

Diagnosing Culture in Healthcare Organizations

CASE STUDY

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The critical incident technique was used successfully to assess a bottom-up view of the culture of a healthcare organization.

In the 50 years since Flanagan¹ first published the seminal piece “The critical incident technique,” this method has progressed through a variety of applications in many different settings. Critical incident technique (CIT) was designed originally to develop procedures for selecting and classifying U.S. Air Force aircrew personnel. Since then, the original application of the CIT has proven useful for the selection and classification of employees in many other settings.

More recently, the CIT has been used in more novel situations identifying good and poor service episodes in retail and healthcare settings. After reviewing the many uses of CIT, we designed and applied a methodology to surface cultural information in a healthcare organization using critical incidents via a pencil-and-paper format.

Using the CIT to Assess Culture

The CIT¹ offers a rich methodology for surfacing an organization’s culture from a bottom-up perspective. Most culture measurement tools require the application of a set of predetermined cultural attributes.

Critical incident analysis allows for the emergence rather than the imposition of an evaluative schema and focuses on the events and dimensions of the patient experience that are most salient, memorable, and most likely to be retold to others.²

This allows easy comparison with other organizations and between units within the same organization. The predetermined set of attributes, however, limits the scope of cultural findings to those found in the measurement tool.

Categorizing responses from the CIT data collection identifies cultural attributes, many of which may not have been determined beforehand. The

incidents themselves provide rich content to understand the culture and to make service improvements. Using incidents about excellent service sets a benchmark for employees to follow and communicates service expectations in great detail.

For a critical incident report to be useful, collect at least three pieces of information: a description of the situation that led to the incident; the actions of the focal person in the incident; and the results or outcomes of the incident.³

In addition, Anderson and Wilson³ include a Likert-type scale for respondents to indicate the incident’s effectiveness. This allows for qualitative analysis of the incident report along with quantitative analysis of the effectiveness data, which, in turn, provides an avenue to produce summary information about how many incidents were positive, negative, or neutral. We used a similar effectiveness item for respondents to rate their incidents.

Methodology

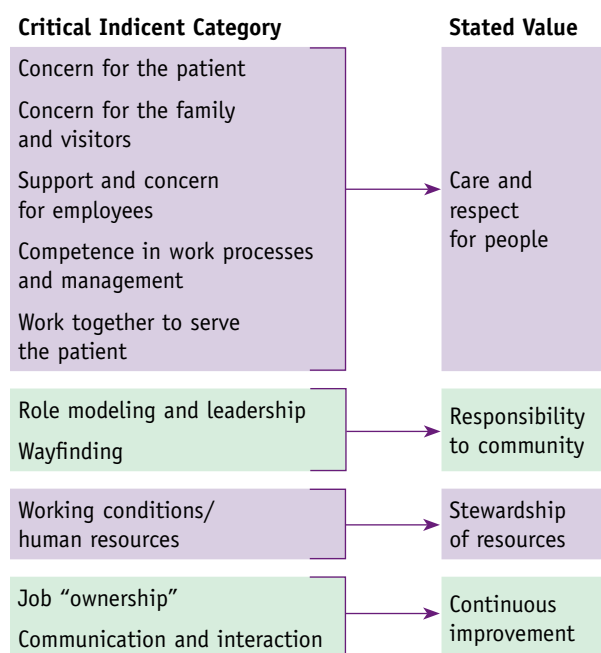
In this study, critical incidents were collected as part of a larger study⁴ of culture at a healthcare provider in the Midwest. Nearly three-fourths of participants provided one or more critical incidents. The study was limited to employees because the provider had existing mechanisms to survey patients and physicians.

Respondents were asked to share incidents where an employee’s action either supported or worked against the firm’s culture. Analysis led to categories of culture (e.g., values). Positive incidents showed the strength of the particular value and negative incidents indicated areas where interventions may be used to strengthen the culture.

Results

Ten resulting critical incident categories generally reflected the organization’s stated cultural values, yet provided greater detail and differentiation concerning those cultural values. To effectively diagnose and shift culture, the detail and differentiation from the

Figure 1: Critical incident categories mapped to the organization's stated values



critical incident technique provided better insight into how a particular value was put into action.

A comparison of critical incident categories to the organization's stated values provided an interesting method to highlight differences in how employees experience the organization's culture. Figure 1 shows a mapping of the critical incident categories to the organization's stated values.

This mapping highlights the differences in emphasis on values between employees and senior management. Clearly, these two groups have different perspectives on the organization. A nurse who spends a 12-hour shift tending to patients does not have much time to think about "responsibility to community," let alone perform a behavior in support of that value. That does not mean the value is not important to the nurse; it merely means that in the course of the work day, the types of behaviors the nurse performs or observes primarily relate to patient care activities and interactions with other employees.

Effectiveness scores were collected for each critical incident. Respondents supplied a rating on a Likert-type scale to show whether the reported incident was highly ineffective (score of 1) to highly effective (score of 7). Mean scores were calculated for each critical incident category.

Along with the distribution of incidents across categories, the mean effectiveness scores provided an assessment on how well the organization performed with respect to that value. For the studied organization, nearly two-thirds of the incidents scored 5 or higher. The incidents provide detailed stories for feedback to employees, demonstrating how a certain value has been practiced in clear behavioral terms, and potentially as input to training materials. The presence of effectiveness ratings allows a quick read of how well that value is practiced.

Putting Results to Work

The use of critical incidents to assess and change organizational culture in healthcare organizations is a new application. The organization in this case study, however, found several avenues for putting these critical incident findings to work. The most popular application was using several CIT stories to exemplify the good aspects of the culture that were already present; and, since the organization's focus was on change, using stories to show what needs to change.

For example, with "concern for the patient" being strongly held, the CIT stories provided rich detail on specific actions employees have taken to live this value. These stories have been shared in briefings of the culture survey results, staff meetings, and in other organizational celebrations. Negative stories have been used more selectively to reduce emphasis on blame-finding and focus more on resolving the underlying issues.

Still, other outlets exist for using the CIT data. Often, training modules for customer service, patient care, and other topics rely on scenarios to illustrate a particular point. With CIT, the organization has a database of rich stories that can show employees how things should be done or how they are being done poorly. Training sessions become real grounds for improvement using actual examples, rather than constructing scenarios that may bear little semblance to the organization's actual experience. On the implementation side, using CIT to manage and change culture takes no more time than using typical survey results. In fact, CIT usually provides more detailed, targeted information than typical survey data, which eliminates a lot of the interpretation and guesswork concerning what needs to change.

Discussion

This application of CIT to assess organizational culture bears several implications for practice. Culture is complex and systemic; no one technique or method can or should be used to construct a definitive description of the culture. Members of the organization often take cultural practices for granted; that is the nature of a culture and one of its purposes; as such, a trained observer outside of the organization can identify many of these cultural practices and attributes that an insider cannot. Carefully designed instrumentation needs to capture specifics of the organization under study. The focus should not only be on changing the culture, but also on continuing the desired attributes that are already in place.

- *Do not rely on one method.* An organization's culture is a product of many complex factors: people, behavior, history, its environment, competitors, location, industry, and more. Reliance on a single method to measure culture will produce results containing the bias of that method. "Cracking" the culture requires a fair amount of evidence; evidence that only can be gleaned from a variety of sources. In this study, we used a modified version of the Competing Values Framework⁵, a custom-tailored culture strength scale, and CIT.
- *Use the rich descriptions of your organization's culture.* Numbers on a survey report are one thing; actual stories about how employees behave on the job are another. Using CIT to assess culture will surface rich descriptions of how an employee went above and beyond to meet a patient's need, yet it may also surface how an employee shirked his or her job and created a dissatisfied patient. Once aware of the types of data produced by CIT, managers can be prepared to handle the output of this technique. The main outcome of CIT is the categories of incidents, but the more interesting outcome is the stories that describe what people in the organization are actually doing.
- *CIT produces a bottom-up view of organizational culture.* In contrast with most popular surveys for measuring culture, CIT has no predetermined categories for analysis; the data themselves produce the categories. In this manner, the employees produce their view of the culture, from a bottom-up perspective. The hospital learned about cultural events that would never have been included in a standardized survey instrument. Disregarding these data perpetuates the myth that leadership alone constitutes the organization's culture. If the organization is the culture, then all employees influence the culture. In a strong culture, nearly all employees respond to specific situations uniformly.
- *Get outside help.* In the same vein as "physician, heal thyself," an organization cannot easily assess its own culture. Culture is "the way we do things around here" and operates on the basis of deeply rooted assumptions. As such, for an insider, an organization's culture does not typically operate at the level of consciousness needed to conduct an objective analysis.⁶ An outside resource, properly trained, can gather poignant insights to culture and place those insights in the context of the overall culture measurement process. An outside agent will provide respondents with anonymity and should result in better data collection. Of course, over-reliance on outside help is a problem, too. This can lead to a lack of internal motivation and a dependence on the outsider to initiate internal change, when such change is the responsibility of the internal employees. What is needed here is the proper balance to provide the organization with cultural information.
- *Carefully design the instrumentation and data collection processes.* Critical incident data collection can be viewed as time consuming and therefore avoided for its resource consumption. Using the questionnaire method to collect data (as opposed to face-to-face interviews) can dramatically cut data collection time without sacrificing quality. Independent of the method, the narrative data need analysis, and this is much more involved and different than traditional quantitative analysis. Reduce the costs associated with analysis by having clerical employees enter the incidents into a database.

Since this study was conducted, the use of sentiment analysis has emerged as a viable method for analyzing critical incidents. Sentiment analysis involves the application of computational algorithms to process and gain understanding from collected data, particularly narrative-type data found

in critical incident studies. Sentiment analysis was used to validate manual methods used to analyze the data from this study⁷ and further reduces the time required and the tedious nature of analyzing hundreds of narratives.

As discussed earlier, questionnaire methods produce similar data at a fraction of the cost to collect data via interviews. Using an effectiveness rating for each incident provides respondent-supplied data of how well the value is being practiced. This removes the analyst's bias in assigning ratings based on the collected incidents. Once the incidents are collected and sorted into categories, compare the resulting categories to existing statements of organizational values. The incidents will reflect the respondents' experience, which may differ greatly from what administration would like the organization to espouse as its desired values. Gaps between these two value sets supply additional information for culture and behavior change efforts.

- *Sustain and change the culture.* Culture has been likened to a large ship moving through a sometimes calm, sometimes turbulent environment. The organization's course, however, has been set and minor corrections keep the organization on track. Organizations seeking to strengthen their culture should have a sound strategy in place and have one or more strongly held key values. An essential process of culture measurement is to assess the culture's strength by how well employees hold the organization's values. An essential outcome of culture measurement is identifying which values and practices should be sustained by identifying and reinforcing behaviors that support those values. Of course, many organizations seek to change culture, but culture change should be approached carefully because of long-term and broad-ranging implications for how the organization accomplishes its objectives. Deeply rooted values are one reason why many employees elect to work at an organization and why they stay.⁸ Changing those values takes time and takes its toll; some employees may leave or may be forced out by value changes. These departures are expected and help the organization achieve its culture change goals.

Conclusions

The CIT provides a rich, bottom-up view of culture. This view can be compared to more structured means of measuring the culture as well as the organization's statements of its desired or existing culture. In this manner, we can see that gaps exist between what management believes the culture is (or what they desire the culture to be) and what employees are experiencing concerning the culture.

CIT involves measuring positive and negative cultural events from the perspective of various stakeholders; in this case the employee perspective was used. First-hand stories shared by employees contain rich detail about the culture. Alone, these stories provide interesting examples of where the culture went right and where it went wrong. In aggregate, they provide a powerful view of the organization's true value structure making up its culture.

The use of CIT has specific benefits and costs, including:

- CIT yields a rich, bottom-up description of the culture.
- CIT provides both positive and negative behavioral examples of how the culture is practiced.
- When compared with conventional culture measures, CIT provides an internal point of comparison.

Of course, these benefits require some costs: to collect, enter, and analyze CIT data necessitates a few more resources compared to machine-scored instruments. The additional resources are limited to a few hours of clerical time and a few days of professional time. Most organizations seeking an honest evaluation of their culture should readily see the value of the CIT.

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