and everyone becomes, then negative and it adversely affects their, yeah, work culture…” (B)

Participant L identifies some of the negative outcomes that can occur from having informal leaders or cliques, each clique within the team will have their own values base and attitudes will differ amongst each clique. Overall, this results in them not being consistent in their approach or attitude. This could further impact on the care delivered to clients if there are inconsistencies amongst the wider team. Participant B identified the influence of group conformity, reflecting it only takes a few members of staff to be negative in their attitudes or views to influence the wider team. This participant reflected on it becoming a negative impact on work culture.

Participants discussed the need to be able to feel confident in discussing concerns whether these are professional or personal difficulties. If they feel their confidentiality is not maintained or they feel judged, this can have a negative impact upon culture and beliefs. Practice concerns were also identified in teams who did not take responsibility and did not feel accountable for their actions.

”An effective team in my view is that the staff feel accountable, that they take some responsibility and accountability when things do go wrong and having the trust in each of them...'' (B)

Participants also discussed the importance of staff being offered training to ensure their skill set continues to develop.

"*I think they got the mandatory training and things but then I don't think we do well in terms of keeping up with continuous look, professional training. Yes, the absolute essential ones we do, quite, but over and above I'm not sure if we do any. Certainly not linking up with external organisations which would be helpful…" (B)*

If staff are not offered the opportunities to develop their skills, this may impact on their ability to complete their duties to the highest standards. Staff are supporting clients who have complex needs and associated risk, it is vital that staff are offered appropriate training programs to ensure they have the ability to appropriately support the clients.

Conclusion

The research undertaken sought to explore components of culture in community homes through interviewing staff who work in or support a forensic community home. Through thematic analysis, themes within interviews were identified and discussed. The main themes included; the organisation, forensic risk management, the home manager and the care team. The research also identified areas that can have a negative impact on staff culture. These included

a lack of leadership, cliques forming in teams as well as closed cultures in which communication is not effective. As discussed in the systematic review, a lack of leadership and ineffective communication can be indicators of closed cultures.

The research highlighted how prominent leadership is on implicitly influencing culture on different levels. Participants discussed the importance of there being a clear management structure within the organisation. This provides staff with the awareness of who is responsible for each aspect within the organisation. Participants discussed the importance of clear communication from management, including direct communication from the executive board and communication passed down from middle managers. It was highlighted that staff expect the executive board to implement changes, they reflected it is important that staff understand why the changes are occurring and how they should be implemented. Participants reflected that if this does not happen it can create animosity amongst the staff team, this directly impacts on the team culture.

The findings from this study will be used to develop a psychometric tool that measures staff culture in forensic community homes. The themes and sub-themes will be used to categorise the domains and sub-domains on the tool. Items will be developed to inform a measure of each domain.

Limitations

A potential limitation could be the generalisability of the findings. All of the staff interviewed were from the same organisation. On reflection it may have been preferable to interview staff from different organisations to increase generalisability. It is noted that participants have worked in different

organisations, and some drew upon these experiences when responding to questions which would increase the generalisability of findings. Collecting data within one facility enabled sampling across the range of staff roles, which may have been harder if recruiting participants from several different organisations. However, due to the small sample of participants, all of whom were recruited from the same organisation the generalisability of the results should be interpreted with caution. It is possible the findings are a representation of the concept of culture in the organisation the participants were recruited from. Further consideration of exploring culture should be made if the tool is to be administered more widely. Additional interviews could be undertaken with participants from alternative organisations, subsequent interviews may further contribute to the understanding of culture in forensic settings. As discussed throughout the thesis different teams have different cultures, it is possible that further exploration into the concept of culture within different organisations may expand the domains and sub-domains captured in the tool.

Another potential limitation is the information participants were willing to discuss within the interviews. Participants were discussing the organisation that they are employed by. It may only be natural for them to feel that there are some aspects of the company that they do not want to mention, and this may have been further heightened as the interviews were audio recorded. Throughout some interviews participants did question who would be hearing the recording or would have access to the information. Participants were assured prior to the interview starting that anonymity would be maintained; however, as some asked about this later within the interview, it could suggest that they were concerned

about who from within the organisation may have access to their contributions. There may have been a degree of acceptability bias in their responses.

When the data was coded the codes were reviewed and informed the thematic maps. The researcher reviewed the data set with the understanding that the themes would inform a psychometric tool. It is difficult to ascertain whether this influenced the analysis. A reflection on the data analysis is subconsciously the coding of themes may have been impacted by this. To increase the reliability of the findings, it would have been beneficial for a second coder to independently analyse a section of data (Belotto, 2018).

It is acknowledged that six members of staff is a relatively small sample size. For this research the sample size was believed to be adequate as it was large enough to provide a rich understanding of views, but small enough to manage the material (Sandelowski, 1995). As part of the research protocol, subsequent interviews could have been undertaken if data saturation had not been achieved. This meant if after six interviews had been conducted new themes continued to be identified additional interviews could have been facilitated. As discussed by Bowen (2008), there are practical constraints on how many participants can be interviewed, therefore saturation may not be reached. If data saturation had not been reached, it would not have invalidated the findings. It would have indicated further research should be undertaken (O'Reilly & Parker, 2012).

Reflection

On reflection, it is important to acknowledge the potential influence of the researcher on the findings. The researcher undertook the study with the

intention to develop a psychometric tool. The role of the researcher was highly prominent throughout the tool development. The researcher spent a significant period researching into the topic of culture, the researcher developed the interview questions based on these findings.

It is possible the researcher's interpretation of previous literature, models and concepts influenced the development of the questions, the interpretation of the findings and mapping of the item domains. It is unknown whether the same themes and sub-themes would have been identified if a different researcher undertook the same research.

It is also acknowledged that the researcher had applied clinical experience and had worked in a range of settings, including forensic community homes. It is possible that the researchers' professional experience influenced the perception of the results. The researcher had observed the influence of staff culture on patient rehabilitation and staff practice. It is likely that the researcher may have been influenced by their own previous clinical experience to identify specific themes from the data set, their clinical practice is likely to have influenced the identification of themes and sub-themes.

As this research project was to inform the development of a psychometric tool, it would be expected that the tool may need to be adjusted after sufficient testing.

Chapter Five: Research Project Two

Developing and validating the Cultural Assessment of Staff Teams (CAST) tool.

Summary

This chapter presents the research processes involved in validating the Cultural Assessment Measure of Staff Teams (CAST). Experts were recruited to score the content and face validity of each item. Items that did not meet the pre-determined criteria were removed from the tool. Items that were identified to lack face validity were reworded. Following amendments, the tool was administered to a sample of the target population which is support workers and senior support workers. Cognitive interviews were facilitated to highlight tool instruction and item ambiguity. Following the interviews final adjustments were made to the tool. Items were reduced from an initial 129 to 86. Items are spread across four domains: The Organisation, The House Manager, The Care Team and Risk Management. Future directions for research are discussed, alongside limitations of the study.

Introduction

Community mental health services play an important role in supporting individuals with mental illness. The provision enables individuals to live closer to home, within their community setting. One of the key objectives of the NHS Long Term Plan (2019) is to develop new integrated models of primary and community care that will support adults with mental illness. Part of the role of community care is to prevent individuals from feeling isolated from society, which has been a feature in the history of psychiatry (Loch, 2014).

Role of community homes in rehabilitation

Enabling individuals to live in the community provides a context for people's lives. Research has shown a critical element in recovery is the ability to offer individuals a degree of control over their environment, who they socially interact with, and larger environmental space (Payne & May, 2009). These factors are easier to accommodate in community homes compared to inpatient settings. Supporting individuals to transition from hospital into the community is an important step in the recovery pathway.

It is recognised community living will come with challenges that residents won't have been faced with in hospital. These can include meeting the demands of daily life, cooking for themselves, doing laundry, and managing risk behaviours such as substance abuse. These increased stressors could exacerbate psychiatric or offending risk. Supported community homes have the purpose to continue with rehabilitation in a less restricted environment. The World Health Organisation (2005) have stressed the importance of actively promoting social integration among individuals with mental health needs and expanding their

network. Studies have shown correlations between social support and psychological well-being (Sanderson, 2004). By supporting individuals to live in community homes it provides them with opportunities to develop wider social networks and continue rehabilitation.

Community factors influencing rehabilitation effectiveness

The findings from the systematic review (see chapter two) and the research undertaken in chapter four provide evidence that climate and culture impact on patient rehabilitation. Staff culture has been shown to influence the way team members think, prioritise work and behaviour (Humphreys et al., 2019). It was important to develop a tool that can measure staff culture in forensic community settings.

This study is the second stage of research for the development of the Cultural Assessment of Staff Teams (CAST). Chapter four focused on the exploration of staff culture in forensic community homes. The results informed the development of items, please refer to appendix H for information regarding the initial item development.

The research presented in this chapter is broken into two distinct parts: firstly, the process of attaining content and face validity of items through an expert panel; and secondly, following their feedback, the tool was amended and administered to a sample of the target population. The purpose of the CAST is to provide organisations with a tool to measure their staff team culture.

Aims

The overall research aim was to develop a psychometric tool that can be utilised to measure staff culture in forensic community homes. The study used a mixed methods approach:

A quantitative approach was used for the first aim. This was to ascertain face validity and content validity of items. The purpose of this was to identify items that were to be retained or removed from the tool.

The second aim was to undertake cognitive interviews to mitigate ambiguous and problematic items and instructions. A qualitative approach was used to explore respondent experiences of the tool. Their feedback resulted in further amendments to the tool to increase validity.

Method

Figure 5.1 displays a flow chart that outlines the processes followed in the two parts of this study.

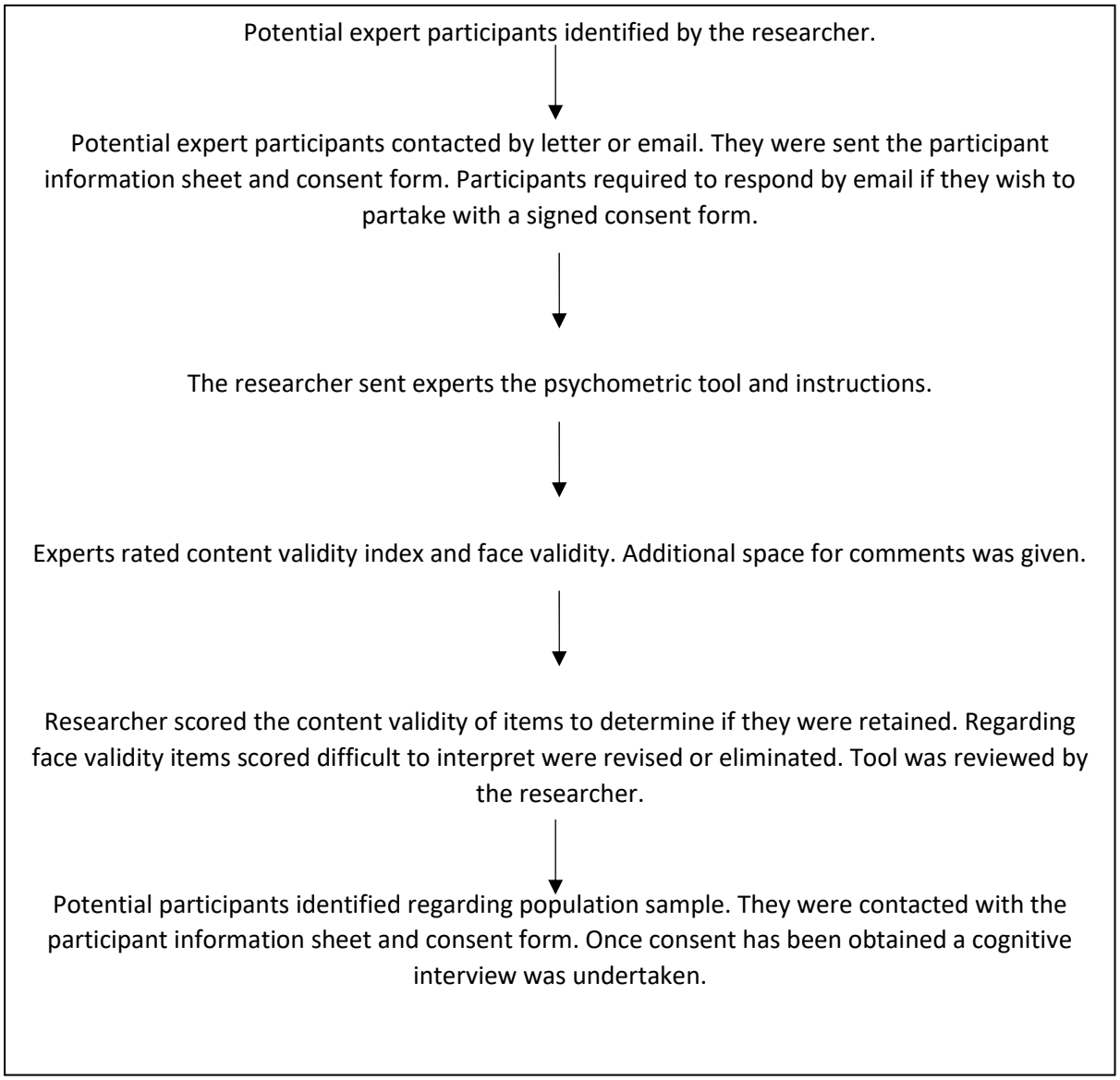


Figure 5.1 A flow chart outlining the methodological process of study two.

Materials

For this study the material required included the psychometric tool, which had been generated from the findings of the first research project. The tool was disseminated through email to participants.

The second resource that was required for this study was a semi-structured interview that guided the cognitive interviews. The questions were based on the items and instructions in the tool.

Procedure

The researcher wrote the study proposal. Ethical approval for both parts of the study was granted from the University of Nottingham's Faculty of Medicine and Health Sciences Research Ethics Committee (FMHS 223-0321) (Appendix I). The same proposal was sent to the organisation involved in the research who also granted ethical approval.

The researcher identified potential expert participants who were recruited from a purposive sampling approach. Experts were known to the researcher through an academic or employment network.

Experts were contacted through email or letter by the researcher. The initial contact outlined the study and included the participant information sheet (Appendix J). Experts were required to contact the researcher on the given details if they were interested or had questions. To ensure they did not feel pressured to take part they were assured they did not need to respond.

Once the researcher received the experts' signed consent form, experts received version 1 of the psychometric tool through email with instructions and a theoretical definition of culture (Appendix K). They were asked to rate each item to assess content validity. An expert panel is the most commonly used approach (Zhang, 2005) to attain content validity. Zaichkowsky's (1985) method was

deployed; which is a dominant method in achieving content validity (Hardesty & Bearden, 2004). Experts were asked to rate on a four-point Likert scale whether the item was 1= not relevant, 2= somewhat relevant, 3= quite relevant or 4= highly relevant to the construct of interest.

Experts were also asked to rate the face validity of each item on a four-point Likert scale. This refers to the item comprehension and clarity. Space for comments was given for each item. After the experts had returned their rated psychometric tool they received an email containing the debrief form (Appendix L).

The researcher scored the validity of each item on the predetermined criteria. This resulted in amendments to the tool according to the feedback received. The amended tool was reviewed again by the research team who have extensive experience in professionally supporting forensic community homes and/ or are academics.

Questions for the cognitive interview were developed in line with the items that had been finalised, this was in a semi-structured format. Potential participants were identified by the researcher, these were support workers and senior support workers. They were contacted with the participant information sheet (Appendix M) and were required to return a signed consent form (Appendix N) if they wished to partake.

Interviews focused on exploring the item structure, instructions, and response options. Interviews were conducted in person or through Microsoft Teams; this

was in line with Covid-19 regulations. Interview timings ranged from 35 minutes to 60 minutes. Once the interview was completed, participants received the debrief form (Appendix O) and were informed that they had two weeks to withdraw their participation. None of the participants withdrew from the study. The researcher utilised the interview data to identify problems within item and instruction wording. The tool was amended following the interviews with the target population. This included amendments to tool instructions, examples of situations to provide further clarity, or punctuation and grammatical changes.

Expert Participants

Experts were recruited to review the items and score the validity. They were recruited through purposive sampling and were deliberately selected due to specific characteristics (Lane et al., 2001). In general, expert reviews should be carried out by individuals with strong credentials in the area topic (Svedbo et al., 2018).

The sample comprised of five experts who were either academics that had published in the field of psychology or were professionals who had supported community homes such as psychologists or psychiatrists. Eight experts were contacted, six of whom expressed interest in participating. Five experts signed and returned the consent form. Five experts reviewed and returned the measure. The experts were from three different organisations and were a combination of applied professionals and academics.

Sample Population Participants

There is no consensus in literature regarding an adequate sample size for an interview study (Beatty & Willis, 2007). It is acknowledged in practice sample size is determined by time constraints and available resource (Beatty & Willis, 2007). Research suggests most critical problems in a questionnaire are revealed by a small sample size, general guidance stipulate between 5 to 15 interviews are conducted (McColl, 2001; Willis, 1994). Five participants were believed to provide an adequate insight into revisions of items or instructions (Beatty & Willis, 2007). The sole inclusion criterion for the participants was to be employed as a support worker in a community home. The five participants recruited were from various community homes all within the same organisation.

Ethical considerations

Emotional harm

The study did not intend to elicit any emotional harm towards the participants. However, if distress was experienced from their involvement in the study participants were signposted to relevant support networks.

Voluntary participation (Coercion)

After the potential participants were identified by the researcher, they were contacted by email from the researcher's university email address. They were asked to respond by email if they were interested in taking part in the research. They were assured they did not need to respond to the correspondence if they were not interested. This approach increases voluntary participation and reduces any risk of coercion.

Confidentiality and anonymity

The researcher knew who the participants were as they needed to contact them during recruitment. However, the researcher did not discuss this with anybody. Contact was made through the researcher's university email account; therefore, only the researcher had access to responses. All the data is safely stored for seven years in line with the University of Nottingham's policy regarding data integrity.

Informed consent

All participants were provided with an information sheet and a consent form. They were given the opportunity to ask questions about the research. All participants were aware of their right to withdraw from the research for up to two weeks following their contribution, without any consequences.

Deception

None of the experts or participants were deceived during the studies. The participant information sheet and consent form outlined the study aims. All participants received a debrief form that reiterated the study aims and an explanation on how to withdraw.

Analysis

The expert feedback was used to calculate the Content Validity Index (CVI) score for the relevance of each item. Based on the Waltz & Bausell (1981) method each item's CVI score was calculated by dividing the total number of experts by the number who scored the item as 3 or 4. Prior to the study being undertaken predetermined guidelines were set. If six or more experts were

recruited the minimum CVI score that would be acceptable for an item was 0.78. However, if three to five experts were recruited a CVI score of 1.00 would be required for an item to be retained; to mitigate the effects of chance agreements. As five experts responded, each item was required to score 1.00 on the CVI calculation. Lynn (1986) developed this approach to mitigate the standard error of proportion.

Face validity was also scored by experts on a 4-point Likert scale. Ratings and comments were evaluated by the researcher. If more than one expert scored the item as needing revision this would be adhered to.

Cognitive interviews were used to explore the ambiguity of items and tool instructions by a sample of the target population. Cognitive interviews are facilitated to probe the understanding of words and phrases, as well as processes used in forming a response to an item (Tomlinson et al., 2016). The researcher collated participants' responses, and these were used to inform item refinement.

Results

Validation by expert panel

The panel of experts reviewed the initial tool comprised of 129 items. All five of the experts rated every item, so there was no missing data. Following the CVI calculations, the number of items was reduced from 129 to 86. The number of domains remained the same (4), while the number of sub-domains was reduced from 12 to 11. Table 5.1 outlines the process of the tool development and the number of items, domains, and sub-domains within each tool version.

Experts were asked to comment on the face validity of each item. Suggestions were given regarding duplication of items and the revision of item wording. It was noted by two experts that the sub-domain 'practice concerns' appeared to relate to other scales and in many cases the sub-domain items were the reverse of other scale items. After review by the researcher, it was agreed that these items would be better placed in different domains as they were merely negatively phrased items of other domains.

Development phase	**Process**	**Number of items and dimensions Tool Version**
Phase 1 Item development	Semi-structured interviews conducted with members of the multidisciplinary team to explore their working experiences.in community homes. Questions were informed by previous research. Through thematic analysis themes and sub-themes were identified.	129 items 4 domains 12 sub-domains Version 1
Phase 2 Expert review content and face validity	Expert review of items. Experts scored the face and content validity of each item. Suggestions regarding item clarity. This resulted in item reduction. Items were reworded and definitions of ambiguous phrases were included.	88 items 4 domains 11 sub-domains Version 2

Phase 3 **Population sample cognitive interviews**	The tool was administered to a sample of the target population. They reviewed the items to evaluate face validity and clarity. They read the tool instructions and feedback their understanding of what they were being asked to do.	86 items 4 domains 11 sub-domains Version 3

Table 5.1 Summary of process in each development phase. Number of items, dimensions, and draft version of the measure.

Cognitive interviews results

To further increase the validity of the tool, five cognitive interviews were conducted individually with a sample of the target population. Five support workers were recruited from different community homes. The interview duration ranged from 20 minutes to 40 minutes. See appendix P for the cognitive interview schedule. During the interview participants' responses were documented. Following the interviews comparisons were made across the participants' feedback.

Tool instructions

Participants were asked to read the tool instructions and describe what they had been asked to do. All participants could clearly state what they had been instructed to do. There was no uncertainty from any participants, this resulted in no further amendments being made to instructions.

Understanding of items

Participants were asked to define words within items. If one or more participants found a word difficult to define or understand this resulted in the amendment of including a definition. The amendments were comprised of adding definitions of phrases or words. One example of an amended definition was under the subdomain 'client risk management'. The item stated 'As a team we are confident in taking positive risks'. Two participants were unsure of what a 'positive risk' referred to. The added definition provided clarity, 'a balanced decision that acknowledges what the client can do, not just how they are limited. For example, giving them the opportunity to take a bus in to town by themselves' was incorporated to the item. This responded to feedback from participants that they were unsure of a definition of positive risk. In total, three additional definitions were added to the tool following the cognitive interviews.

Subdomains and domains

Once participants had completed scoring each subdomain and domain they were asked whether they thought the items were relevant. They were also asked whether they thought there were any items missing. All participants stated that there were no items missing in the subdomains. All participants stated they felt the items were reflective of staff culture and relevant.

Forming an answer

Participants were asked when they formed their response to the items what they reflected on. The participants discussed relevant work experiences, examples of situations that were relevant to the item or feelings they had experienced in relation to a situation. All of the participant responses were relevant to scoring

the item, there were no concerns that thought processes appeared irrelevant to the item topic.

Scoring criteria

Participants were asked to comment on the scoring options. They were asked whether the options appeared relevant. Participants felt that they had available answer options to each item. Participants commented that the scoring options within the 'risk management domain', 'applied practice' for the item 'We maintain personal - professional boundaries' had appropriate scoring options which were 'True for me', 'True for the team', 'Not true for me' and 'Not true for the team'. Participants reflected that they felt the scoring options were relevant for the items resulting in no amendments.

The rounds of cognitive interviews thus further assessed the face validity of the items and tool instructions. The final version of the CAST can be seen in appendix Q. 86 items remained, distributed between four domains and 11 sub-domains. Table 5.2 presents the domains and subdomains for the final version of the CAST. Table 5.3 displays the domains and sub-domains in the first version of the CAST and the final version.

The main changes to the table are relabelling of subdomains and the remapping of subdomains. Within forensic risk management the subdomain was renamed applied practice after previously being called staff practice. This was due to many of the items referring to practical care tasks that staff do in the home. In the care home domain, the subdomains of care team role and team approach were amalgamated to become general care practice. Following feedback there

was a recognition that there was overlap between the sub-themes. Lastly, the home manager domain had two changes to sub domain labelling. The subdomain qualities was relabelled leadership support to reflect the wider support the home mangers offer their staff. The subdomain applied practice was relabelled practice leadership to reflect the leadership aspect of the home manager's applied duties.

Domains	Sub-domains	Explanation
The Organisation	Leadership	The organisation needs a clear management structure that have efficient communication between levels.
	Senior management's awareness	The organisation should understand the needs of its homes and the challenges they face.
	Values	The organisation should promote diversity, equality and protect human rights.
Forensic Risk Management	Client Risk Management	Forensic risk should be managed through appropriate risk assessments which are reviewed in a timely manner. There should be proactive risk management strategies outlined and clear communication between the multidisciplinary team.

	Clinical input	Clients should have treatment plans. There should be formulations of their presentation. Clinicians should offer training that informs staff practice.
	Applied practice	Staff should be positive role models. They should manage challenging behaviour, be consistent with boundaries and be attuned to client behaviour.
House Manager	Leadership support	The home manager should be knowledgeable, supportive, and approachable.
	Practice Leadership	The home manager should be physically present in the home. They should engage staff in reflections. They should utilise staff strength and have awareness of staff developmental needs.
	Home functioning	The home should have appropriate staffing levels, they should be able to retain staff and ensure appropriate mix of clientele.

Care Team	General care practice	The care team should support client rehabilitation, work closely with the multidisciplinary team, support community reintegration and set client goals. The care team should treat the environment like a home, be positive, caring and motivating.
	Practice concerns	The team not feeling valued. The team not working together resulting in team splitting and informal leaders.

Table 5.2 Domains and subdomains of the CAST.

Version 1		**Final Version**	
Domain	**Sub-domain**	**Domain**	**Sub-Domain**
The Organisation	Leadership Management's awareness Values	**The Organisation**	Leadership Senior management's awareness Values
Forensic Risk Management	Client Risk Management	**Forensic Risk Management**	Client Risk Management

	Clinical input Staff practice		Clinical input Applied practice
House Manager	Qualities Applied practice Home functioning	**House Manager**	Leadership support Practice Leadership Home functioning
Care Team	Care Team Role Team approach Practice concerns		General care practice Practice concerns

Table 5.3. Domains and sub-domains in the first and final version of the CAST.

Discussion

This chapter presents the second stage of tool development for the CAST. It outlines and discusses the methodological approaches undertaken. The aim of the study was to achieve face and content validity of items. A panel of experts were recruited to score and comment on the validity of the initial tool. Following amendments, cognitive interviews were conducted with a sample of the target staff population, in order to identify any ambiguities in the tool instructions and item wording. These processes resulted in the tool undergoing two stages of amendments.

Interpretation of these results within the context of the study and previous literature

The domains on the tool have been conceptualised to measure the phenomenon of staff culture in forensic community homes. Conceptualisations of culture have identified that it is multidimensional and published literature has highlighted a distinction between formal and informal organisational culture (Mansell & Beadle- Brown, 2012; Humphreys et al., 2019).

Formal culture refers to job descriptions, policies, training, mechanisms in place to monitor staff performance and organisational planning approaches (Felce et al., 2002). These are factors that are implemented and overseen by management. They are in place and designed to shape the behaviour of staff through providing clear expectations and limiting what staff do (Humphreys et al., 2019). These factors have been captured in 'The Organisation' domain and within 'The House Manager' domain. In comparison, informal culture refers to the relationships of staff, the approaches in their working, staff interactions between staff and clients, and the reasons for staff working (Felce et al., 2002; Hastings et al., 1995). This has been captured within the 'Care Team' domain and elements of the 'Forensic Risk Management' domain.

Researchers have suggested that congruence between informal and formal cultures contributes to a higher quality service, and on the contrary incongruence contributes to lower quality services (Emerson et al., 1994), however there is not empirical evidence that can underpin this currently. The domains on this tool measure both the formal and informal distinctions of

culture. If the tool is administered on a wider basis formal and informal cultures could be explored further.

The four domains that were identified as components of culture were the organisation, the home manager, the care team and risk management. Within the domain of organisation, the final subdomains were the senior management's awareness, leadership, and values. These domains reflect that, for an organisation to have a strong positive culture, the senior management needs to understand the needs within the community home. The organisation needs to have strong clear leadership, with clear organisational values that are actively promoted. These findings are in line with current research. Taylor (2005) suggested the leader's behaviour and values are vital. Aitken (2007) discusses the notion that leaders who act in unison and demonstrate values-based leadership are more able to build a distinctive culture in their staffing team. The pervasiveness of organisational culture needs management to be aware of the influence they have upon employee related variables, such as job satisfaction, performance and their commitment (Tsai, 2011). An organisation with a strong positive culture has common values and codes of conduct for its employees, and this provides them with a clear understanding of goals and shared mission (Tasi, 2011). This is to be led by the overall management.

Within the home manager domain, practice leadership, leadership support and home functioning were the identified subdomains. This means the house manager is required to develop and encourage their staff team. They must offer consistent support to their team regarding both professional and personal situations. Lastly, the house manager must ensure there is adequate resource

available to enable employees to do their job to a high standard. All of these factors contribute to a positive culture. Home managers are a critical influencing factor in shaping the team culture. Block (2003) found that immediate line managers can have a greater influence on employees' perception of culture compared to overall organisational managers. A study that looked at job satisfaction in nurses found those who perceived their managers as supportive and caring had higher job satisfaction (Tsai, 2011). Job satisfaction as shown in the systematic review has been linked to staff burnout and culture.

Within the care team theme, general care practice and practice concerns were identified as subdomains. These subdomains refer to the influence of care practice, both negative and positive on the impact of team culture. These domains align with previous research undertaken into culture in learning disabled group homes (Humphreys et al., 2019; Bigby et al., 2012). They found key aspects of team culture included staff working practices, staff perception of their role and their regard for residents. All of these factors will also impact on the residents' quality of life as they directly affect the care residents receive.

Lastly, the CAST includes a domain of risk management, which includes three subdomains: clinical input, client risk management, and applied practice. These refer to clinicians' input to support the team, ensuring relevant risk assessments and management plans are in place, as well as promoting effective communication across the whole MDT. As discussed, there is no existing tool that has been specifically designed for forensic community homes. Due to the complexity of the clients, staff are exposed to many potential risks (Millar & Sands, 2012), including self-harm, aggression and suicide (Currie, 2002).

Effective communication is imperative for risk management (Arora, 2005). The Department of Health (2010) stipulates for risk management that all health professionals should adopt an evidence-based approach to risk management that is effective and well-co-ordinated: teamwork and effective communication are key features of this (Hogston & Marjoram, 2006; Ndoro, 2014). It is the role of the MDT to some extent to assess, and predict the likelihood of risk, and to ensure relevant risk management strategies are in place (Millar & Sands, 2012). This is reliant on information shared between clinicians, the MDT and the client to enhance safety for everyone (Australian Commission on Safety and Quality in Health Care, 2005).

Limitations

The CAST measures components of culture in forensic community homes. Participants involved in the research had experience of directly working in homes or supporting them, some were classed as experts in the field.

One limitation is that the participants who undertook the cognitive interviews were from the same organisation, although they were recruited from different homes to ensure that different staff teams were represented. Three of the five experts consulted were from the same organisation. This may have resulted in sampling bias, which may limit the generalisability of the findings.

One of the aspects of the cognitive interviews was to explore whether participants thought there were any items missing from each subdomain.
It is acknowledged that as this is a new tool it is likely to require further amendments following wider administration and feedback. Once the tool has

been administered on a wider scale, this will help inform the development of scoring criteria guidelines. Larger samples of the staff population need to be recruited, so that the tool items and scoring guidelines can be developed further. Future research should select participating homes ranging from negative to positive culture. This would suggest underperforming homes would score lower and be identified with a negative culture, these homes would be identified as at risk of having a toxic staff culture. Whilst the higher performing homes would have higher scores indicating a more positive staff culture.

As with other self-report measures, the tool is vulnerable to social desirability. This means respondents might provide answers that frames them to look more socially desirable. It is acknowledged that the tool is measuring a sensitive topic, and as discussed in earlier chapters, negative cultures have been associated abusive and coercive practice in earlier chapters of this thesis if it is a negative culture. It is suggested that, if an organisation wanted to assess the culture of their staff teams, this tool could be used alongside other sources of data collection, such as client interviews, incident reporting, safeguarding referrals, and observations of practice.

Future research

Regarding future work, the current approaches have focused on validity. Interviews with members of the MDT, feedback from a panel of experts, and cognitive interviews with a sample of the target population are aimed at increasing the validity of the tool. For a tool to be considered a good measure it must be reliable and valid. It would be advised that future research of the tool is focused on ascertaining reliability. The most widely accepted statistical method

for calculating internal reliability is Cronbach's alpha (Cronbach 1951; Kline, 2015). This method is relevant for measures that have a Likert scale as the CAST does. There are differing views on the accepted score for reliability, however, a score of 0.8 is interpreted as strong internal reliability (Tavakol & Dennick, 2011). It is indicated that the higher the value the more reliable the survey (Tavakol & Dennick, 2011). Calculating the reliability of the tool is identified as the next stage of research.

The CAST could be developed to be applied to other forensic settings such as prisons or secure hospitals. This may require a similar approach to the interviews undertaken with MDT members in study one. Each setting will have different factors that are relevant to the composition of culture.

Implications of the findings

As discussed in the earlier chapters of this thesis, the development of a tool to measure culture in forensic community homes aims to provide organisations with a resource to gain insight into their team culture. For health professionals, a positive workplace environment is an important factor in providing good quality care (Maassen et al., 2020). It is strongly associated with good clinical outcomes and a prerequisite for a higher performing organisation (Maassen et al., 2020). As discussed in the thesis, the CQC (2021) has suggested that inspectors should be aware of red flags that indicate toxic cultures. There is a need to learn from previous cases of abuse and malpractice to ensure such occurrences are not repeated. This tool can be used to support inspectors to understand the culture of a staff team, so it may help to act as an indicator of any cultural concerns.

Conclusion

Overall, this chapter presents the methods deployed to measure the validity of items. The research process resulted in the number of items being reduced. If an item did not meet the pre-determined CVI score it was removed from the domain. Cognitive interviews were facilitated with a sample of the target population to identify ambiguous wording within an item or tool instructions. This study used a mixed methods approach providing both an in-depth understanding of validity through the qualitative method and applying an evidence-based practice to score validity through a quantitative approach.

Chapter Six: Discussion

The thesis aimed to explore organisational factors that can impact on patient and staff outcomes in forensic settings. The thesis specifically focused on ward climate and staff culture. To achieve this, firstly a systematic review was conducted. This identified existing studies that explored the relationship between ward climate, patient aggression and staff burnout. The systematic review was followed by three chapters that described the development of the CAST. Chapter three presented a methodological report, discussing research approaches that were considered for the tool development. Chapter four presented a thematic analysis of interviews that were facilitated with MDT members. The themes identified were core concepts of staff culture and were used to create Version 1 of the CAST. This was followed by chapter five, which focused on the validation process of the items on the tool. A panel of experts were consulted as well as a sample of the target population. The end product, Version 3 of the CAST, is now available for use and/ or for further testing and refinement.

Summary and discussion of findings

The findings in chapter two from the systematic review provide evidence that the ward climate impacts on both staff and patients. The relationship between climate and the variables is complex. From the studies that were reviewed there was a consistent finding, the EssenCES scores indicative of a positive climate were associated with lower levels of ward security. It appears the higher the security of the ward, the more of an impact the ward climate has on patient aggression. This may be due to patients being exposed to more restrictions which may increase their frustration. Due to the complexity of patients in high

secure it may take patients longer to be discharged compared to this in low secure. A lower secure environment may have more frequent patient admissions this would mitigate against creating a stable ward climate, so climate would consequently be less influential. It could also be due to the greater complexity of the patients detained in high secure in comparison to low secure. Higher secure patients will present with higher risk due to instability in their mental health. It could be suggested that it is the patient characteristics that are shown to impact on patient aggression and staff burnout rather than ward climate. This is consistent with Dickens et al. (2014) who found psychosis and personality disorder to be two diagnoses that correlated to EssenCES scores.

There was a consistent finding across studies that staff scored the Therapeutic Hold domain higher than patients on the EssenCES. This suggests that staff and patients have different perceptions of how the ward operates. One reason for this may result from the difficult task staff have in forensic secure services of balancing risk management and therapeutic care. Staff may perceive they are responding to patients in a therapeutic manner, whilst patients may perceive staff behaviour to be restrictive and controlling. This is interesting as research has shown interpersonal factors such as staff using controlling or coercive behaviours are associated to high patient aggression (Ray & Subich, 1998).
A second possibility as to why there was discrepancy between patient and staff views on Therapeutic Hold is that staff may be experiencing burnout. As discussed in previous chapters, burnout impacts on staff ability to provide higher quality therapeutic care. It impacts on their behaviour and responses to patients who, in turn, may perceive staff to be less therapeutic in their approaches. Aiken et al. (2002, 2012) identified staffing inadequacy and unrealistic workloads as

important characteristics of healthcare environments that contribute to burnout development. This is important to consider as there is a widespread shortage of nurses. It is identified that hospitals rely on agency staff for the hospital to function daily, and this may also impact on the perceived therapeutic hold. The Job Demands Resource Model (Bakker & Demenouti, 2007) stipulates that burnout occurs when job demands are high and job resource is low. From the interviews conducted in chapter four staff in forensic community homes identified the impact high agency reliance has on staff culture. Participants reflected that it is difficult to develop a positive, consistent staff culture when the staff team often contains a high proportion of temporary agency personnel. Specific to the area of forensic settings, it is crucial to respond to clients in a consistent manner to manage risk and ascertain boundaries, this becomes more challenging if there is a high staff turn- over. Within the Culture of Care barometer (Rafferty et al., 2017) it indicates available staff resource, time and development of employees are vital to attain the optimum care culture.

The systematic review found a correlation between job satisfaction and nursing staff receiving supervision that they experienced as supportive. This is an important finding, as forensic services are expected to support patients who present with challenging behaviours. Staff will always be exposed to managing difficult situations. Therefore, forensic services should be aware that providing staff with good quality supervision will increase nurses' job satisfaction. Authentic leadership and structural empowerment have been shown to reduce early career burnout amongst nurses (Boamah et al., 2016). This was reflected in the thematic analysis in chapter four. Participants reflected on the importance of working in an organisation with clear leadership and access to managers who

can provide good quality support. Within the CQC Quality of Life Tool (2021) it is identified authentic leadership, staff skill set, and training are vital components of providing high quality care.

Some of the studies in the systematic review reported behavioural data across a two-week period. It was highlighted in the chapter that this is a relatively short time period and would not truly encapsulate behaviours. Changes on a ward can have immediate impacts on the patient dynamics and aggression displayed. Changes such as new admissions or staff leaving can imminently impact the incidents involving patients. This was corroborated in the findings from chapter four, where participants reflected on the influence client dynamics can have on community homes and the impact clients can have on each other's rehabilitation. Participants identified staff resources such as staff skill, and low use of agency to impact positively on staff culture and the functioning of the home. Further studies into social climate would benefit from deploying longitudinal research designs, it is more likely causality would be established.

The remaining chapters focused on the development of the CAST, the purpose of developing this tool was to enable future organisational development research to be undertaken in forensic community homes. Chapter three provides a detailed description of the methodological considerations of the tool development. It discusses the rationale behind the approaches undertaken in studies one and two. The thesis aimed to develop a tool that could measure staff culture in forensic community homes. The research studies are focused on each stage of tool development and there is relevant rationale regarding the approaches undertaken. The items of the tool were developed on current research studies

and through the semi-structured interviews with members of the MDT in community homes. These were collated to inform the domains and subdomains of the tool. The subsequent research focused on ascertaining item validity. Items were reduced from 129 to 86. The subdomains were reduced from 12 to 11, whilst the domains remained at four.

The research informing the CAST identified four components of culture within forensic community homes (chapter four). The components were the organisation, the home manager, the care team, and risk management. The findings reflect that for a staff team to have a strong clear culture they are required to have guidance from the organisation. This is consistent with previous findings that highlight the influences organisations have on culture (Taylor, 2005). This is also replicated within the Care of Culture Barometer (Rafferty et al., 2017) it is recognised visible leadership, good organisational communication and staff feeling valued and cared for increase the culture of care. If staff are led by an organisation who demonstrates values-based leadership, it builds a more distinct culture among the team. This is important as small cliques within a team suggests that there are informal leaders within the team (Tsai, 2011). This dilutes the consistency of care clients would receive from staff.

Regarding the house manager domain, research has shown the importance of staff being led by a manager who is supportive and caring (Tsai, 2011). As discussed in chapter five, line managers have been shown to be more influential on employees' perception of culture compared to the wider organisation's management (Block, 2003). Line managers in forensic settings are expected to provide staff with supervision and, as shown in Berry and Robinson's (2019)

study within the systematic review, effective clinical supervision can reduce levels of burnout and stress.

In relation to the care team domain on the CAST, research has found that staff perceptions of their role and their working practices impact on the culture of the home (Bigby et al., 2012). This highlights the impact the care team could potentially have on the overall culture. Throughout many of the studies and models discussed in this thesis there are links made between the care team, high agency use, client aggression, lack of team cohesion and burnout (Turnbull & Patterson, 1999; Berry & Robinson, 2019; Totman et al., 2011). The Care of Culture Barometer (Rafferty et al., 2017) stipulates the importance of the care team feeling valued, feeling respected and feeling cared for. Their perceptions of this will impact on the care delivered to clients.

Lastly, risk management was the final domain found to be influential on staff culture. It is imperative that there is effective communication from all members of the MDT. Studies have shown how communication is imperative to risk management (Arora, 2005). This domain also referenced the importance of ensuring appropriate risk assessments were in place and were reviewed accordingly.

Limitations

At the end of each chapter limitations were discussed. However, in order to interpret the findings of the thesis into context an overview will be discussed. For chapter two which presented the systematic review it was acknowledged that it was difficult to fully compare and contrast findings due to the heterogeneity of

the approaches. Some of the studies found that patient characteristics were significant for the EssenCES scores. It was also noted that the level of ward security influenced scores. Some of the studies included a range of different security levels, they combined patients with differing diagnoses and utilised diverse methodological approaches to measure patient aggression. The studies included may have been subject to publication bias. Studies that were not in the English language were not included. Unpublished studies were also excluded due to concerns that they would not have gone through peer review, and the quality of the research would not have been established. Although, in the event, during the searches no such studies were identified.

Regarding the research undertaken in studies one and two (chapters four and five, respectively), both projects used purposive sampling as the recruitment method. It is acknowledged that the selection was not random. Participants were selected on specific characteristics. This is a widely used approach in qualitative research for the identification of information-rich participants in relation to the phenomenon of interest (Palinkas, 2016). It involves as discussed selecting individuals that are especially knowledgeable or experienced in the topic of interest (Creswell & Plano Clark, 2011), so thus was the most appropriate approach for the studies.

Unlike quantitative studies which have clear guidelines about the desired number of participants, qualitative studies do not. The principles of qualitative approaches suggest data saturation should inform participant recruitment. This means no further participants should be recruited once there are no new themes or insights emerging (Bryman, 2001). However, this requires the researcher to

combine the steps of sampling, data collection, and analysis, in comparison to treating them as individual stages of a linear process (Bryman, 2012).

There is a further limitation to the research. The quality of the homes involved in study one was not known to the researcher. It would be a weakness in the research if all of the homes were of poor quality. Gaining views from staff in a mix of homes including good quality homes would provide different perceptions. This would increase the likelihood that all components of culture have been identified. If this study was undertaken again it would be suggested that the researcher had an understanding of the quality of the homes involved. This could ensure that a range of qualities would be included. However, when undertaking the research, the unknown quality of the homes enabled the researcher to perform the initial exploratory work without any prior assumptions. Possibly if the researcher knew the quality of the homes prior to interview this could have introduced an element of researcher bias.

Study one (chapter four) explored MDT staff perspectives of working in forensic community homes, whilst one of the foci of study two (chapter five) was to facilitate cognitive interviews with a sample of the target population. Both participant samples were recruited from the organisation they work in. There is a potential limitation within this method of recruitment. Social desirability bias with the participants providing the answers they believe the researcher was looking for is another potential limitation of the thesis. Additionally, there may have been additional anxiety that they were discussing processes and experiences that are related to their place of work. Assurance regarding confidentiality was given at several points of the recruitment process, however it

is not known to what extent this reassured them. There is also the potential limitation of how comfortable participants felt discussing their work experiences within study one, or how confident they felt to express item ambiguity in study two. The importance of building a rapport is considered to reduce anxiety, and assurance confidentiality will be maintained, as well as the assurance there is no right or wrong answer.

The CAST has been developed to measure staff culture in forensic community homes. It is acknowledged that homes with a closed, toxic culture have been linked to abusive practice. The tool developed is a self-report measure. It relies on respondents to be self-aware and honest when answering the items. Due to the sensitive nature of the topic, it could be suggested that those homes who are at risk of practising within a closed culture, may not answer truthfully. Therefore, it would be recommended that the tool is only used as an additional guide alongside current measures that are in place to mitigate such cultures.

Lastly, Version 3 of the CAST is comprised of 86 items. It is acknowledged that this is a large number of items. Additional item reduction may be required. This would further ensure the tool is user friendly and reduce respondent fatigue whilst scoring the measure.

Implications and future directions

Despite the limitations this thesis provides insight into how ward climate impacts patient aggression and staff burnout. This is essential as working with mentally ill offenders is challenging for staff, and it is also vital to understand the role of the ward climate to ensure staff have the appropriate support.

The results from the systematic review highlight the importance of measuring organisational factors such as ward climate in secure settings. Regarding clinical implications, it is important that MDTs have an awareness of how the environment impacts upon patient behaviour, especially aggression. Measuring climate would enable MDTs to assess whether environmental factors are contributing to residents aggression and they can then act accordingly. Using measures like the EssenCES this will provide organisations with further insight into these factors.

The studies found that ward climate was linked to patient outcomes. This highlights the importance of forensic secure services having an awareness of their organisational factors on patient rehabilitation. They should make attempts to monitor and improve the ward climate. There should be a process to ensure there is frequent evaluation of the ward climate. This can be used to inform an evidence base of what contributes to a positive climate in forensic hospitals. The EssenCES could also be used to support patients to have a voice to discuss how the climate of the ward can be improved. Collaborative working with patients is an importance aspect of patient rehabilitation. The thesis has shown how the EssenCES has been used to provide an evidence base of the influence of organisational factors. The CAST could be used on the same premise in the future, in community settings.

The CAST was developed to enable culture to be quantified in forensic community settings for organisational development. As discussed, the tool is in the initial stages. Through wider use and testing, reliability of the items can be

established, which will add further strength to the properties of the tool. The CAST's implications for applied practice include the possibility for organisations to quantify the staff culture in their staff teams in forensic community homes. It will provide organisations with the opportunity to identify areas of culture that require further development. The tool will provide organisations with insight into the strengths of the team. The tool has distinct domains: the organisation, the house manager, the care team, and risk management. From the respondents it will provide insight into where problems may lie. This will enable organisations to understand which specific areas need to be targeted to strengthen the culture within the team. Homes that are identified to have a strong positive culture across all areas can be used to model practice and processes for homes that are underperforming and have been identified as having a weak, negative culture.

From the investigations into homes that have abusive practice, toxic culture has been identified as a factor perpetuating the abusive practice. The CAST could also act as a preliminary tool to identify concerns of staff culture in forensic community homes. It may provide organisations with the opportunity to identify homes that are at risk of developing abusive practice and intervene. As discussed in the methodology chapter, the CQC has outlined a list of 'red flags' for inspectors to be aware of. The CAST could provide inspectors with additional insight into the culture of the home. If the tool is administered quarterly, the scores could be summed and plotted to display a quantitative measure of culture in the home. The same approach could be followed for the requirement of community homes needing to show inspectors client care plans or behavioural incident data, so they could also be required to provide staff-reported scores of team culture on the CAST.

As discussed in the systematic review, studies have explored the relationship between climate, patient aggression, staff burnout, amongst other variables. Once the CAST is fully established, similar studies can be undertaken in community homes. They could explore the relationship between staff culture, beliefs regarding client behaviour or attitudes towards behaviour support plans. The CAST could also be used from an organisational development perspective. The scores on the measure could be used to track the impact of organisational development action plans. Again, this could be followed up by research studies that explore staff culture and organisational development.

Conclusion

This research thesis aimed to explore organisational factors in secure settings. Firstly, it explored the impact of ward climate on staff and patient outcomes. It was acknowledged that exploration of organisational factors has predominantly focused on climate and less so on culture. Therefore, the thesis aimed to develop a measure that could be used to quantify staff culture in forensic community homes. This thesis presents the development of the CAST, the first available measure of staff climate for forensic community settings. It is hoped this can developed further, and future research can explore the relationship between culture and staff and patient outcomes.

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Appendices

Appendix A Quality Assessment Form Systematic Review

Criterion	Yes (2)	Partly (1)	No (0)	Unsure (0)	Comments
1.Did the study address a clear focused issue? Consider: Was a clear background/ rationale for the study given? Were aims and objectives clearly stated? Was the population studied made clear?					
2a. Were participants recruited in an acceptable way? Consider: The eligibility criteria Sources and methods of selection of participants **(b) Is there a clear description of the participant sample?** Consider: Distribution of demographic/ background (age, gender, SES, ethnicity) Number of participants given at each stage of the study Reasons for any non- participants at each stage The number of participants with missing data					
3. Were the data collected in a clear manner? Consider: Are the methods of data gathering clearly explained? Are justifications given for the data collection methods? Do these methods address the research issue?					

4. Was an appropriate assessment measure used? Consider: Was the measure used relevant to the area being examined? Was the measure standardised? Was the reliability/ validity of the measure discussed? Was the outcome assessed the same way across the sample?					
5. Was the data analysis sufficiently rigorous? Consider: Are sufficient data presented to support the findings? Was the analysis sufficiently in-depth? Are appropriate statistical tests used?					
6. Are the results presented clearly? Consider: Size of the p-value and confidence intervals Whether results have been adjusted to take account of any confounding variables					
7. Is there a clear statement of findings? Consider: If the findings are explained clearly? Discussion of the credibility of the findings. Discussion of any limitations of the study. Have any potentially confounding variables been discussed? If the findings are discussed in relations to the original aim and objectives of the study.					
8. How valuable is the research? Consider: If the researchers have discussed whether/ or how the findings can be transferred to other populations, or considered other ways the research may be used					

Appendix B Data extraction grid

Study details	
Title	
Author(s)	
Year	
Country of study	
Specific Information	
Aims and objectives of the study	
Methodology	
Design	
Measures used for patients and staff outcomes	
Standardisation, reliability and validity of outcome measures	
Participant and hospital information	
Number of participants: staff and patient	
Hospital security level	
Study results	
Study findings	
Study limitations	
Conclusion	
Quality assessment score	

Appendix C Interview question schedule

Firstly, I would like to thank-you for taking part in the research today, especially in the current climate when everyone is experiencing increased feelings of stress and anxiety. The questions are designed to explore what culture is in community forensic homes. There are 14 questions in total, the interview is not expected to last longer than 1 hour. You were contacted in regards to the study as you work/ provide in-put in to such a home. Therefore, the aim of the interview is to try and capture your experience of working in the home.

If you want to stop the interview at any time, please just state this, you do not need to provide a reason why and there will be no negative consequence in doing so. The interview will be audio recorded and I will make you aware of when I begin to record. The interview will be stored on One Drive. Once I have transcribed the interview your voice will be distorted on the recording, so it is not recognisable. When the research is written, you will be given a pseudonym name.

You have two weeks post interview to withdraw your input from the study. You would need to provide your participant number that you will be given at the end of the study. This will be outlined in the debrief form that you will be emailed after the interview.

The interview is not designed to cause upset or distress. However, if you experience this and I am not aware, please inform me and we can terminate or pause the interview.

If you report something that is a cause of concern, I am duty bound to report this accordingly. I would make you aware that I would need to report this information before doing so. Do you have any questions?

I am turning on the audio recording and will begin with the first question.

1. What do you think makes an effective staff team in a forensic community home?

2. What do you think are important values for a forensic community home to have?

3. How would you describe the leadership within the organisation and the community home?

What do you think makes effective leadership in a forensic community home?

4. How do senior management work with the home? What impact does senior management have in regards to the culture of forensic community homes?

5. What makes an effective house manager? How do they impact on staff culture?

6. What makes an effective support worker in a forensic community home? How do they impact on staff culture?

7. What makes an effective clinician in a forensic community home? How do they impact on staff culture?

8. What do you think makes a community forensic home successful?

9. What do you think the staff culture is in the home you work in? What components is the culture comprised of?

10. When interacting with clients, what is important to be mindful of? As a staff team what views are held in regards to the clients in the home?

11. How do staff provide residents with support? What do you think are the important elements of staff practice? What factors would you identify within staff working practices that assist rehabilitation of individuals?

12. How would you describe the influence of staff attitude on resident's behaviour?

13. What would you describe as being some of the challenges of working within a forensic community home?

14. What are the rewards of working within a forensic community home?

15. What factors do you believe impact on the functioning of the home?

16. Do you wish to make any other comments in regards to staff culture and the functioning and success of a forensic community home?

Appendix D Participant information sheet study one

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The study aims to explore what staff perspectives of culture are in forensic community homes. This will be achieved by interviewing staff members from a multi-disciplinary teams. The data from this study will inform subsequent research which aims to develop a tool that can measure staff culture in forensic community homes. This is important as staff culture can impact upon a service user's recovery.

Why have I been invited to take part?

You have been invited to take part in this research because you are part of a multi-disciplinary team that work with a forensic community home.

The inclusion criteria is you will be working in a forensic community home within XX Healthcare. Staff will be on a permanent contract and over the age of 18. Staff will have worked in the organisation for at least 1 year.

We will be recruiting 6 to 10 participants in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. If you agree to participate, you will need to contact the researcher on the email address below. You will be emailed a consent form that you will be required to sign before the interview will be undertaken. You will need to email the researcher a signed copy and you can keep a copy for yourself.

However, you would still be free to withdraw from the interview at any time, without giving a reason and without any negative consequences, by advising the researchers of this decision. This would not affect your legal rights. You have up to two weeks after your interview to withdraw your data from the study. You would need to contact the researcher and provide them with your participant number, which will be allocated to you following interview.

1. What will happen to me if I take part?

If you are interested in partaking in the research, please contact the researcher on the email address below. You will be given the opportunity to discuss the research over phone call or through email. If you decide you would like to have an interview you will be sent a consent form, this needs to be signed and emailed back to the researcher before the interview.

At a time convenient to you an interview will be arranged. This will be in the format of a video call using Microsoft Teams software. The researcher will be by themselves when conducting the interview. You would also be requested to be by yourself during the interview for confidentiality purposes. You would be advised to place 'do not disturb' sign on the door whilst completing the interview.

The interview will involve answering questions that are based around your experiences and opinions of working within a forensic community home. Your answers will provide information on aspects of staff culture. The interview should take no longer than 1 hour.

Following the interview, you will be emailed a debrief form outlining the study procedures. On the form will be information on how to withdraw your data from the study if you wish to do so. You do not need to provide a reason for this and there will be no negative consequences. You will be required to state your participant number to withdraw your data.

2. Are there any risks in taking part?

There is minimal risk.

3. Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research but your contribution may help increase the knowledge base on staff culture in forensic community homes.

4. Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study. You will not be required to travel as the interview will be undertaken through video call at your place of work.

5. What happens to the data provided?

The research data will be stored confidentially onto the University of Nottingham's One Drive. To help ensure your privacy, you will be assigned a volunteer study identification number, and it will be used instead of your name.

Your name and any information about you will not be disclosed outside the study centre. Your audio recording will be distorted so you are not recognisable by voice. You will be allocated a pseudonym so you are not identifiable in the research write up.

Personal data will be stored confidentially using the University of Nottingham's One Drive. The only personal data collected will be your signed consent form. This will be protected so only the researcher will have access to this.

The student researcher and the research team will have access to research data.

We would like your permission to use fully anonymised direct quotes in research publications.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

6. What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study up to two weeks post interview, without giving any reason and without your legal rights being affected. Any personal data will be destroyed.

If you choose to withdraw your data not used within the research write up and it will be destroyed.

7. Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. Any audio digital recordings and electronic data will be anonymised as discussed. Storage devices will be encrypted while transferring and saving of all sensitive data generated in the course of the research. All such data are kept on password-protected databases sitting on a restricted access computer system.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

Anything you say during an interview will be kept confidential, unless you reveal something of concern that may put yourself or anyone else at risk. It will then be necessary to report to the appropriate persons.

8. What will happen to the results of the research?

The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be written up as dissertation for the degree of Doctorate in Forensic Psychology.

9. Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 42-0620).

10. Who is organising and funding the research?

The research is being organised through the University of Nottingham and XX Healthcare.

11. What if there is a problem?

If you have a concern about any aspect of this project, please speak to the researcher (Rachel Isgar) or the Chief Investigator's (Dr XXX and Dr XXXX) who will do their best to answer your query. The researcher should acknowledge your concern and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

12. Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Rachel Isgar

Student Researcher

Doctorate Forensic Psychology

Email: Rachel.isgar@nottingham.ac.uk

Dr XXX University of Nottingham,

Yang Fujia Building, Jubilee Campus, Nottingham,

NG7 2TU.

Email: XXX

Dr XXXX Consultant Forensic and Clinical Psychologist.

Email: XXXX

Appendix E Study one evidence of ethical approval

University of Nottingham
UK | CHINA | MALAYSIA

Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH
Email: FMHS-ResearchEthics@nottingham.ac.uk

02 July 2020

Rachel Isgar
Top Up Doctorate Forensic Psychology Student
c/o Dr Shihning Chou
Associate Professor/Director Doctorate in Forensic Psychology
Forensic and Family Psychology Centre
Psychiatry and Applied Psychology
Yang Fujia Building, Jubilee Campus
University of Nottingham
Wollaton Road, Nottingham
NG7 2TU

Dear Ms Isgar

Ethics Reference No: FMHS 42-0620 **– please always quote**	
Study Title: Exploring staff perspective of culture with forensic community homes.	
Chief Investigator/Supervisor: Dr Shihning Chou, Associate Professor, School of Medicine	
Lead Investigators/student: Rachel Igar, Top Up Doctorate Forensic Psychology Student	
Other Key investigators: Dr Andrew Hider, Clinical Director, Consultant Forensic and Clinical Psychologist, Ludlow Street Healthcare, Cardiff	
Proposed Start Date: 01.07.2020	**Proposed End Date:** 31.12.2020

Thank you for submitting the above application which was considered at the Committee meeting on 12 June 2020 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 24.05.2020

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Bethan E Phillips, Associate Professor
Clinical, Metabolic & Molecular Physiology, Medical Sciences & Graduate Entry Medicine
Acting Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix F Study one consent form

Title of Study: Exploring staff perspective of culture within forensic community homes.

REC ref: (FMHS 42-0620).)

Name of Researchers:

Chief Academic/Supervisor: Dr XXX, University of Nottingham, Yang Fujia Building, Jubilee Campus, Nottingham, NG7 2TU.

Other key researchers/collaborators: Dr XXXX, Clinical Director, Consultant Forensic and Clinical Psychologist. XX Healthcare,

Students name and course: Rachel Isgar, Forensic Psychology Top Up DForenPsy. Rachel.isgar@nottingham.ac.uk

Name of Participant:

1. I confirm that I have read and understand the information sheet version number 1 dated 01.05.20 for the above study which is attached and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview, without giving any reason and without disadvantage. ☐

3. I understand that I can withdraw my interview data up to two weeks following my interview. I am aware I will be required to state my participant number that I will be allocated on completion of the interview. ☐

4. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

☐

5. I understand that the interview will be audio recorded using a digital device and that anonymous direct quotes from the interview may be used in the study reports.

6. I understand that information about me recorded during the study will be made anonymous before it is stored. It will be uploaded into a secure database on a computer kept in a secure place. Data will be kept for 7 years after the study has ended and then destroyed. ☐

7. I understand that what I say during the interview will be kept confidential unless I reveal something of concern that may put myself or someone else at any risk. It will then be necessary to report this to the appropriate persons. ☐

8. I agree to take part in the above study. ☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

Appendix G Study one debrief form

Thank you for taking part in this study.

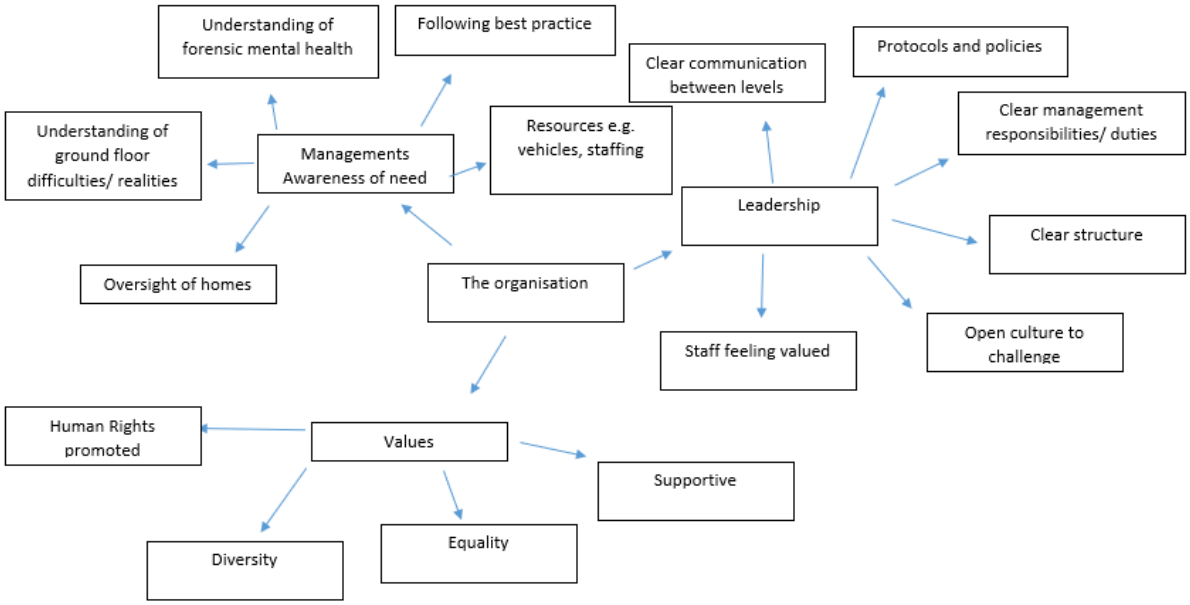
The research is exploring components of staffing culture in forensic community homes. The information collated through staff interviews along with published literature will subsequently inform the development of a psychometric tool that aims to measure staff culture in forensic community homes.

When partaking in the research you were not asked to provide your name and can be assured that the confidentiality of your identity will be maintained, and information will be stored securely. Data will be safely stored for seven years and then it will be destroyed.

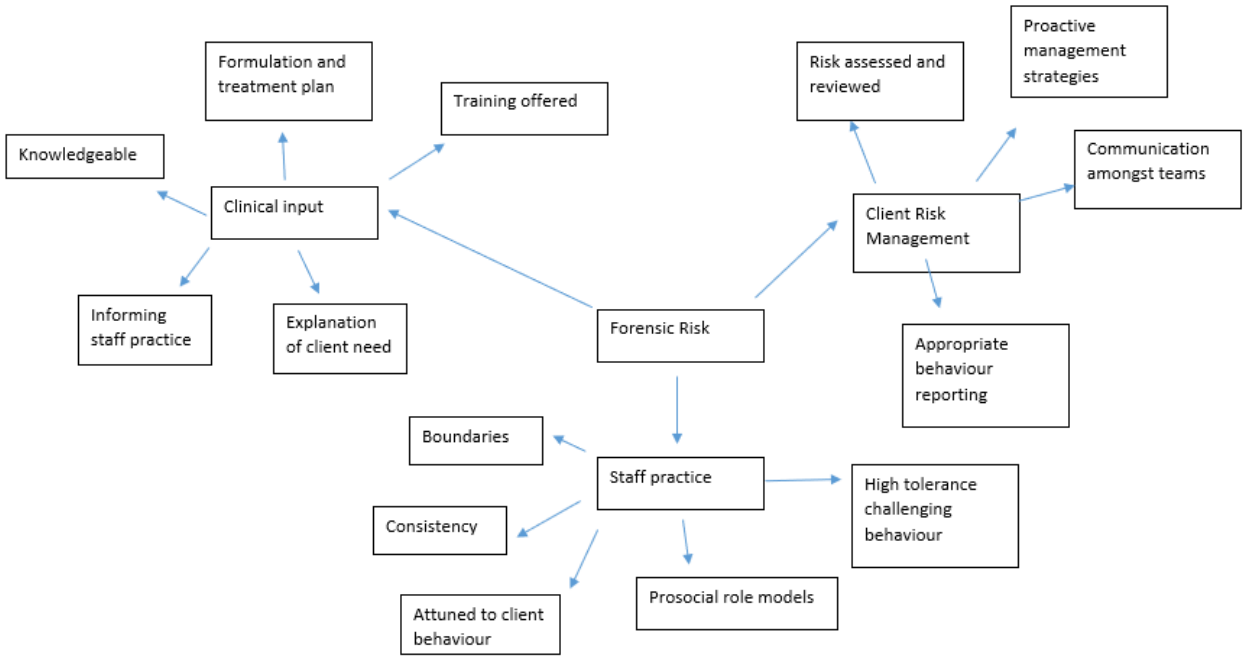
You have the right to withdraw from the study up to two weeks after completion, you do not need to provide a reason for withdrawal. In addition, there will be no negative consequences following withdrawal. If you wish to withdraw please contact the researcher through email: Rachel.isgar@nottingham.ac.uk and provide your participation number. Furthermore, if you have any questions please contact the researcher through the aforementioned details.

Appendix H Procedure to develop initial item list

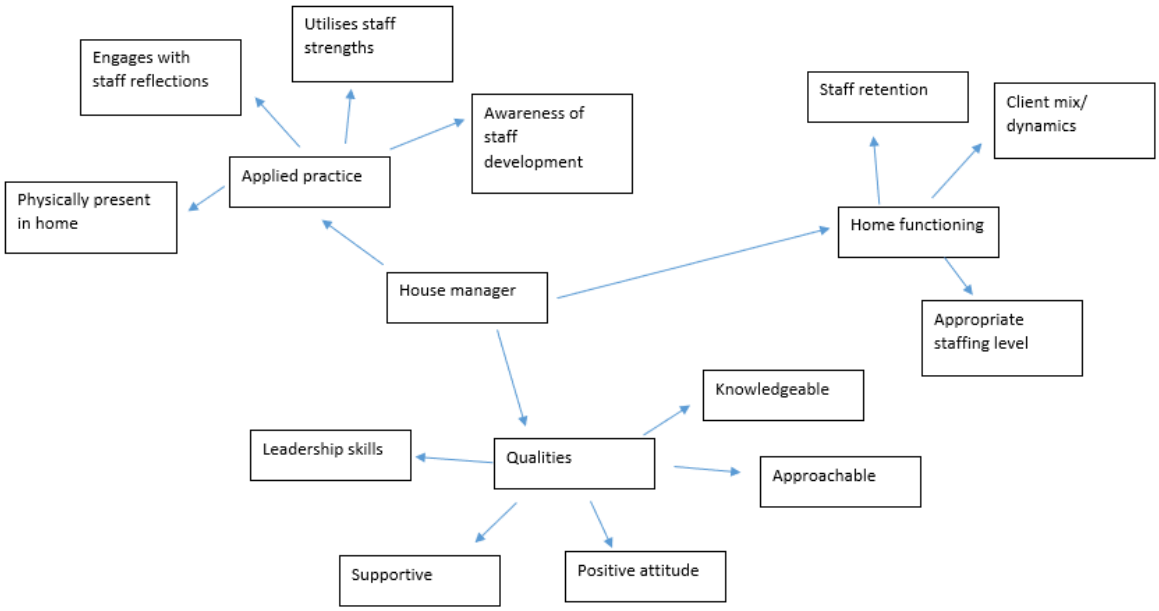
Chapter four presents the research methods used to inform the construct of culture. Each interview was transcribed and coded. The codes were grouped to identify themes and sub-themes within the data set, each theme was mapped. The theme maps below display the construct areas that had been informed by the interviews which directly informed the item development. To inform the wording of items, the initial codes within the data set were referred to and some direct quotes were used within the items. Research that had been undertaken on culture was also used to inform item development. Please see below for each theme map.



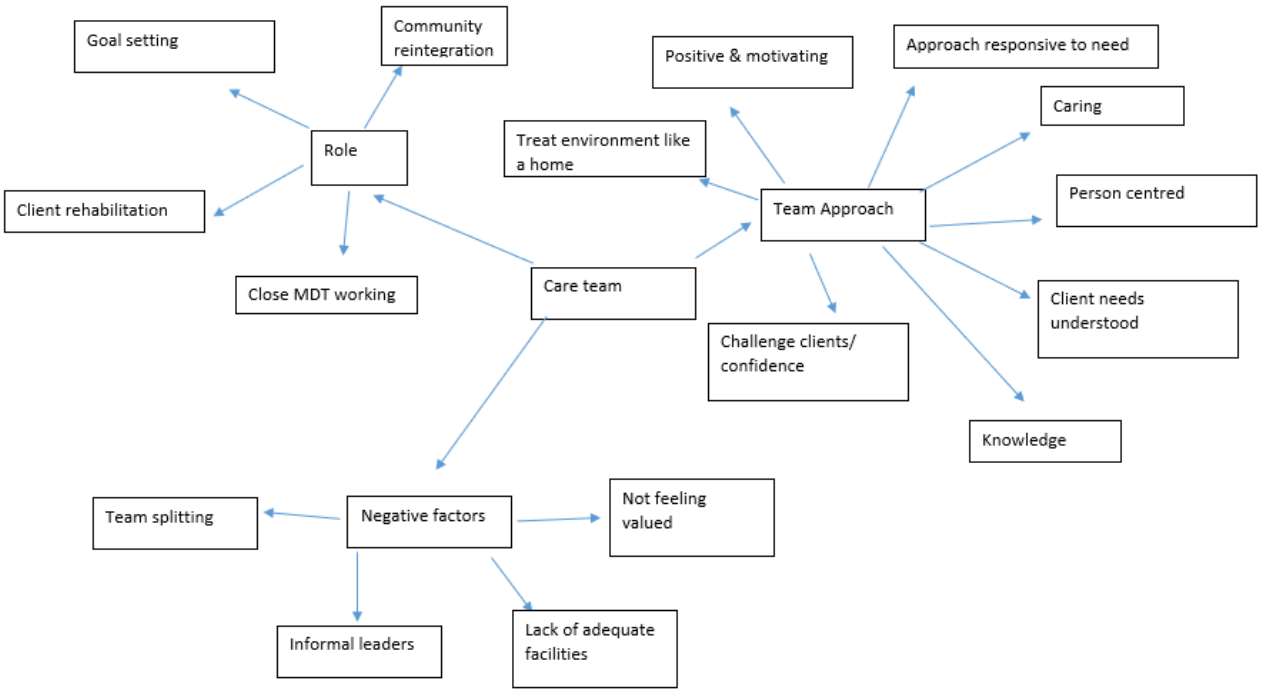
Theme map of 'The Organisation'



Theme map of 'Forensic Risk'



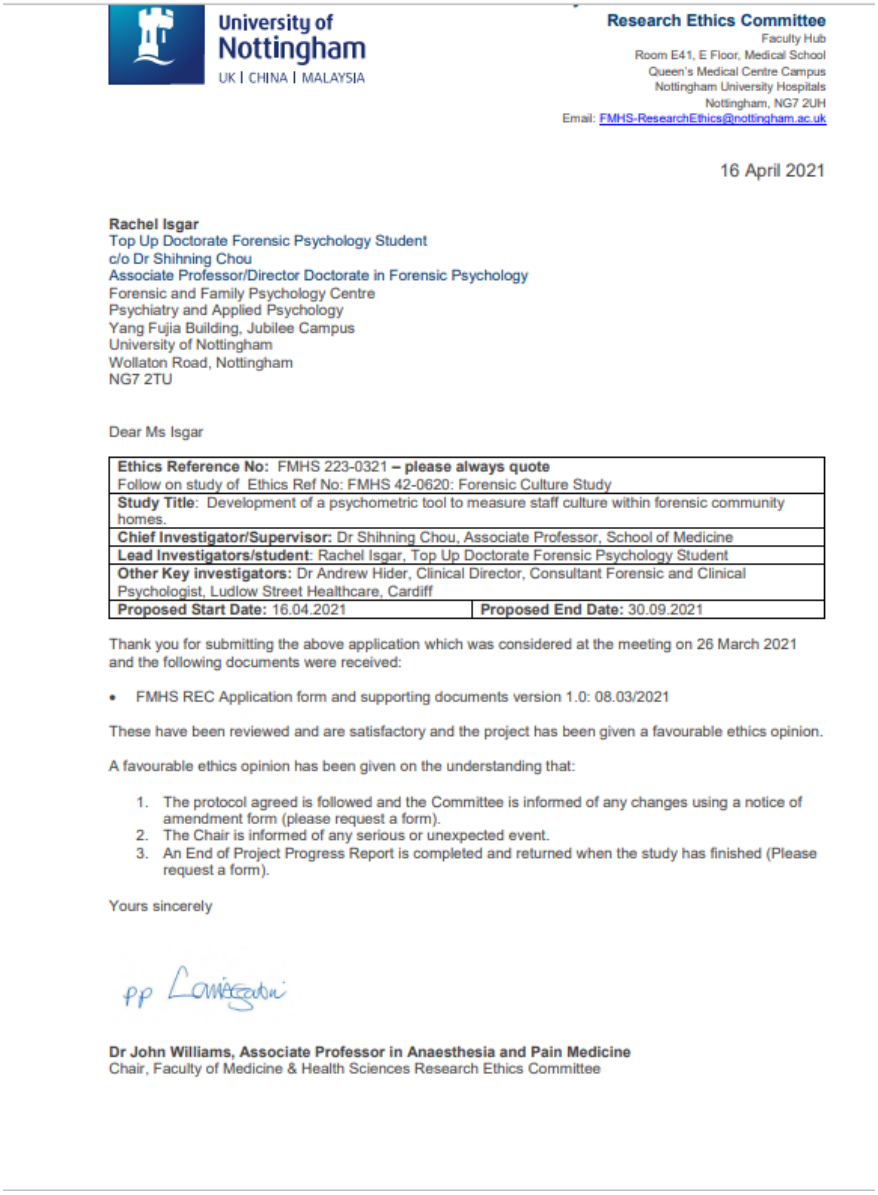
Theme map of 'House Manager'



Theme map of 'Care Team'

Items were developed to ensure a spectrum of positive and negative aspects within the construct had been measured. The initial tool included 129 items. Writing more items than is required enables the researcher and expert panel to identify the items with the highest validity and clarity (Saville & MacIver, 2017). To further ensure that the items fully measured the construct, experts were asked to comment on whether they thought there were any areas not covered. Participants were also asked during the cognitive interviews to comment if they thought there were any missing items or areas not covered. No further items were suggested by the experts or by participants completing the cognitive interviews.

Appendix I Study two evidence of ethical approval



University of Nottingham
UK | CHINA | MALAYSIA

Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH
Email: FMHS-ResearchEthics@nottingham.ac.uk

16 April 2021

Rachel Isgar
Top Up Doctorate Forensic Psychology Student
c/o Dr Shihning Chou
Associate Professor/Director Doctorate in Forensic Psychology
Forensic and Family Psychology Centre
Psychiatry and Applied Psychology
Yang Fujia Building, Jubilee Campus
University of Nottingham
Wollaton Road, Nottingham
NG7 2TU

Dear Ms Isgar

Ethics Reference No: FMHS 223-0321 **– please always quote** Follow on study of Ethics Ref No: FMHS 42-0620: Forensic Culture Study	
Study Title: Development of a psychometric tool to measure staff culture within forensic community homes.	
Chief Investigator/Supervisor: Dr Shihning Chou, Associate Professor, School of Medicine	
Lead Investigators/student: Rachel Isgar, Top Up Doctorate Forensic Psychology Student	
Other Key investigators: Dr Andrew Hider, Clinical Director, Consultant Forensic and Clinical Psychologist, Ludlow Street Healthcare, Cardiff	
Proposed Start Date: 16.04.2021	**Proposed End Date:** 30.09.2021

Thank you for submitting the above application which was considered at the meeting on 26 March 2021 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.0: 08.03/2021

These have been reviewed and are satisfactory and the project has been given a favourable ethics opinion.

A favourable ethics opinion has been given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

pp

Dr John Williams, Associate Professor in Anaesthesia and Pain Medicine
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix J Study two expert participant information sheet

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this carefully and discuss it with others if you wish. Ask us anything that is not clear.

What is the purpose of the research?

The study aims to develop a psychometric tool that measures staff culture in forensic community homes. The first stage of the study was focused on exploring staff perspectives of culture in forensic community homes. This was achieved by interviewing staff members from a multi-disciplinary team. The data from that study along with current research in the field has informed items on the psychometric tool.

The purpose of this stage of research is to ascertain content and face validity of the items on the tool.

From research we understand that staff culture impacts on many factors including a service user's rehabilitation. It would be of benefit to have a psychometric tool that can measure staff culture in forensic community homes.

Why have I been invited to take part?

You have been invited to take part in this research because you are classified as an expert in the field. This is because you are either directly involved with supporting forensic community homes and/ or you are an academic in the field.

We will be recruiting three to eight participants in this study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. If you agree to participate, you will need to contact the researcher on the email address below. You will be emailed a consent form that you will be required to sign before you will be sent the psychometric tool. You will need to email the researcher a signed copy and you can keep a copy for yourself.

However, you would still be free to withdraw from the study, without giving a reason and without any negative consequences, by advising the researchers of this decision. This would not affect your legal rights. You have up to two weeks after you have return the psychometric tool back to the researcher to withdraw your data from the study. You would need to contact the researcher and provide

them with your participant number, which will be allocated to you following your in-put.

What will happen to me if I take part?

If you are interested in partaking in the research, contact the researcher on the email address below. You will be given the opportunity to discuss the research over phone call or through email. If you decide you would like to partake you will be sent a consent form, this needs to be signed and emailed back to the researcher.

The researcher will send you an electronic copy of the psychometric tool. There will be clear instructions attached. You will be asked to firstly rate the relevance of the items to the field of staff culture in forensic community homes. You will be asked to rate this on a four point Likert scale. Secondly, you will be asked to rate the clarity of the wording of the item. Once you have completed this you will be asked to email back the completed measure to the researcher

Your scoring will firstly determine whether items need to be eliminated from the psychometric tool if experts deem it not to be relevant to the topic. Secondly, the wording of the item will be amended if expert deem it to be ambiguous and lack clarity.

Following the return of the measure you will be emailed a debrief form outlining the study procedures. On the form will be provided with information on how to withdraw your data from the study if you wish to do so. You do not need to provide a reason for this and there will be no negative consequences. You will be required to state your participant number to withdraw your data.

Are there any risks in taking part?

There are no identified risks in you taking part in this study.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research but your contribution will help the development of a psychometric tool that measures staff culture. This could be used to identify strengths and areas of improvement in the culture of forensic community homes.

Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study.

What happens to the data provided?

The research data will be stored confidentially onto the University of Nottingham's One Drive. To help ensure your privacy, you will be assigned a participant identification number, which will be assigned to the psychometric tool you return. Your name and any information about you will not be disclosed outside the study centre.

Personal data will be stored confidentially using the University of Nottingham's One Drive. The only personal data collected will be your signed consent form. This will be protected so only the researcher will have access to this.

The student researcher and the research team will have access to research data.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study up to two weeks after returning the completed psychometric, without giving any reason and without your legal rights being affected. Any personal data will be destroyed.

If you choose to withdraw your data will not be used within the research and it will be destroyed.

The researcher will have an awareness of who you are as they will have created the participant number, however, you can be reassured that there would be no negative consequences from withdrawing.

Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. All such data is kept on password-protected databases sitting on a restricted access computer system.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

What will happen to the results of the research?

The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be written up as dissertation for the degree of Doctorate in Forensic Psychology.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS 223-0321).

Who is organising and funding the research?

The research is being organised through the University of Nottingham and XX Healthcare.

What if there is a problem?

If you have a concern about any aspect of this project, please speak to the researcher (Rachel Isgar) or the Chief Investigator's (Dr XXX and Dr XX) who will do their best to answer your query. The researcher should acknowledge your concern and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

1. Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Rachel Isgar

Student Researcher

Doctorate Forensic Psychology

Email: Rachel.isgar@nottingham.ac.uk

Dr XX, School of Medicine, University of Nottingham,

Dr XXX Healthcare

Appendix K CAST Version 1

Expert tool instructions

Tool instructions

Thank-you for taking the time to participate in this research. Below are the preliminary items that have been generated for the psychometric tool that is aimed at measuring staff culture in forensic community homes. The items have been informed from interviews with participants who work in or professionally support forensic community homes. The items have also been informed by current research in the field.

Before this tool can be used in practice it needs to be validated. As an expert you are being asked to score the content validity of the item and the face validity.

Please rate the relevance of the item to the construct on culture by scoring it one of the following;

1= not relevant, 2= somewhat relevant, 3= quite relevant or 4= highly

Theoretical definition of the culture: *Organisational culture can be comprised as the philosophy and shared beliefs among staff. It impacts upon staff attitude, motivation, goals and behaviours. It defines who the staff team are as a collective and maintains boundaries of socially acceptable behaviour.*

Please rate the clarity of the item by scoring it one of the following;

1=item does not make sense, 2= item needs major revisions, 3= item needs minor revisions to be clear, 4= item is clear

If you wish to expand upon your scoring there has been a space provided under each item. If you have rated an item as not clear or needing major revisions and you have a suggestion for improved phrasing please write it in the comments section.

Measure of Staff Culture in Forensic Homes

1. **The Organisation**

This domain is measuring the organisation's influence on culture within the community home you work in. It focuses on the senior management's awareness of what the home needs to provide good quality care. Senior management's leadership and the values that are promoted within the organisation.

Management's awareness of need

1. **Senior management are aware of the needs of the home**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **Senior management are supportive of the homes need**

Relevance score: ___ /4 Clarity score: ___/4

3. Additional comments ……

4. **Senior management understand the general challenges we face in the home**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **Senior management understand the current demands on the home**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **Senior management are responsive to the needs of the home (e.g. they provide support and resource to manage challenges)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Leadership

1. **There is a clear management structure within the organisation**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **I am aware of who I need to speak to if I have a problem**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **Management communicate effectively across the organisation**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **There are policies in place that support me in work**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **If I needed a specific policy I would know where to find it**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **If a policy is changed, management communicate the reason for this**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **If a policy is changed, management support us as a team to make the required changes**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **I feel valued by the organisation**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Values

1. **The organisation promotes diversity within the staff team (e.g. promoting people's different cultures, backgrounds and beliefs)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **The organisation promotes client diversity (e.g. promoting clients' different cultures, backgrounds and beliefs)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **The organisation promotes equality within the staff team (e.g. everyone has equal opportunities regardless of their background, lifestyle and ability)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **The organisation promotes client equality (e.g. supporting clients' to have access to equal opportunities)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The organisation is supportive of my individual needs**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The organisation is ethical in their approaches[1] (for example not over prioritising profit to client need, the organisations tries to do the right thing)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **I understand the organisations' values**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **As a team we promote the organisations' values**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **Forensic Risk Management**

This domain focuses on forensic risk. It will measure clinical input, client risk management and staff practice in regards to influencing clients forensic risk.

Clinical input

1. **The clinical team is approachable**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

[1] Safety and quality of care is not compromised over financial considerations

2. **The clinical team listen to us**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **The clinical team provide understandable explanations of client behaviour**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **If I didn't understand something that the clinical team recommended I would feel confident to say this**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The clinical team support us to understand client need**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The clinical team offer relevant training to support our needs**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **The clinical team don't understand the challenges we endure**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **The clinical team criticise us**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **The clinical team have realistic expectations from us as a staff team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. **The clinical team have realistic expectations from the service users**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. **I understand service user's formulations**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

12. I understand service user's treatment plans

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

<u>Client risk management</u>

1. **There is effective communication between members of the home's staff team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **There is effective communication between members the wider multidisciplinary team (psychiatrist, psychologist, social worker etc.)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **There is effective communication between members of the home staff team and the clinical team.**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **Clients' have risk assessments**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **Client risk assessments are reviewed regularly**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **We use proactive strategies to manage client risk (e.g. managing situations to prevent a crisis occurring, using clients' support plans to inform this)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **We know how to support clients who are deteriorating in terms of behaviour and/or distress**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **I feel confident in reporting client behaviour to the wider team (e.g. house manager, psychologist, psychiatrist etc.)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. I know who to report changes in client behaviour to

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. I am aware of the potential risks presented by each client

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. I am aware of the strategies used to manage each risk

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

12. As a team we have the appropriate level of experience and skill to manage client risk

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

13. As a team we follow legal restrictions for clients

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

14. **As a team we are too risk adverse to clients (e.g. reluctant to take positive risks)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Staff practice

1. **The staff team understand how to maintain a professional relationship (they compassionately communicate, not overly punitive, doesn't cross into personal relationship areas)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **The staff team are attuned to client behaviour (e.g. recognising, understanding and engaging with how clients feel)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **The staff team remain professional and compassionate when facing highly challenging behaviour**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **The staff team act as prosocial role models**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The staff team are consistent in their approach**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The staff team hold judgment regarding crimes some of the clients have committed**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **As a team we are confident to speak up if there is a problem**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **We seek support from outside the home when times get tough (e.g. communicating to management that additional support is required)**

   Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **Home Manager**

This domain refers to the house manager who is responsible for the functioning of the home. This area will measure the house managers applied practice, their qualities and how the home functions.

Practice Leadership

1. **The house manager is physically present in the home during the week**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **The house manager is aware of my developmental needs**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **The house manager is aware of the staff team's needs**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **The house manager considers my strengths when allocating tasks**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The house manager utilises the teams' strengths**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The house manager supports the team to engage in reflection**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **The house manager supports the team to develop their skills**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **The house manager understands what the clients need**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **The house manager understands the challenges the team experiences with clients**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. **The house manager is supportive of the team emotionally**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. **The house manager is supportive of the team practically**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

12. I follow the house managers suggestions of how of carry out my work

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

13. The team follows the house managers suggestions of how to carry out work

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

14. The house manager is overly critical of what we do

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

15. The house manager regularly works alongside the team to demonstrate good practice and adherence to care plans on the floor

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Leadership support

1. The house manager is approachable

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. The house manager supports me at work

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **If I had a problem in my personal life that may impact me at work I would feel confident in seeking support from the house manager**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **If I don't feel confident in a particular area the house manager gives me the opportunity to develop my skills. (This may be specific training or worked on within supervision)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The house manager has a positive attitude**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The house manager is knowledgeable**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **The house manager has the skills to lead our team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **The house manager shares their knowledge**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **I respect the house manager**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. The team respects the house manager

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. I do not feel supported by the home manager

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Home functioning

1. The home has appropriate staffing levels

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. There is a low turnover of staff at the home

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. We don't rely on agency staff

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **Generally there is a good compatibility of clients in the home (clients do not negatively impact on each other's rehabilitation)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **The location of the home provides the clients with the ability to access good quality community facilitates**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The resources in the home allow us to provide good quality care (e.g. vehicles)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **The care Team**

This domain is a measure of the functioning of the team. It looks at the teams approach, staff roles and practice concerns.

Team approach

I have confidence in my colleague's abilities

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

1. **As a team we respect the environment and treat it like our clients' home**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **As a team we focus our efforts on helping our clients to build positive skills**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **As a team we motivate each other**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **As a team we motivate service users'**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **As a team we are responsive to client need**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **We work from a person centred perspective**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **As a team we are confident in compassionately challenging unhelpful client behaviour**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **I am confident in compassionately challenging client behaviour when it threatens the clients or others safety**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **I can develop therapeutic relationships with clients in which they feel safe and secure**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. **As a team we are working towards the same shared goals**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. **As a team we support each other**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

12. **Our care practice balances validation, reassurance and challenge when necessary**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

13. **As a team we are able to manage unpredictable situations effectively**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Role

1. **We support clients to reintegrate into the community**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **We support client rehabilitation**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **We support clients to develop their independent living skills**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **As a staff team we work closely with the wider multidisciplinary team (psychology, psychiatry etc.)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **We support the clients to work towards achievable goals**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **The clients goals are reviewed at regular intervals**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **We use the clients' care plans to inform practice**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **I am actively involved in providing feedback to review clients plans, such as behaviour support plans**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **We are working hard to help the clients make progress**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. **It feels rewarding when clients do make progress**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Practice concerns

1. **As a team we have raised a lack of resources to management (for example over reliance on agency, lack of vehicles)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

2. **There are informal leaders in the team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

3. **The staff team has split, there are cliques within the team (small teams formed that don't follow the main team's approach or attitudes)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

4. **We don't have a safe space to discuss concerns within the team (a space in which you feel you are able to discuss your concerns without being judged or confidentiality will be broken)**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

5. **We don't have relevant access to training to develop our skills**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

6. **I often think about work when I am at home**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

7. **People in this team keep mistakes and errors from management**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

8. **I feel scared to admit to a mistake**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

9. **It is hard to be a newcomer in this team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

10. **Sometimes, new members of staff just don't fit in to the way we like to do things here**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

11. **I have felt bullied and targeted by colleagues in the team**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

12. **Some members of the team ignore care plans and do their own thing**

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

13. Some members of the team think that bad behaviour needs to be punished

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

14. I have seen incidents happen that I know have been caused by the way that a service user has been supported

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

15. Management don't have a clue about the culture in this team

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

16. I would feel wary of challenging a colleague if I saw them do or say something to a service user that I felt was wrong

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

17. This team can be dismissive towards service users' needs

Relevance score: ___ /4 Clarity score: ___/4

Additional comments ……

Appendix L Expert debrief form

Thank you for taking part in the research.

The study is developing a tool focused on measuring staff culture in forensic community homes.

When partaking in the research you were not asked to provide your name and can be assured that the confidentiality of your identity will be maintained, and information will be stored securely. You were asked to score the clarity of the wording of items on the psychometric tool. You were also asked to score the relevance of the item in regards to staff culture in forensic community services. The data you provided will be safely stored for seven years and then it will be destroyed.

You have the right to withdraw from the study up to two weeks after completion, you do not need to provide a reason for withdrawal. As the researcher has identified you as an expert in the field they have an awareness of who you are if you chose to withdraw, however, you can be assured there would be no negative consequences by withdrawing. If you wish to withdraw please contact the researcher through email: Rachel.isgar@nottingham.ac.uk and provide your participation number.

It is requested that you do not discuss your participation or views with colleagues outside of the study. This is to ensure you don't unwittingly influence each other's participation.

Furthermore, if you have any questions please contact the researcher through the aforementioned details.

Appendix M study two population sample participant information sheet

We would like to invite you to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read this carefully and discuss it with the researchers if you wish. Ask us anything that is not clear.

Please be reassured that how you are treated in the company will not be affected in any way by your decision to participate or decline.

What is the purpose of the research?

The study aims to develop a psychometric tool that measures staff culture in forensic community homes. The first stage of the study was focused on exploring staff perspectives of culture in forensic community homes. This was achieved by interviewing staff members from a multi-disciplinary team. The data from that study along with current research in the field has informed items on the psychometric tool.

The second stage focused on the tool being reviewed by experts in the field of forensic psychology who support community homes.

The current stage is focused on recruiting participants to complete the tool who work in forensic community homes. This stage will ensure the tool instructions and items can be understood and are not ambiguous.

From research we understand that staff culture impacts on many factors including a service user's rehabilitation. It would be of benefit to have a psychometric tool that can measure staff culture in forensic community homes.

Why have I been invited to take part?

You have been invited to take part in this research because you are a support worker or senior support worker who is employed to work in a forensic community home within XX Healthcare.

We will be recruiting five participants in this part of the study.

Do I have to take part?

No. It is up to you to decide if you want to take part in this research. If you agree to participate, you will need to contact the researcher on the email address below. You will be emailed a consent form that you will be required to sign. You will need to email the researcher a signed copy and you can keep a copy for yourself.

However, you would still be free to withdraw from the study, without giving a reason and without any negative consequences, by advising the researchers of this decision. This would not affect your legal rights. You have up to two weeks after you have return the psychometric tool back to the researcher to withdraw your data from the study. You would need to contact the researcher and provide them with your participant number, which will be allocated to you following your in-put.

What will happen to me if I take part?

If you are interested in partaking in the research, contact the researcher on the email address below. You will be given the opportunity to discuss the research over phone call or through email. If you decide you would like to partake you will

be sent a consent form, this needs to be signed and emailed back to the researcher.

The researcher will arrange a time convenient to you to meet. You will complete the psychometric tool that has been developed. The researcher will ask you questions in regards to how clear the wording is on the tool and whether the items have clarity. The purpose of this stage is to ensure the tool can be distributed to a wider population and that instructions and items are clear and easy to understand.

Your participation will provide insight on whether instructions need to be re-worded. Whether items have been worded correctly to measure what it is intended to measure. Revisions of the tool can be made following this.

Following the completion of interview you will be given a debrief form outlining the study procedures. On the form will be provided with information on how to withdraw your data from the study if you wish to do so. You do not need to provide a reason for this and there will be no negative consequences. You will be required to state your participant number to withdraw your data.

Are there any risks in taking part?

There are no identified risks in you taking part in this study.

Are there any benefits in taking part?

There will be no direct benefit to you from taking part in this research but your contribution will help the development of a psychometric tool that measures staff

culture. This could be used to identify strengths and areas of improvement in the culture of forensic community homes.

Will my time/travel costs be reimbursed?

Participants will not receive an inconvenience allowance to participate in the study.

What happens to the data provided?

The research data will be stored confidentially onto the University of Nottingham's One Drive. To help ensure your privacy, you will be assigned a participant identification number, which will be assigned to the psychometric tool you return. Your name and any information about you will not be disclosed outside the study centre.

Personal data will be stored confidentially using the University of Nottingham's One Drive. The only personal data collected will be your signed consent form. This will be protected so only the researcher will have access to this.

The student researcher and the research team will have access to research data.

All research data and records will be stored for a minimum of 7 years after publication or public release of the work of the research.

What will happen if I don't want to carry on with the study?

Even after you have signed the consent form, you are free to withdraw from the study up to two weeks after participating, without giving any reason and without

your legal rights being affected. Any personal data will be destroyed. If you choose to withdraw your data will not be used within the research and it will be destroyed. The researcher will have an awareness of who you are as they will have created the participant number, however, you can be reassured that there would be no negative consequences from withdrawing.

Who will know that I am taking part in this research?

Data will be used for research purposes only and in accordance with the General Data Protection Regulations. All such data is kept on password-protected databases sitting on a restricted access computer system.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx/

Designated individuals of the University of Nottingham may be given access to data for monitoring and/or audit of the study to ensure we are complying with guidelines.

What will happen to the results of the research?

The research will be written up as a thesis. On successful submission of the thesis, it will be deposited both in print and online in the University archives, to facilitate its use in future research. The thesis will be published open access.

The research will be written up as dissertation for the degree of Doctorate in Forensic Psychology.

Who has reviewed this study?

All research involving people is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee (Reference number: FMHS223-0321).

Who is organising and funding the research?

The research is being organised through the University of Nottingham and XX Healthcare.

What if there is a problem?

If you have a concern about any aspect of this project, please speak to the researcher (Rachel Isgar) or the Chief Investigator's (Dr XX and Dr XXX) who will do their best to answer your query. The researcher should acknowledge your concern and give you an indication of how he/she intends to deal with it. If you remain unhappy and wish to complain formally, you can do this by contacting the FMHS Research Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical

Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk.

1. Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

Rachel Isgar

Student Researcher

Doctorate Forensic Psychology

Email: Rachel.isgar@nottingham.ac.uk

Dr XX University of Nottingham

Dr XXX, Healthcare

Appendix N Study two population sample consent form

Title of Study: Development of a psychometric tool to measure staff culture within forensic community homes.

REC ref: (FMHS223- 0321)

Name of Researchers:

Chief Academic/Supervisor: Dr XX

Other key researchers/collaborators: Dr XXX

Students name and course: Rachel Isgar, Forensic Psychology Top Up Doctorate Forensic Psychology. Rachel.isgar@nottingham.ac.uk

Name of Participant:

I confirm that I have read and understand the participant information sheet version number 1 dated 23.02.21 for the above study which is attached and have had the opportunity to ask questions. ☐

I understand that my participation is voluntary and that I am free to withdraw during and up to two weeks after completing the interview, without giving any reason and without disadvantage. ☐

I understand that I can withdraw my data up to two weeks after completing the interview. I am aware I will be required to state my participant number that I will be allocated after the interview. ☐

I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have ☐

access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

I understand that my input into the research will be made anonymous before it is stored. It will be uploaded into a secure database on a computer kept in a secure place. Data will be kept for 7 years after the study has ended and then destroyed. ☐

I agree to take part in the above study. ☐

Name of Participant Date Signature

Name of Person taking consent Date Signature

Appendix O Study two population sample debrief form

Thank you for taking part in the research.

The study is focused on refining a new psychometric tool that measures staff culture in forensic community homes.

When partaking in the research you were not asked to provide your name and can be assured that the confidentiality of your identity will be maintained, and information will be stored securely. You were asked to score the psychometric tool. The researcher asked you a series of questions that were in relation to the instructions and items on the tool. The purpose of this is to ensure the instructions are clear, items are not ambiguous and the tool is generating information that it is intended to.

The data you provided will be safely stored for seven years and then it will be destroyed.

You have the right to withdraw from the study up to two weeks after completion, you do not need to provide a reason for withdrawal. As the researcher has identified you as working in a forensic community home they have an awareness of who you are if you chose to withdraw, however, you can be assured there would be no negative consequences by withdrawing. If you wish to withdraw please contact the researcher through email: Rachel.isgar@nottingham.ac.uk and provide your participation number. Furthermore, if you have any questions please contact the researcher through the aforementioned details.

Appendix P Cognitive interview schedule

Measure of Staff Culture in Forensic Homes

This questionnaire has been developed to measure staff culture in forensic community homes. Please complete every item by scoring the response that most represents the extent to which you agree. If you work across several homes, focus your responses on the one home where you spend the majority of your time.

Can you describe what the tool instructions asked you to do?

1. **The Organisation**

This domain is measuring the organisation's influence on culture within the community home you work in. It focuses on the senior management's awareness of what the home needs to provide good quality care. Senior management's leadership and the values that are promoted within the organisation. Senior management is defined as directors, area managers and higher management.

Senior management's awareness

1. Senior management understand the general challenges we face in the home

Strongly agree Agree Disagree Strongly Disagree

What does general challenges mean to you?

2. Senior management understand the current demands on the home

Strongly agree Agree Disagree Strongly Disagree

3. Senior management don't have a clue about the culture in our community home staff team

Strongly agree Agree Disagree Strongly Disagree

Tell me what you would think about when answering this question?

4. As a team we have raised a lack of resources to senior management and had no response (for example over reliance on agency, lack of vehicles)

Strongly agree Agree Disagree Strongly Disagree

5. People in this team keep mistakes and errors from senior management

Strongly agree Agree Disagree Strongly Disagree

Was there anything missing in the organisational leadership domain?

Leadership

1. There is a clear management structure within the organisation

Strongly agree Agree Disagree Strongly Disagree

2. I am aware of who I need to speak to if I have a problem at work

Strongly agree Agree Disagree Strongly Disagree

3. Management communicate effectively across the organisation

Strongly agree Agree Disagree Strongly Disagree

What do you think of when you answer this question?

4. If a policy is changed, management support us as a team to make the required changes in a timely manner

Strongly agree Agree Disagree Strongly Disagree

What do you think of when you answer this question?

5. I feel valued by the organisation

Strongly agree Agree Disagree Strongly Disagree

How are you coming up with an answer to question 5?

Values

1. The organisation promotes and supports diversity within the staff team (e.g. promoting people's different cultures, backgrounds and beliefs)

Strongly agree Agree Disagree Strongly Disagree

2. The organisation promotes and supports client diversity (e.g. promoting clients' different cultures, backgrounds and beliefs)

Strongly agree Agree Disagree Strongly Disagree

What do you think of when answering this question?

3. The organisation promotes equality within the staff team (e.g. everyone has equal opportunities regardless of their background, lifestyle and ability)

Strongly agree Agree Disagree Strongly Disagree

4. The organisation promotes client equality (e.g. supporting clients' to have access to equal opportunities)

Strongly agree Agree Disagree Strongly Disagree

What does equality mean?

5. The organisation is supportive of my individual needs

Strongly agree Agree Disagree Strongly Disagree

6. Safety and quality of care is not compromised over financial considerations

Strongly agree Agree Disagree Strongly Disagree

7. As a team we work in ways that promote the organisations' values

Strongly agree Agree Disagree Strongly Disagree

Were the values questions relevant to you? How does it apply to your role?

2. Home Manager

This domain refers to the house manager who is responsible for the home. This area will measure the house managers practice leadership, their qualities and how the home functions.

Practice Leadership

1. The house manager is physically present in the home during the week

Strongly agree Agree Disagree Strongly Disagree

2. The house manager is aware of the staff team's needs and actively supports developmental need

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this?

3. The house manager considers my strengths when allocating tasks

Strongly agree Agree Disagree Strongly Disagree

What do you think of when reading 'my strengths'?

4. The house manager utilises the teams' strengths

Strongly agree Agree Disagree Strongly Disagree

5. The house manager supports the team to engage in reflection (to think about why something happened and what could be different next time, discusses feelings regarding work situations)

Strongly agree Agree Disagree Strongly Disagree

Is this question relevant to staff culture? If so, how? If not, why?

6. The house manager understands what the clients need

Strongly agree Agree Disagree Strongly Disagree

7. The house manager understands the challenges the team experiences with clients

Strongly agree Agree Disagree Strongly Disagree

What do you think of when answering this?

8. The house manager is supportive of the team emotionally

Strongly agree Agree Disagree Strongly Disagree

9. The house manager is supportive of the team practically

Strongly agree Agree Disagree Strongly Disagree

10. As a team we follow the house managers suggestions of how to carry out our work

Strongly agree Agree Disagree Strongly Disagree

11. The house manager is overly critical of what the staff team do

Strongly agree Agree Disagree Strongly Disagree

Are the answer options applicable?

12. The house manager regularly works alongside the team to demonstrate good practice and adherence to care plans in the home

Strongly agree Agree Disagree Strongly Disagree

Is there anything missing from this subdomain?

Leadership support

1. The house manager is approachable

Strongly agree Agree Disagree Strongly Disagree

What does approachable mean to you?

2. If I had a problem in my personal life that may impact me at work I would feel confident in seeking support from the house manager

Strongly agree Agree Disagree Strongly Disagree

3. The house manager is knowledgeable about working in this setting

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this question?

4. The house manager has the skills to lead our team

Strongly agree Agree Disagree Strongly Disagree

5. I respect the house manager

Strongly agree Agree Disagree Strongly Disagree

6. The team respects the house manager

Strongly agree Agree Disagree Strongly Disagree

7. I do not feel supported by the home manager

Strongly agree Agree Disagree Strongly Disagree

Is there anything missing from the leadership support domain?

Home functioning

1. There is a low turnover of staff at the home

Strongly agree Agree Disagree Strongly Disagree

What does low turnover mean to you?

2. We don't often rely on agency staff, we have appropriate staffing levels

Strongly agree Agree Disagree Strongly Disagree

3. Generally there is a good compatibility of clients in the home (clients do not negatively impact on each other's rehabilitation)

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this question?

4. The resources in the home allow us to provide good quality care (e.g. adequate access to vehicles)

Strongly agree Agree Disagree Strongly Disagree

Is there anything missing in this subdomain? Do the items impact on staff culture?

3. Care Team

This domain is a measure of the functioning of the team. It looks at the teams general care practice and practice concerns.

General care practice

1. I have confidence in my colleague's abilities to support me if I needed it

Strongly agree Agree Disagree Strongly Disagree

What are you thinking about when answering this? How would you answer it if some of the team offered support but others didn't?

2. As a team we treat the house like the clients' home

Strongly agree Agree Disagree Strongly Disagree

What does this item mean to you?

3. As a team we motivate each other to work compassionately

Strongly agree Agree Disagree Strongly Disagree

What does 'work compassionately' mean to you?

4. As a team we motivate clients to get the best out of each day

Strongly agree Agree Disagree Strongly Disagree

5. As a team we are responsive to client need

Strongly agree Agree Disagree Strongly Disagree

What does 'responsive to client need' mean to you?

6. We work from a person centred perspective

Strongly agree Agree Disagree Strongly Disagree

7. As a team we are working towards the same shared goals

Strongly agree Agree Disagree Strongly Disagree

What do the 'same shared goals' mean to you?

8. As a team we support each other

Strongly agree Agree Disagree Strongly Disagree

9. The support we offer to service users balances validation, reassurance and challenge as appropriate

Strongly agree Agree Disagree Strongly Disagree

What does validation, reassurance and challenge mean to you?

10. We seek support from outside the home when times get tough (e.g. communicating to management that additional support is required)

Strongly agree Agree Disagree Strongly Disagree

Is this relevant to you?

11. We support clients to reintegrate into the community

Strongly agree Agree Disagree Strongly Disagree

12.We support clients to develop their independent living skills

Strongly agree Agree Disagree Strongly Disagree

13.We support the service users' goals

Strongly agree Agree Disagree Strongly Disagree

14.It feels rewarding when clients do make progress

Strongly agree Agree Disagree Strongly Disagree

Is there anything missing in this domain?

Practice concerns

1. We don't have a safe space to discuss concerns within the team (time to discuss concerns confidentially)

Strongly agree Agree Disagree Strongly Disagree

What does 'safe space' mean to you?

2. I often think about work when I am at home

Strongly agree Agree Disagree Strongly Disagree

3. I feel scared to admit to a mistake

Strongly agree Agree Disagree Strongly Disagree

4. It is hard to be a newcomer in this team

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this question?

5. I have felt bullied and targeted by colleagues in the team

Strongly agree Agree Disagree Strongly Disagree

6. I have seen incidents happen that I know have been caused by the way that a client has been supported

Strongly agree Agree Disagree Strongly Disagree

What does the term 'incident' mean to you?

7. The staff team has split, there are cliques within the team (small groups in the team who do their own thing)

Strongly agree Agree Disagree Strongly Disagree

8. This team can be dismissive towards service users' needs

Strongly agree Agree Disagree Strongly Disagree

What does this item mean to you?

9. Some members of the team think challenging behaviour needs to be punished

Strongly agree Agree Disagree Strongly Disagree

What does 'challenging behaviour' mean to you?

4. Risk Management

This domain focuses on forensic risk. It will measure clinical input, client risk management and staff practice in regards to influencing clients forensic risk.

Clinical input

The clinical team include and are not limited to professionals such as psychiatry, psychology, occupational therapy and speech and language.

1. The clinical team is approachable

Strongly agree Agree Disagree Strongly Disagree

2. The clinical team listen to the homes staff team

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this?

3. The clinical team work alongside home staff to offer understandable explanations of client behaviour

Strongly agree Agree Disagree Strongly Disagree

What does this item mean to you?

4. The clinical team support us to understand client need

Strongly agree Agree Disagree Strongly Disagree

5. The clinical team offer relevant in-put to support our needs such as training, reflective practice, supervision

Strongly agree Agree Disagree Strongly Disagree

6. The clinical team don't understand the challenges we face

Strongly agree Agree Disagree Strongly Disagree

What do you think about when answering this?

7. The clinical team criticise us frequently

Strongly agree Agree Disagree Strongly Disagree

8. The clinical team has realistic expectations from us as a staff team

Strongly agree Agree Disagree Strongly Disagree

What does 'realistic expectations' mean in this item?

9. I use the clients' formulations to inform how I support clients

Strongly agree Agree Disagree Strongly Disagree

10. I understand and implement client's treatment plans

Strongly agree Agree Disagree Strongly Disagree

What does 'client treatment plans' mean to you? What documents would you think about?

Is there anything that is not covered in the clinical input domain?

Client risk management

1. There is effective communication between members of the home's staff team about client risk

Strongly agree Agree Disagree Strongly Disagree

What does 'client risk' mean to you?

2. There is effective communication between members of the home staff team and the clinical team about client risk

Strongly agree Agree Disagree Strongly Disagree

3. Clients' have risk assessments that are reviewed regularly

Strongly agree Agree Disagree Strongly Disagree

Is this relevant to you? What would you think about to answer this question?

4. We use proactive strategies to manage client risk (e.g. managing situations to prevent a crisis occurring, using clients' support plans to inform this)

Strongly agree Agree Disagree Strongly Disagree

5. We use individual care plans that inform our practice to support clients who are deteriorating in terms of behaviour and/or distress

Strongly agree Agree Disagree Strongly Disagree

What are you thinking about when answering this item?

6. I feel confident in reporting changes in client behaviour to the wider team (e.g. house manager, psychologist, psychiatrist etc.)

Strongly agree Agree Disagree Strongly Disagree

7. I am aware of the potential risks for each client

Strongly agree Agree Disagree Strongly Disagree

How are you forming an answer to this item?

8. As a team we have the appropriate level of experience and skill to manage client risk

Strongly agree Agree Disagree Strongly Disagree

9. As a team we are confident in taking positive risks

Strongly agree Agree Disagree Strongly Disagree

What does positive risk mean to you?

Applied practice

1. We maintain personal - professional boundaries.

True for me True for the team Not true for me Not true for the team

What does personal – professional boundaries mean to you?

2. The staff team remain professional and compassionate when facing highly challenging behaviour

Strongly agree Agree Disagree Strongly Disagree

What does professional and compassionate mean to you?

3. The staff team are consistent in their approach

Strongly agree Agree Disagree Strongly Disagree

4. Negative judgment some staff hold in regards to clients history affects how we support clients

Strongly agree Agree Disagree Strongly Disagree

What are you thinking about when answering this?

5. I can develop therapeutic relationships with clients in which they appear to feel safe and secure

Strongly agree Agree Disagree Strongly Disagree

6. As a team we are able to manage unpredictable situations effectively

Strongly agree Agree Disagree Strongly Disagree

7. The staff team act as prosocial role models

Strongly agree Agree Disagree Strongly Disagree

Were the tool options relevant for every question?

Did you feel there was always an appropriate option to pick to share your views?

Was there anything that didn't feel relevant in the tool?

Do you think there is anything missing? Does it cover areas that impact on the staff culture in the home?

Appendix Q Final version of the Cultural Assessment of Staff Teams

This questionnaire has been developed to measure staff culture in forensic community homes. Please complete every item by scoring the response that most represents the extent to which you agree. If you work across several homes, focus your responses on the one home where you spend the majority of your time.

The Organisation

This domain is measuring the organisation's influence on culture within the community home you work in. It focuses on the senior management's awareness of what the home needs to provide good quality care. Senior management's leadership and the values that are promoted within the organisation. Senior management is defined as directors, area managers and higher management.

Senior management's awareness

1. Senior management understand the general challenges we face in the home

Strongly agree Agree Disagree Strongly Disagree

2. Senior management understand the current demands on the home

Strongly agree Agree Disagree Strongly Disagree

3. Senior management don't have a clue about the culture in our community home staff team

Strongly agree Agree Disagree Strongly Disagree

4. As a team we have raised a lack of resources to senior management and had no response (for example over reliance on agency, lack of vehicles)

Strongly agree Agree Disagree Strongly Disagree

5. People in this team keep mistakes and errors from senior management

Strongly agree Agree Disagree Strongly Disagree

Leadership

1. There is a clear management structure within the organisation

Strongly agree Agree Disagree Strongly Disagree

2. I am aware of who I need to speak to if I have a problem at work

Strongly agree Agree Disagree Strongly Disagree

3. Management communicates effectively across the organisation

Strongly agree Agree Disagree Strongly Disagree

4. If a policy is changed, management support us as a team to make the required changes in a timely manner

Strongly agree Agree Disagree Strongly Disagree

5. I feel valued by the organisation

Strongly agree Agree Disagree Strongly Disagree

Values

1. The organisation promotes and supports diversity within the staff team (e.g., promoting people's different cultures, background, and beliefs)

Strongly agree Agree Disagree Strongly Disagree

2. The organisation promotes and supports client diversity (e.g., promoting clients' different cultures, background, and beliefs)

Strongly agree Agree Disagree Strongly Disagree

3. The organisation promotes equality within the staff team (e.g., everyone has equal opportunities regardless of their background, lifestyle, and ability)

Strongly agree Agree Disagree Strongly Disagree

4. The organisation promotes client equality (e.g., supporting clients' to have access to equal opportunities)

Strongly agree Agree Disagree Strongly Disagree

5. The organisation is supportive of my individual needs

Strongly agree Agree Disagree Strongly Disagree

6. Safety and quality of care is not compromised over financial considerations

Strongly agree Agree Disagree Strongly Disagree

7. As a team we work in ways that promote the organisations' values

Strongly agree Agree Disagree Strongly Disagree

Home Manager

This domain refers to the house manager who is responsible for the home. This area will measure the house manager's practice leadership, their qualities and how the home functions.

Practice Leadership

1. The house manager is physically present in the home during the week

Strongly agree Agree Disagree Strongly Disagree

2. The house manager is aware of the staff team's needs and actively supports developmental need

Strongly agree Agree Disagree Strongly Disagree

3. The house manager considers my strengths when allocating tasks

Strongly agree Agree Disagree Strongly Disagree

4. The house manager utilises the teams' strengths

Strongly agree Agree Disagree Strongly Disagree

5. The house manager supports the team to engage in reflection (to think about why something happened and what could be different next time, discusses feelings regarding work situations)

Strongly agree Agree Disagree Strongly Disagree

6. The house manager understands what the clients need

Strongly agree Agree Disagree Strongly Disagree

7. The house manager understands the challenges the team experiences with clients

Strongly agree Agree Disagree Strongly Disagree

8. As a team we follow the house manager's suggestions of how to carry out our work

Strongly agree Agree Disagree Strongly Disagree

9. The house manager is overly critical of what the staff team do

Strongly agree Agree Disagree Strongly Disagree

10. The house manager regularly works alongside the team to demonstrate good practice and adherence to care plans in the home

Strongly agree Agree Disagree Strongly Disagree

Leadership support

1. The house manager is approachable

Strongly agree Agree Disagree Strongly Disagree

2. If I had a problem in my personal life that may impact me at work, I would feel confident in seeking support from the house manager

Strongly agree Agree Disagree Strongly Disagree

3. The house manager is knowledgeable about working in this setting

Strongly agree Agree Disagree Strongly Disagree

4. The house manager has the skills to lead our team

Strongly agree Agree Disagree Strongly Disagree

5. I respect the house manager

Strongly agree Agree Disagree Strongly Disagree

6. The team respects the house manager

Strongly agree Agree Disagree Strongly Disagree

7. I do not feel supported by the home manager

Strongly agree Agree Disagree Strongly Disagree

Home functioning

1. There is a low turnover of staff at the home

Strongly agree Agree Disagree Strongly Disagree

2. We don't often rely on agency staff, we have appropriate staffing levels

Strongly agree Agree Disagree Strongly Disagree

3. Generally, there is a good compatibility of clients in the home (clients do not negatively impact on each other's rehabilitation)

Strongly agree Agree Disagree Strongly Disagree

4. The resources in the home allow us to provide good quality care (e.g., adequate access to vehicles)

Strongly agree Agree Disagree Strongly Disagree

Care Team

This domain is a measure of the functioning of the team. It looks at the team's general care practice and practice concerns.

General care practice

1. I have confidence in my colleague's abilities to support me if I needed it

Strongly agree Agree Disagree Strongly Disagree

2. As a team we treat the house like the clients' home

Strongly agree Agree Disagree Strongly Disagree

3. As a team we motivate each other to work compassionately

Strongly agree Agree Disagree Strongly Disagree

4. As a team we motivate clients to get the best out of each day

Strongly agree Agree Disagree Strongly Disagree

5. As a team we are responsive to client need

Strongly agree Agree Disagree Strongly Disagree

6. We work from a person-centred perspective (care that is delivered for the specific needs of the client)

Strongly agree Agree Disagree Strongly Disagree

7. As a team we are working towards the same shared goals (there is a clear understanding of what we are trying to achieve with each client)

Strongly agree Agree Disagree Strongly Disagree

8. As a team we support each other

Strongly agree Agree Disagree Strongly Disagree

9. The support we offer to service users balances validation, reassurance, and challenge as appropriate (showing that we understand how the client feels, offering them support and when required redirecting them)

Strongly agree Agree Disagree Strongly Disagree

10. We seek support from outside the home when times get tough (e.g., communicating to management that additional support is required)

Strongly agree Agree Disagree Strongly Disagree

11. We support clients to reintegrate into the community

Strongly agree Agree Disagree Strongly Disagree

12. We support clients to develop their independent living skills

Strongly agree Agree Disagree Strongly Disagree

13. We support the service users' goals

Strongly agree Agree Disagree Strongly Disagree

14.It feels rewarding when clients make progress

Strongly agree Agree Disagree Strongly Disagree

Practice concerns

1. We don't have a safe space to discuss concerns within the team (time to discuss concerns confidentially)

Strongly agree Agree Disagree Strongly Disagree

2. I often think about work when I am at home

Strongly agree Agree Disagree Strongly Disagree

3. I feel scared to admit to a mistake

Strongly agree Agree Disagree Strongly Disagree

4. It is hard to be a newcomer in this team

Strongly agree Agree Disagree Strongly Disagree

5. I have felt bullied and targeted by colleagues in the team

Strongly agree Agree Disagree Strongly Disagree

6. I have seen incidents happen that I know have been caused by the way that a client has been supported

Strongly agree Agree Disagree Strongly Disagree

7. The staff team has split, there are cliques within the team (small groups in the team who do their own thing)

Strongly agree Agree Disagree Strongly Disagree

8. Some members of the team think challenging behaviour needs to be punished

Strongly agree Agree Disagree Strongly Disagree

Forensic Risk Management

This domain focuses on forensic risk. It will measure clinical input, client risk management and staff practice in regards to influencing clients forensic risk.

Clinical input

The clinical team include and are not limited to professionals such as psychiatry, psychology, occupational therapy and speech and language.

1. The clinical team is approachable

Strongly agree Agree Disagree Strongly Disagree

2. The clinical team listen to the homes staff team

Strongly agree Agree Disagree Strongly Disagree

3. The clinical team work alongside home staff to offer understandable explanations of client behaviour

Strongly agree Agree Disagree Strongly Disagree

4. The clinical team support us to understand client need

Strongly agree Agree Disagree Strongly Disagree

5. The clinical team offer relevant in-put to support our needs such as training, reflective practice, supervision

Strongly agree Agree Disagree Strongly Disagree

6. The clinical team don't understand the challenges we face

Strongly agree Agree Disagree Strongly Disagree

7. The clinical team criticise us frequently

Strongly agree Agree Disagree Strongly Disagree

8. The clinical team has realistic expectations from us as a staff team

Strongly agree Agree Disagree Strongly Disagree

9. I use the clients' formulations to inform how I support clients

Strongly agree Agree Disagree Strongly Disagree

10. I understand and implement client's treatment plans

Strongly agree Agree Disagree Strongly Disagree

Client risk management

1. There is effective communication between members of the home's staff team about client risk

Strongly agree Agree Disagree Strongly Disagree

2. There is effective communication between members of the home staff team and the clinical team about client risk

Strongly agree Agree Disagree Strongly Disagree

3. Clients have risk assessments that are reviewed regularly

Strongly agree Agree Disagree Strongly Disagree

4. We use proactive strategies to manage client risk (e.g., managing situations to prevent a crisis occurring, using clients' support plans to inform this)

Strongly agree Agree Disagree Strongly Disagree

5. We use individual care plans that inform our practice to support clients who are deteriorating in terms of behaviour and/or distress

Strongly agree Agree Disagree Strongly Disagree

6. I feel confident in reporting changes in client behaviour to the wider team (e.g., house manager, psychologist, psychiatrist etc.)

Strongly agree Agree Disagree Strongly Disagree

7. I am aware of the potential risks for each client

Strongly agree Agree Disagree Strongly Disagree

8. As a team we have the appropriate level of experience and skill to manage client risk

Strongly agree Agree Disagree Strongly Disagree

9. As a team we are confident in taking positive risks (a balanced decision that acknowledges what the client can do, not just how they are limited. For example, giving them the opportunity to take a bus in to town by themselves)

Strongly agree Agree Disagree Strongly Disagree

Applied practice

1. We maintain personal - professional boundaries.

True for me True for the team Not true for me Not true for the team

2. The staff team remain professional and compassionate when facing highly challenging behaviour

Strongly agree Agree Disagree Strongly Disagree

3. The staff team are consistent in their approach

Strongly agree Agree Disagree Strongly Disagree

4. Negative judgment some staff hold regarding client history affects how we support clients

Strongly agree Agree Disagree Strongly Disagree

5. I can develop therapeutic relationships with clients in which they appear to feel safe and secure

Strongly agree Agree Disagree Strongly Disagree

6. As a team we are can manage unpredictable situations effectively

Strongly agree Agree Disagree Strongly Disagree

7. The staff team act as prosocial role models

Strongly agree Agree Disagree Strongly Disagree