Negotiation of person-centred values and change perception within organisational culture: a case in Dutch elderly care

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A qualitative study on different change perceptions on person-centred changes at an elderly care organisation, related to the different values and organisational cultures that exist at three different locations.

Master thesis

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Preface

It seems suitable that in a year of almost overwhelming personal changes – a move to a different city, the ending of a relationship, the loss of a familymember, a new academic direction – the universe took it up another notch. The Covid-19 outbreak marked the beginning of many more adjustments, not just for me. The global corona pandemic had demanded the whole world to adjust to a new reality. I consider myself lucky and privileged, as this earth-shattering event did not take any loved ones from me. It did not pull my financial security from under my feet. It did not provide me with harsh evidence of my vulnerable socio-economic status or even worse, prejudice against my race. That being said, it did affect my personal and academic life the past couple of months.

During my search to specify a thesis topic and establish contact with an organisation that would suit my interests, it became clear the Covid-19 outbreak would change the game. Lock-down scenarios became reality, especially in the health care sector, where my search was just navigating towards. In the light of this new situation, I needed to act quickly to assure that I could even start my master thesis at an organisation. I felt immensely dependent during this time. I was dependent on the course of outspread of Covid-19, the willingness and ability of an organisation, the leniency of the university of Utrecht if problems occurred and the flexibility of my supervisor to keep up with all my considerations.

But eventually a possibility opened up and all I could do was jump and hope for the best. And I landed in an organisation that had, just like myself, gone through a lot of changes this past year and yet was thriving through the Covid-19 outbreak. I remember being surprised with the rest and flexibility within the organisation and thinking: “Why aren’t they falling apart?”. Ironically, this is in hindsight what many of the people around me thought of me and my turbulent year. When I reflect on my own reasons for not falling apart during so many life changes, it all depended on the support of people around me.

This realisation sheds a new light on the gnawing feeling of dependency I experienced at the beginning of this process. I now feel extremely fortunate to have had so many people – from loved ones to people I have just met – to depend on. I am grateful for their openness, kindness, understanding and compassion. I want to thank Jaap, who took me under his wing to search for a suitable organisation in his field. Not only did you take the time to get to know me and pitch my research to your contacts, but you respected my opinions on texts we exchanged and gave me confidence that insights I had to offer were valued. I want to thank the organisation, specifically Patricia and Djamila, for giving me the opportunity and trust to work there, speak to employees and be of contribution to the organisation.

Furthermore, I want to thank my fellow students, especially my inter vision group, friends and sisters for being there when everything just sucked. And for making me realise that I am not alone, even though we could not be together in person for weeks. I want to thank my mother that did deal with me in person and endured to see the struggle I went through, without giving unwanted advice. And I really want to thank Ozan, for giving me all the advice I did want and need. Every time I needed feedback, you made yourself available. You were there for thorough comments on my writings, reminded me to remain critical, gave the best suggestions for readings and above all, you were supportive. Through every alteration of the course of this study, you went with it and assured me it would be all right.

Each of you have given me the support I needed to not fall apart and I am proud to have been dependent on such great people during the writing of this thesis.

Abstract

This qualitative study explores how organisational members perceive person-centred change in an elder care home in the Netherlands and negotiate about the change related values in the change process. Fifteen in-depth interviews are conducted through all organisational levels and at its three unique locations to shed light on the relationship between organisational change and organisational culture. This study shows how values that prioritise "the person behind the patient" interact with a variety of values from different organisational cultures, and how these values are embedded within societal values. This study draws on the theoretical model of Williams (1980), which notes that dominant culture is defined by daily negotiations between residual, dominant and emergent cultures. That perspective respectively holds past, present and potential future values. This study emphasises that dominant values serve as a lens through which emergent values are evaluated, and therefore affect how change based on emergent values is perceived. Traditional health care values that are disease- and task-centred, which are still present in dominant organisational culture, offer challenges. It is found that through the process called selective tradition, person-centred values that conflicted dominant values got excluded or diluted. Other conflicting values related to organisational culture, like giving centre-stage to collegial relations or following protocols, enforced this. When (diluted) person-centred values were espoused, this could also challenge person-centred culture, because change was perceived not necessary. Findings also indicate the importance of leadership, and how societal embeddedness of the values influence the change process. The study contributes to the discussion of person-centred culture change, by highlighting the complex, multi-layered and embedded nature of value negotiation during organisational change. From a practical perspective, the study highlights case-specific challenges for person-centred culture change and the importance of the consideration of various sets of values that are at the root of these challenges.

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1. Introduction

Signals of change have been all around the Dutch elderly care sector for the past several decades. Changes include rapid technological advancements, adapting to digitalisation, a slimming labour force and scarce funding that puts a strain on organisations (Grit, Van de Bovenkamp & Bal, 2008, pp. 13-14). Along with this, our elongated life expectancy and related increase of long-term diseases highlight the importance of providing good elderly care. In the meantime, the values that define good health care are shifting as well. Developed western societies have acquired wealth applying capitalistic values, leading to more emphasis on autonomy and free choice. Concurrently, our elders have become more heterogenic, knowledgeable and demanding. This societal value shift has sparked a demand for a more individualised approach (Koren, 2010, p. 2; Scalzi et al., 2006, p. 369; White et al., 2012, p. 525).

Adjusting to these broader values, person-centred care is offered as a guideline to provide good care. The goal is set to shape an environment where every client is respected as an individual, with emphasis on their rights, quality of life, dignity and freedom of choice (Koren, 2010, p. 2; Scalzi et al., 2006, p. 369; White et al., 2012, p. 525). With that thought shift, there has been an emphasis to transform the traditionally disease-centred elderly care institution into a person-centred home (Koren, 2010, p. 2; Ekman et al., 2011, p. 249).

However, while clients desire the person-centred culture change, it often stagnates at the espousing of its values by health care administrators, rather than consistently practising it (Moore et al., 2017, p. 662). The problem at the base of this seems to be a conflict of values in elderly care, that inhibits the full emergence of person-centred culture. Because there exists a conflicting basis of former traditional values and structures, this serves as a lens through which we view our world. In turn, this lens taints the perception of what good care means and thus defines the direction of change we decide on (Corazzini et al., 2015, p. 621; Ekman et al., 2011, p. 249). This process suggests that the perception of person-centred changes has links to both the past and future. Therefore, this study aims to understand the negotiation of values within elderly care, from a perspective that respects this embeddedness. The framework that is employed for this is the theoretical model of Williams (1980), which sets out the negotiation between dominant, emergent, and residual culture. These respectively correspond with: the current hegemony of values, upcoming values and experiences, and the residue of past social structures and values (Williams, 1980, p. 39).

This qualitative case study provides in-depth data of the influences of value negotiation on change perception, by interviewing health care administrators and managers going through a process of person-centred change. Since this is done at three different locations, this study deciphers how these three organisational cultures can have different consequences on change, by negotiating different values.

In doing so, this study generates case specific data that contributes to a complex understanding of value negotiation in relation to person-centred change and organisational culture. Furthermore, this understanding can contribute to case-specific practical implications, by identifying challenges within the researched organisation.

2. Literature review

2.1 Organisational culture and its influence on the perception of change

Organisational culture can be defined as the norms, values and basic assumptions of a given organisation (Schein, 1990, p. 109). Organisational culture is often nested in a societal culture that affects widespread norms, values and policies, prescribing and teaching us the correct way to perceive, feel and act in relation to circumstances (Bolman & Deal, 2017, p. 258; Schein, 1990, p. 111). This broad definition is suitable for this study because it leaves room to incorporate values that people explicitly espouse, as well as the values and assumptions rooted in practice that can be interpreted in statements, behaviours, rituals and artefacts. Additionally, attention towards the embeddedness in broader societal culture is of importance to this study because of the societal origin of the person-centred change.

Schein (2010, p. 24) offers three major levels that can be considered during the analysis of cultures, namely, artefacts, espoused beliefs and values, and basic underlying assumptions, as can be seen in Figure 1. Espoused beliefs and values and basic underlying assumptions can both be defined as values in the sense that they prescribe what is ought to happen. The underlying assumptions are more unconsciously practiced, taken for granted values that are considered as less negotiable than espoused beliefs and values (Schein, 2010, pp. 25-26). This study will incorporate both levels when speaking of values, as values at both these levels serve as a mental system of beliefs, rules and norms that guide our behaviour.

The three levels of culture

Artefacts

- Visible and feelable structures and processes
- Observed behaviour
  - *Are difficult to decipher*

Espoused beliefs and values

- Ideals, goals, values, aspirations
- Ideologies
- Rationalisations
  - *May or may not be congruent with behaviour and artefacts*

Basic underlying assumptions

- Unconscious, taken for granted beliefs and values
  - *Determine behaviour, perception, thought and feeling*

Figure 1. The three levels of culture. Adapted from Organisational culture and leadership (24), by E. H. Schein, 2010, John Wiley & Sons. Copyright 2010 by John Wiley & Sons.

Although organisational culture is a broadly researched subject, it often lacks definitional consensus. Common viewpoints tend to describe culture as something an organisation *has*, assuming a more rigid and stable social order. This perspective often frames organisational culture as an organisational variable, that is subject to the control of management (Bryson, 2008, p. 744; Ogbanna & Wilkinson, 2003, p. 1153). Recently, there has been more academic attention for the notion that an organisation *is* culture. It is viewed as an ongoing process, that is not always observable and can be negotiated within the organisation (Bryson, 2008, p. 744). This dynamic component is portrayed by Schein (2010) as well, who states that organisational culture can be continuously re-enacted and shaped by behaviours

and interactions with the environment. This definition leads to less emphasis on the manageability of culture. It does however highlight the importance of leadership, that is influential in shaping values and behaviours of employees (Schein, 2010, p. 3).

This study adapts the view of organisational culture as a result of dynamically negotiated values. Bryson (2008) argues changes in organisational culture occur due to a process of constant negotiation, in which the daily negotiation of values is linked to the past. This idea comes from Williams' (1980) theoretical model that distinguishes between dominant, emergent and residual societal culture. Dominant culture, described as the current hegemony of values and meanings, is re-enacted daily. The residual culture holds the residue of previous hegemonies of values and social formations, and can influence dominant culture. For example, if residues that originate from past values, like religious values or assumptions that come from a colonial past, are still practiced in dominant culture. Residual culture can also legitimise the dominant culture because of certain overlapping values, that therefore gain strength in the negotiation. Finally, emergent culture is described as the new values and experiences that are either incorporated or excluded from the dominant culture (Williams, 1980, pp. 39-41).

Williams (1980, p. 39) describes the incorporation of values depends on a struggle between his three concepts of culture. Corresponding residual, dominant and emergent values, are constantly negotiated within the dominant culture. Linked to the levels of culture, the negotiation that takes place is thus between residual, dominant and emergent artefacts, espoused values, and the implicit underlying assumptions behind them (Schein, 2010, pp. 24-26; Williams, 1980, pp. 39-41).

In this struggle the dominant culture exhibits a "selective tradition", emphasising and excluding certain kinds of behaviour and values from the past and present, often unconsciously. Even more crucial, the dominant culture can dilute or reinterpret past values, to make them fit in the dominant tradition. Simply put, looking at past, present and future values with a lens of present dominant values. This leads to the re-enactment and remaking of the dominant culture, because it keeps reaffirming its own dominant values. This is often reinforced by educational institutions. Furthermore, selective tradition filters what emergent values will be incorporated from the emergent culture (Williams, 1980, p. 39).

Within organisational culture, it can be argued, this process works the same. Hence, Williams' (1980) framework will be employed as a lens for this study, as it has proved useful to provide explanatory depth to analyse organisational cultures (Bryson, 2008, pp. 746-747). Henceforth, residual, dominant and emergent values will be discussed in the context of organisational cultures, and represent the mental systems of beliefs, rules and norms that guide behaviour, within the residual, dominant or emergent culture.

The focus on perception of change, in relation to organisational culture, stems from the notion that basic underlying assumptions and espoused values can influence perception. Hence, organisational culture can determine perception. On the other hand, a shared perception of change can influence organisational culture through hegemonic assumptions (Schein, 2010, p. 25). This is consistent with Williams' (1980, p. 39) assumption that there are different "truths" perceived within organisations, with their own set of values. Moreover, it implies that a shared "truth" or perception is embedded in a dominant set of values, and it can reaffirm itself by the same process of selective tradition (Bryson, 2008, p. 746). The perceptions employees consider to be "truths" about person-centred change can be negotiated against the backdrop of dominant culture. This iterative process between change perception and values can therefore influence the course of cultural change.

In practice, management can initiate person-centred changes in the organisation. With this initiation, management asserts that the beliefs and values should be: “the person behind the disease should be central when providing care”. This value is then up for questioning and negotiation by employees. As it is perceived through the lens of the dominant values, this can result in selective tradition and the cherry-picking of values to incorporate. In the mentioned example, this can lead to the alteration of this value. Toning it down to “the person behind the disease is very important when providing care”, can make it more fitting in the current viewpoint (Bryson, 2008, p. 746). When efficiency is valued in the dominant culture, for example, person-centred values are perceived through the lens of efficiency. Thus, the values get diluted to fit into efficient structures, emphasising the value of person-centred care only if there is time for it. This can result in organisational members still operating from dominant underlying assumptions that do not prioritise person-centred care.

The penetration of values into deeper levels of culture seems to be influenced by the success of a value as well. For example, if employees are convinced to behave concordant with the values of the management, and this behaviour proves itself successful. In this case, employees can be convinced or persuaded to practice person-centred care at artefact level. An experience that is commonly perceived as a success, for instance due to positive reactions of clients, can gradually transform into a shared value or belief. The next step would be a transformation into a shared underlying assumption, if the behaviour and espoused values prove to be continually successful (Schein, 2010, pp. 25-26). As such, the negotiation of perceptions can be seen as a gateway towards the negotiation of values and changing dominant culture.

Thus, a shared perception is no guarantee that the associated shared values get embedded into the organisational culture. There are several more factors to consider, besides successful outcomes. First, this depends on the reliability of the associated value. For example, values are considered reliable if person-centred care continually provides a good quality of care, while it is considered to be achievable as well. Second, not all values are clearly testable, for example the desire to deliver good quality of care. For some this will depend on positive reviews of clients, for others it means following protocol. Thus, what constitutes good quality is by definition subjective. Especially when moral matters arise, like making decisions between quantity or quality of life, a value is often not clearly right or wrong. This makes social consensus less self-evident. Third, a link between the outcome and strategy can be hard to test. For example, if next to person-centred care, better treatments can improve the quality of care. Because this is not clear-cut, organisational goals like delivering person-centred care, might get stuck in the category of espoused beliefs and values (Schein, 2010, p. 26).

Multiple perspectives within organisations can be explained by the notion that employees have different dominant sets of values serving as their lens. Organisational members’ personal values are embedded in different cultural backgrounds, (educational) institutes, experiences, interests and social interactions (Grandy, 2017, pp. 175-176). Therefore, they can even have a different perception of the past of the organisation. All these factors accumulate into a variety of residual values in employees, which in their turn influence dominant values that lead to different orientations on the present and future. This can enforce differences in perception of change. As the notion of an absolute truth grows faint, employees’ acceptance of managerial perceptions and therefore their credibility becomes increasingly important to organisations. Therefore, a growing emphasis arises on dialogues and co-creation of values (Bryson, 2008, pp. 746-747).

2.2 Setting the stage: a broad societal value shift

The broader embeddedness of dominant values is getting increasingly recognised as an influence on organisational culture, whereas before, organisational culture was mostly depicted as a closed-off system of organisational artefacts and values. This open system view of organisational culture underlines that societal norms, values, institutions and economic context are serving as a base for embedding (Bryson, 2008, p. 745). This acknowledges that organisations are influenced by macro-level changes. Thus, it is no coincidence that the overarching shift towards person-centred culture has overlaps with societal changes associated with individualism. In the sixties and seventies nursing homes received critique for being repressive systems, that leave little room for individual needs of clients and pave the way towards frailty, because of the structural dependence of elders on health care administrators. Concurrently, the Western society is described as becoming more individualised since then, ascribing more value to independence (Grit et al., 2008, pp. 13-14).

The individualised culture is seen as the consequence of an emerging consumer ethic increasingly defined by individualism and materialism, cultivated by Fordism that provided steady pay checks and the production of standardised mass-produced goods. Both enabled consumers to up their demands of products and organisations. This type of capital accumulation by organisations created an impulse to focus on the managing of impressions of good performance. Therefore, organisations required employees to value quality, flexibility and added-value, in order to satisfy acquisitive consumers (Willmott, 1993, pp. 518-519). Along with the incorporation of this new set of values, this led to the "*desire to bind employees their hearts and minds to the corporate interest".* This explains the instrumentalisation of culture as a normative control mechanism (Bryson, 2008, p. 746; Kunda, 1992, p. 218).

Organisations are additionally pressured by circumstances like the welfare state crisis and more knowledgeable and therefore demanding clients (Numerato, Salvatore & Fattore, 2012, p. 626). Thus, organisations further encourage employees to adopt market-like values. These values encourage them to take responsibility for their performance and be of use to the organisation. Training and selective recruitment are often used to enforce these market values, eliminating other values (Willmott, 1993, pp. 522-524). This is an example of selective tradition of the dominant culture on an institutional level (Bryson, 2008, p. 746).

As the emerged market-like values are incorporated in the dominant culture of health care organisations, this individualistic tendency is reflected in clients' care demands. A number of reasons contribute to this fact. First, due to the higher educational level and access to information, people have become more articulate about their needs and wants. Second, secularisation and the diminishing power of moral codes of conduct have paved the way to develop different individual life styles. Third, growing financial prosperity has given clients the means to buy additional services. Fourth, the organisation of clients has given them a collective third-party role in the health care arena, next to health care insurers and providers. Fifth, because of the portrayal of health care in media, the realisation of lacking quality arose amongst clients and their families. As a consequence of these trends, the negotiation culture rapidly emerged as well (Grit et al., 2008, pp. 13-14).

In line with these trends, client advocacy groups claim more control over decisions concerning their lives. As the client becomes more central in developing care, health care becomes increasingly demand-driven. This tendency is enforced by the liberalisation of the Dutch national health care policy. The Dutch government has indirect control, having delegated the responsibilities for long-term care to private institutions. In this light, care can be seen as a commodified good, and patients, becoming clients in this new discourse, are

more and more regarded as critical consumers nowadays (Grit et al., 2008, pp. 13-14; Schäfer et al., 2010, pp. 35-36).

Nowadays, all these intertwined developments contribute to a societal structure wherein dominant health care culture is embedded. Individualistic and market-like values are currently incorporated in most dominant organisational cultures (Grit et al., 2008, pp. 13-14).

2.3 Movement towards person-centred values

In the traditionally biomedically orientated health care field, a dominant disease-centred culture was the status quo for a long time. This culture prioritised the illness rather than the person. Nowadays, these values are still recognisable in the residual and dominant culture in the sector, as disease-centred care can be perceived as more feasible or valuable by them (Corazzini et al., 2015, p. 621). This culture often is simultaneously associated with task-centred culture, as many tasks are of a medical nature (Ekman et al., 2011, p. 249). Exemplary values that can be associated with these dominant cultures (Ekman et al., 2011, p. 249) can be seen in Table 1.

Table 1. *Values associated with person-centred, task-centred and disease-centred culture*

Person-centred culture	**Task-centred culture**	**Disease-centred culture**
A client is seen as a person with feelings, wants and needs, that is an active partner in its own care	A client is seen as 'one who is acted upon', and hence as a passive subject to perform tasks on	A client is seen through the lens of their disease, and hence as a passive subject of treatment
The person is prioritised over tasks and disease	Tasks are prioritised over the person (and disease)	Disease is prioritised over the person (and non-disease related tasks)
The subjective narrative with the client is seen as the basis of action	Tasks that are objectively formulated (beforehand) are the basis of actions	The disease and objective medical treatments are the basis of action
Management facilitates what is necessary to prioritise person	Management provides caregivers with clears tasks	Management focusses on disease and facilitates all that is necessary for care

However, values have been shifting in the long-term care field over the past three decades. The societal individualistic tendency has tainted the lens by which we review emerging changes in health care. This makes the health care field prone to endorsing individualistic values. Owing to the fact that there is an emphasis on choice and autonomy, the person-centred perspective is gradually emerging. The person-centred perspective promotes autonomy and choice for clients and empowerment for employees, meant to increase quality of life for both (Snoeren et al., 2014, p. 350). Person-centred care does not reduce patients to their disease but regards them as persons. Therefore, taking their subjective ideas, personal situations, strengths, plans and rights into account (Ekman et al., 2011, p. 134).

This is also reflected in organisational values and practices. For instance, within personal-centred organisational culture, clients' autonomy is enhanced by actively involving them in managing their treatment or daily activities. In long-term care, wellbeing is increasingly prioritised over treatment. As all this is valued by clients as well, person-centred

culture seems to have a large influence on the quality of care provided in elderly homes (Patterson et al., 2011, p. 4; Wild & Kydd, 2016, p. 37).

In consideration of these values, a person-centred facility is characterised by a homelike atmosphere and more collaborative decision-making (Koren, 2010, p. 2; Scalzi et al., 2006, p. 369; White et al., 2012, p. 525). Meaning clients and their loved ones are entitled to make decisions about their care and occupational and leisure activities. Regarding the employees, person-centred care is associated with professional autonomy and empowerment, that comes with authority and capability to make decisions about how they provide the desired care (Schäfer et al., 2010, p. 38; Snoeren et al., 2014, p. 349).

In the meantime, the dependence of elderly people to the caregivers increases due to more complex health issues, leading to the expectation that care professionals should safeguard their autonomy (Wild & Kydd, 2016, p. 37). In case of long-term illness, especially neurodegenerative diseases, health care administrators are then expected to form a partnership with clients and their loved ones, to formulate a common person-centred goal (Ekman et al., 2011, p. 2050).

As the societal values are increasingly incorporated in dominant culture, this movement has cultivated a new organisational culture to achieve high quality person-centred care along with a positive work climate for employees (Scalzi et al., 2006, p. 369). Person-centred care is expected to meet three standards. First, the partnership around managing care, between client (and loved ones) and health care administrator. Second, a thorough elicitation of the clients' personal ideas, wants and needs. And third, the documentation of both this partnership and thorough client narrative. In practice however, most health care organisations do not meet these three standards and therefore do not fully apply person-centred care (Ekman et al., 2011, p. 134).

2.4 Challenges for shifting towards person-centred culture

According to several studies, there are challenges in shaping a new culture around person-centred care specifically. These challenges often result in a negative perception of change towards a person-centred culture, because the person-centred values are perceived less important or desired. This is characterised by a lack of employee motivation to change (Bryson, 2008, p. 755; Snoeren et al., 2014, p. 350; White et al., 2012, p. 530). The challenges are summarised in Table 2, after which they are elaborated on.

Table 2. *Summary of challenges for shifting towards person centred culture*

Challenge	*Description*
Embeddedness in dominant disease- or task centred culture	Dominant disease- or task-related values can exclude person-centred values and practices by selective tradition or dilution of these value.
• ***Falling back on disease-centred care***	Because of residual and dominant disease- or task centred culture, it is natural to fall back on. Especially when the means (time, staffing ratio or structures such as documentation) are lacking
• ***Lack of meaningful relations between client, loved ones and health care administrator***	Meaningful relations can be hard to establish, while they are a prerequisite to elicit the client narrative needed for person-centred care. Because of a lack of means, such as time, traditional structures and education on communicating effectively
• ***Lack of means and structures that enable person-centred values***	Time constraints, staffing ratios, traditional structures and the lack of person-centred education make applying person-centred care less successful and renegotiate these values
Stakeholders have different interest	Different stakeholders prioritise different values that correspond with their own interests. As a consequence, no consensus on values is reached
Faulty perception of practising person-centred care	Health care administrators that espouse person-centred values wrongfully perceive they act according to them. Consequently, they feel less necessity for change

The foremost challenge is that of the embeddedness in dominant disease- or task centred cultures. When employees are ascribed adaptive problems with person-centred values, these values deviate from their dominant more disease-centred culture, and disease-centred care can be perceived as more feasible or valuable by them (Corazzini et al., 2015, p. 621). Selective tradition then excludes person-centred values from the dominant culture. It is likely that embedded routines make the adaption of person-centred care in practice even more difficult, as these routines keep re-enacting dominant and residual culture, underlining matching values. Several studies describe the limited room to manoeuvre around traditional paradigms and structures (Bryson, 2008, pp. 746-747; Ekman et al., 2011, p. 249; Moore et al. 2017, pp. 666-667)

A second challenge, that arises from this embeddedness, is the prioritisation of medical care when faced with time constraints. Even when health care administrators try to apply person-centred care, it can still come more natural to heath care administrators to deliver disease-centred care. This makes it easier to relapse in this modus, that is still part of the dominant and residual health care culture. It is found that person-centred therefore takes conscious effort (Ekman et al., 2011, p. 250; Moore et al. 2017, p. 668). Health care administrators also bring forth the technical challenge of insufficient staffing ratios, not having enough help and therefore lacking time to incorporate client preferences in their daily work (Corazzini et al., 2015, p. 622).

The residual and dominant disease- or task-centred culture is also still reflected in traditional structures such as documents, the lay out of the home and existing hierarchy. This also provides a challenge, because the embeddedness re-enacts residual and dominant disease- or task-centred values, reaffirming these values in the dominant culture. For example, the lack of space to document person-centred information in anamnesis impedes the upbringing of individual narratives of clients (Moore et al. 2017, p. 666-667). The documentation in clients' records therefore often neglects their values, preferences and other subjective narratives. This prioritisation of biomedical information, coming from disease-centred culture, implies that this information is less valued (Ekman et al., 2011, p. 250).

Another challenge is that of different stakeholders in health care. White et al. (2012, p. 530) ascribe different perspectives and prioritisations on person-centred culture change to different groups of stakeholders such as employees, residents and their family. This acknowledges the fact that values can be negotiated due to the different perceptions of "truth" (Bryson, 2008, pp. 746-747). Interests of one group can conflict with other stakeholders. For example, the importance that clients and family attribute to the independence for clients is not recognised as much by employees. Their truth is influenced by their preference for a healthy workload (White et al., 2012, p. 530).

There can also be a lack of meaningful relations between the client, family and employee, that can challenge the incorporation of person-centred culture (Snoeren et al., 2014, p. 350). Because of the embeddedness of health care routines in traditional structures, there is not much room left for establishing the client-care administrator relationship that is seen as a requisite for person-centred care (Ekman et al., 2011, p. 249; Moore et al. 2017, p. 666-667). Another barrier to establishing this relationship is the lack of professional education and training specified to improve effective person-centred communication with the client and their loved ones, for example, in asking of open questions (Moore et al. 2017, p. 669). This corresponds with the notion that dominant culture can be remade within educational settings (Bryson, 2008, pp. 746-747).

Furthermore, a faulty perception of delivering person-centred care can be a challenge. Research discovered that employees often perceive that they already practice person-centred care, when they do in fact not act according to the standards of person-centred care (Ekman et al., 2011, p. 250; Moore et al. 2017, p. 668). For example, health care administrators could espouse person-centred values, while in practise this was often not practised systematically and consistently, or safeguarded by documentation of it (Ekman et al., 2011, p. 249). This does not necessarily result in a negative perception of change. It does however reduce the motivation to change, as health care administrators don't see the necessity.

This can be explained by applying Williams' (1980) theoretical model. Within the current dominant health care culture, emergent person-centred values are already partially incorporated. This causes residual disease-centred or efficiency values of the past to be less emphasised by selective tradition. Instead, the past practices that fit these new values are emphasised. Hence, health care administrators have the perception of already applying person-centred care (Bryson, 2008, pp. 746-747). This shows that the basis of not sufficiently providing person-centred care could very well be something other than a lack of motivation derived from laziness or disinterest, as an erroneous perception of the care that is given can cease further incorporation of person-centred practices (Bryson, 2008, pp. 746-747; Ekman et al., 2011, p. 250; Moore et al. 2017, p. 668).

3. Problem statement and research question

This study took place at the elderly care organisation Helleborus-Viburnum[1], a recently merged organisation consisting of three unique elderly homes (Helleborus, Viburnum and Campanula). The separate locations each have their own organisational culture that interacts with the emerging person-centred culture. Therefore, there exist various perceptions of change at the organisation.

Change efforts in the past year ranged from structural changes, to new leadership and policy, but were all means to shift towards person-centred care. Providing consistent person-centred care requires a value shift from task- or disease-centred values towards person-centred values (Bryson, 2008, pp. 746-747; Ekman et al., 2011, p. 249).

With the dust just settling from a merger and the assignment of a new director, the organisation is now steering towards a shift to person-centred care. This means person-centred values are up for negotiation, since all three unique locations have their own unique organisational culture. These organisational cultures are already loaded with values such as culture-specific values, societal values and residual disease- and task-centred values. As many tasks in elderly homes are treatment related, these values tend to overlap in practice (Bryson, 2008, pp. 746-747; Ekman et al., 2011, p. 249). This leads to a complex situation where lots of different perceptions, values and underlying assumptions about care may clash. It is therefore likely the three locations, and perhaps also organisational levels within locations, will have different perceptions of change. This can lead to different behaviour, for different reasons. Therefore, it is useful to gather insight in the perceptions about the recent and current person-centred changes, in relation to their underlying and espoused values.

3.1 Research goals

The organisational research field is in need of linking person-centred change theory to practice in specific case-studies (Moore et al., 2017, p. 663), therefore this study aims to do so. This aim also fulfils the need of evidence-based research for the organisation, that can facilitate person-centred culture change (Wild & Kydd, 2016, p.37). Therefore, a scientific goal of this research is to gather case-specific findings. These findings might contribute to understanding of specific and complex processes of organisational change, such as the implementation of person-centred changes in specific organisational cultures and how these changes are perceived and reacted to as a consequence of that.

One of the personal motives behind this study is to understand how organisational change is perceived and addressed within an organisation, especially when it is as complex as cultural change. This world is rapidly changing and developing, and there is often dispute about what is right and wrong. Therefore, it seems crucial to understand why different meanings are ascribed to changes. This personal interest in what drives people to interpret different meanings to change, leads me to several intellectual goals, as Maxwell (2008, p. 221) describes them. The foremost goal is to understand how organisational members make sense of the changes at the organisation and why this varies. Furthermore, this goal contributes to getting a grasp on practical implications of the variety of perceptions (Maxwell, 2008, p. 221).

A practical goal for this master thesis is to provide insight into the organisation on how changes are received and perceived by different employees throughout the three locations.

[1] Helleborus-Viburnum, as well as the location names Helleborus, Viburnum and Campanula, are pseudonyms to safeguard the anonymity of the organisation

By revealing the meaning behind a positive or negative perception of change, this could become fruitful data that can act as input for policy makers. More insight in meanings employees ascribe to changes and their explicit and implicit assumptions about it, will result in a better understanding of this specific change. Implicit assumptions that are made explicit by the research can as such be of use to improve the current policies (Carlon et al., 2012, p. 800).

Moreover, a practical goal is to communicate this to the organisation in an comprehensible manner. Hence, the thesis will be translated into a document that is more advisory in nature, written in Dutch. This will be conducted during the classes of the advisory honours track of the Utrecht University School of Governance.

3.2 Research question

This study emphasises the influence perception has on the incorporation of values and vice versa, therefore the research question involves both perception and organisational culture. The emphasis on perception also stems from methodological restraints. A more ethnographic approach to researching organisational culture, by elaborate participatory observation, was not possible during the Covid-19 period. Thus, the methodology of choice became interviews. This methodology permits to elicit foremost the espoused values and perceptions employees have about the changes. Therefore, the main research question of this study is:

How are person-centred changes perceived at the organisation Helleborus – Viburnum, and what is the relation of this change process with the organisational culture at the three different locations?

3.3 Relevance

First, this study explains the demand for person-centred care on a complex cultural level, providing more insight in why the organisation is implementing person-centred changes. Furthermore, this study will address a broad view of perceptions of change, incorporating personal perceptions and the embeddedness within organisational and societal culture. Therefore, this study promotes the understanding of different perspectives and different reactions to change. Moreover, it identifies challenges towards person-centred change, that can cause insight in what causes negative perceptions. This can help management improve policy, to meet the needs of clients and employees. The understanding of challenges can evoke a considerate approach towards employees from management, while giving them handles to improve policy, making this research beneficial for all stakeholders involved (Snoeren et al., 2014, pp. 369-370).

For me personally as a researcher, this study provides me with an enhanced awareness of the influence of values and what influences our values. Whether this is on a societal, organisational or personal level, every person has their own set of values through which they perceive changes. Diving into this complex theory, has made me prone to underlying structures and embeddedness. Henceforth, having done this research will trigger curiosity, reflexivity and critical thinking.

4. Methodology

The main goal of this study was to investigate perceptions on changes towards a person-centred culture, which was researched in one umbrella organisation among different organisational levels and at its three different locations. Since this study assumes that values are embedded and constructed within social interactions, this study is conducted from a constructivist epistemology. According to this epistemology human knowledge is socially constructed. This derives from a relativist ontological stance, that there is no objective truth waiting to be discovered out in an external world. Instead, only subjects' constructs of reality are observable to generate knowledge (Flick, 2017, p. 2018; Gray, 2004, p. 19; Guba & Lincoln, 1994, p. 110).

Each individual has a unique ongoing process of making sense of their world, influenced by former experiences, new experiences and interaction with others. Because of this personal sensemaking process, every subject can construct a different meaning, regardless of similar interaction. Hence, multiple perceptions of the "truth" can exist and be equally valid. Within an organisation, these multiple truths can be negotiated among members of the organisation (Flick, 2017, p. 2018; Gray, 2004, p. 19; Guba & Lincoln, 1994, p. 111). As a consequence, this study does not aim to "know" reality or find consensus on value or meaning. Rather, this study focusses on getting to know different perceptions of reality.

Constructivism also emphasises that knowledge is embedded in social interactions. Constructing reality and understanding this reality happens "against a backdrop of shared understandings, practices and language, and so forth" (Schwandt, 2000, p. 197). The perception of reality is therefore embedded as well, and is based on the ongoing interaction between individuals, systems, cultures, structures and histories (Grandy, 2017, pp. 175-176). Therefore, next to the focus on individual meaning, there is also an emphasis on the broader embeddedness of perception in a shared organisational culture. Organisational culture, in its turn, is viewed as a dynamic phenomenon, that is constantly negotiated through social interactions, throughout time (Bryson, 2008, p. 744). This is done by applying the lens of Williams' notion of organisational culture, that emphasises the contested and embedded nature of culture by focussing on residual, dominant and emergent culture. By doing so, this study attempts to do justice to the complexity of both perception and organisational culture.

Assuming that knowledge and reality are constructed and embedded, this study aims to understand and unravel multiple perceptions, the research question focussed on 'how' change is perceived, rather than 'what' that phenomenon is. Moreover, this study aims to understand how these perceptions are constructed through the negotiation of person-centred values, and the embeddedness of perception within the organisational culture (Flick, 2017, p. 2018; Gray, 2004, p. 19).

In line with this overarching paradigm, this approach relies on the subjective interpretation and reconstructing of the researcher. As a researcher, I will interpret meaning and construct reality true my own framework of truths, incorporating my own values, assumptions and past experiences. This fact emphasises that a researcher cannot assume a value-neutral position (Grandy, 2017, pp. 175-176). The implications of this will be discussed in the research quality section of this chapter.

In-depth interviews are chosen as the main research instrument, in order to interpret subjective feelings and values employees experienced during changes. This methodology lends itself to elicit individual constructs through one-on-one interaction. In-depth dialogues also offer the opportunity to give back interpretations of respondents their constructs, to

discuss and compare meanings that I as a researcher have ascribed to them. Going back and forth in interaction aims to distil an informed consensual construct, that allows me as an etic researcher to understand the construct as much as possible (Guba & Lincoln, 1994, p. 111).

The choice is made to conduct these interviews in one in-depth case. This is a suitable approach for a number of reasons. First of all, it is argued in the field of organisational culture theory that in-depth case studies are appropriate to thoroughly interpret shared artefacts, values, and their underlying constructions (Alvesson & Sveningsson, 2015, p. 47). Furthermore, the single case-study approach emphasises on the unique attributes of culture within every group or organisation, allowing to explore characterising patterns of values and beliefs within a given organisation (Schein, 2010, p. 28).

4.1 Research setting

The case study organisation, the foundation Helleborus – Viburnum consist of three locations in a city in the province of Brabant in The Netherlands. This foundation is the result of the merge of Viburnum and Helleborus. The latter consists of the locations Helleborus and Campanula. These locations are culture specific elderly homes, respectively for Indonesian and Mollucan and Turkisch elders. Viburnum does not provide culture specific care. Apart from the elderly homes, Viburnum and Helleborus both have a district care team suitable for their target group. The merged organisation Helleborus-Viburnum employs a total of 386 employees. A new director was assigned right after the merger in June.

Helleborus has its origins in the 1950's, and has always focussed on Indonesian and Mollucan elders, that came to the Netherlands after world war two. The colonial history and occupation of Indonesia by the Netherlands is at the base of this. The objective of Helleborus was to provide a home for those who were torn between two worlds, a cultural-specific home were the values of their native country were respected.

Campanula was founded 2008, especially for Turkish elders. Turkish guest workers were asked to come to the Netherlands in the 1960, to overcome the shortage on the labour market during the rebuild after the Second World War. First generation Dutch Turks were often strongly tied to their Turkish identity and spoke little or no Dutch because of poor integration measures of the Dutch government. Therefore, Campanula was founded as a home were their Turkish identity and values could be maintained.

Viburnum originated from an elderly home that Franciscan Sisters founded in 1993, to care for members of their congregation. In 2001 so-called laypersons were welcome to the elderly home as well, that was still located at a convent then. In 2017 Viburnum moved to a new building, were small-scale care could be provided. This move marked the untangling from the congregation.

4.1.1 Change vision "Samen Kleurrijk"

The new director of Helleborus-Viburnum has written a vision document that offers substantiation to the envisioned developments. The main goal is further developing the person-centred care of all three locations. The document propagates the rethinking of the starting principles: *"not the elderly home (system), but the person should be the starting point of our actions".* Additional aims that contribute to this are professionalising and facilitating the primary process. Professionalising is construed as having expertise and responsibility within your profession. This is concurrent with the philosophy behind the vision, that is based the Rhenish organisation principle. This principle states that professional expertise, autonomy and the organisation of your own occupations should be central. The primary process of care

leads the way and should be facilitated by all other services. As a consequence, the organisational structure is adapted from a traditional pyramid scheme (with the director on top), to the one in Figure 2. This also translated in creating fewer hierarchical levels in the organisation. Only leaving the cluster mangers responsible for leading and facilitating the health care teams.

The underlying assumptions and espoused values throughout the document are that the client should be central and the health care administrators (supported by other organisational levels) are responsible for this. Policy levels and cluster managers are instructed to espouse this vision and act concordantly with it.

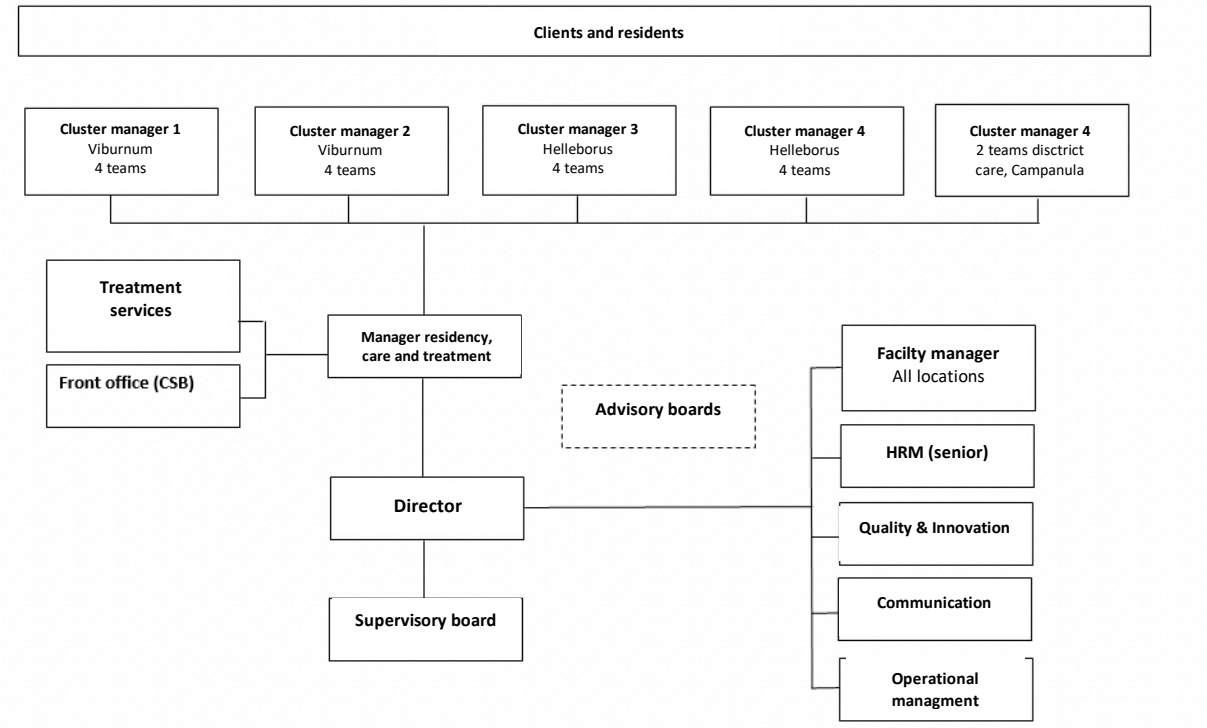

Figure 2. *Organisational structure portrayed in vision document "Samen Kleurrijk"*

4.1.2 Change programme "Waardigheid & Trots op Locatie"

This change programme originated from the Ministry of Health, Welfare and Sport in 2019. It has three pillars by which they want to improve the quality of elderly care. The first and foremost is person-centred care. The two other pillars are key conditions for providing person centred care. These are the sufficient deployment of motivated employees and improvements through learning and innovating.

To work on person-centred care and its prerequisites, an intensive coaching process has started at Helleborus-Viburnum from the fall of 2019. This focusses on the strengthening and securing of person-centred care. There is special attention for wellbeing of clients and learning and development of employees. In the coaching sessions employees are coached towards acting according to person-centred values (like: "client is regarded as a person that can feel, want and need," "client is a partner in decisions about care," and "the person is prioritised over disease or task"). In the coaching sessions several related topics are explored, such as giving each other feedback to improve person-centred care and how to focus on wellbeing rather than care alone.

Furthermore, the programme has supported in modifying the staff composition. This had the objective to ensure professional development. So that there is enough attention and presence of staff, that they have specific skills and knowledge and the opportunity to reflect and learn. Several shifts were added that provided employees with the idea that there was more room to provide person-centred care.

4.2 Data collection

The data for this research was collected through three sources. The prime mode of data is collected through in-depth face-to-face interviewing. 15 semi-structured interviews were conducted. The interviews were loosely based on a topic list and some pre-defined questions, that can be seen in Appendix A. This structure was chosen because the intention was for respondents to freely bring up their own constructs and focus points. Because of the natural flow of the conversation, unexpected data could emerge.

They took place in the office or common activity room of the location the subject was working at, depending on where there was space and privacy to talk freely. Also, it was regarded that 1.5-meter distance could be kept, concerning the Covid-19 measures. One interview was conducted over the phone, because of the home situation of that respondent. All interviews lasted between one and two hours.

Participation was on a voluntary basis. When conducting the interview, respondents first received an informed consent form. This explained the research in short and informed them on their rights. After walking them through the document, both parties signed. Then permission was asked to record the interview. Every respondent agreed to this, so all 15 interviews were recorded. The recordings were deleted after fully transcribing and anonymising them.

Second, the organisation provided access to the policy documents associated with the change efforts. This data served as an insight in the context of the change and a perspective on the intentions of the change policy.

Third, an arrangement was made to participate in the organisation, by supporting the communication advisor of the organisation for two days a week. Due to the Covid-19 measures, most of the work was done from home. Approximately 1 or 2 days every two weeks I was welcome to work at the office. The majority of the time this was at Helleborus and four times at Viburnum. Campanula was only visited once, during the interviews there, because of a lack of office space. Furthermore, the office workplaces were restricted from the elderly home. Observations during this time were written down in fieldnotes in a research notebook, as soon as possible after the observation took place. The fieldnotes consisted of a factual, descriptive column and an interpretation column, to ensure the factual events could be re-interpreted during the analysis if needed. Because of restrictions in time spend at the organisation as well as the locations I could observe; the field notes are not the main source of data, but act as supporting data.

4.3 Sampling

For the interviews a purposive sample was chosen, to ensure representation of all levels and locations of the organisation. The sample of 15 respondents consists of the director of the organisation, a Human Resource employee, five cluster managers (of which one is responsible for Campanula and the district care, two for the teams at Viburnum and the other two for the teams at Helleborus), a coordinator of services, two health care workers of Viburnum and Helleborus and three health care workers at Campanula. This ensured an even distribution of

representation of all locations. Their age, gender and background are summarised in Table 3, other demographics are left out in order to ensure anonymity within this medium-sised organisation.

The health care workers were selected on the basis of availability and their experience with changes in the organisation. They were selected by the cluster managers, that were aware of the goal of the study. Cluster managers were instructed to pick respondents that would have been involved in changes. Either because they worked at the organisation for a longer time or experienced a change in their daily functioning. This was done in order to ensure respondents would have enough input on the organisational culture throughout time and had enough exposure to changes to construct their perception.

Because of the limited time and access to infiltrate the organisation, this snowball sampling was convenient to get interviews with health care workers that were willing and able to talk about their experiences with change. However, this way of sampling could have led to biases because the cluster managers would possibly be biased in picking employees that share their own perceptions. Further, the Human Resource employee was selected because of the direct contact with the employees and her position in the policy workgroup. The coordinator of service was chosen because of her direct contact with the housekeeping staff, that next to the health care workers is an important and big group of employees on the work floor. They were considered to have central roles in the organisation. The director was chosen to further explore her vision behind the change policy.

Table 3. *Table of respondent demographics in randomised order*

Respondent number	Age range	Gender	Location
1	45-55	Female	Helleborus
2	40-50	Female	Viburnum
3	20-30	Female	All
4	50-60	Male	Campanula
5	35-45	Female	All
6	35-45	Male	Helleborus
7	25-35	Female	Viburnum
8	45-55	Female	All
9	35-35	Female	Helleborus
10	40-50	Female	Viburnum
11	55-65	Female	Viburnum
12	30-40	Female	Campanula
13	20-30	Female	Campanula
14	25-35	Female	Campanula
15	55-65	Female	Helleborus

4.4 Data analysis

The interview data was transcribed and anonymised, preparatory to the thematic analysis, leading to more than 250 pages of transcribed data. Thematic analysis is used to make sense of patterns or threads within the data set, identified by the discovering of general concepts that emerge throughout the data set. This analysis suits the interest in similarities and differences among perceptions, as it uncovers and tries to explain connections between different responses and their relation to organisational culture (Gifford, 1998, p. 546). Through an iterative process, the code tree was drawn up, that can be seen in Appendix B. For this the qualitative research analysis program NVivo was used, in order to process the large set of data thoroughly. The code template was be revised until all relevant information for the aim of the research seemed extracted. The stages of this process are described in Table 4. After revising the code tree multiple times during these stages, the template could be interpreted, by defining relations between codes and linking it to theory (Cassell & Symon, 2004, pp. 259-266).

To aid this process of interpretation, a findings summary table was incorporated (Table 5 in the findings section) to provide findings "at a glance". This was helpful to map which phenomena are occurring at the organisation and how these relate to one another. Furthermore, it provides the reader an overview of which data supports the main themes. This gives the reader insight in how a conclusion was reached (Saldaña, 2015, pp. 283-284).

Table 4. *Summary of phases of the thematic analysis* (Braun & Clarke, 2006, p. 87)

Phase	**Description of action**
Familiarising with data	Transcribing, rereading transcripts and data and making notes of initial ideas to obtain a sense of the whole
Pre-defining codes	To provide some structure, choosing some pre-defined codes, such as: past culture, current culture, positive and negative perception
Initial coding	Open coding, letting categories emerge, and systematically coding to existing codes. Also grouping codes and creating initial categories
Searching for themes	Grouping codes under higher order themes, gathering all categories that fit under one theme
Linking themes and theory	As part of the iterative process, revising the theory on the basis of the emerged themes and codes. This provided more insight in relations between categories
Reviewing themes in relation to literature	further specify themes with insights from literature and check if the coded extracts are suitable for each theme and categories
Defining themes	Analysis of the overall story the themes tell, generating clear final names and definitions
Selection for report	Selection of clear, vivid coded extracts that tell the overall story. Including a final analysis of the selected extracts in relation to the research question

4.4.1 Use of literature

As stated above, the reviewing of literature was used to make sense of the data. A fundamental dilemma was whether to review literature up front of the data collection, or first letting data emerge and then inductively searching for explanatory literature afterwards. The risk of reviewing literature up front is that this can limit the researchers focus. However, conceptual clarity can offer guidance in choosing a research question (Karsten & Tummers, 2008, p. 5). For this study, the choice was made to read a broad selection of literature up front, in order to create a sensitivity to certain concepts without narrowing down the focus too much. During the collection of data, additional literature was reviewed. This created an iterative process of letting data emerge and clarifying theory behind it. The final literature review was not written until after the data collection. During the thematic analysis, the literature was revised again. During this stage the literature review provided the needed structure to create coherence in the emerged story from the data.

4.5 Quality of the research

To ensure the rigor of this study, the trustworthiness of the research is addressed. The trustworthiness of the constructivist paradigm rests on credibility, transferability, dependability, and confirmability (Flick, 2017, p. 576; Guba & Lincoln, 1989, pp. 240-244). First of all, the triangulation of methods supports the credibility of this study, by supplying confirming or refuting data (Flick, 2017, p. 490). This makes sure the findings are correctly understood. Furthermore, the purposive sampling, with identification of central players in the organisation and representation of all levels, contributes to the credibility of this study. The inductive component of this study, allowing themes to emerge from the data itself, is another factor that assures credibility. As well as the small sample of 15 interviews at one organisation, ensuring credibility by leaving room for detailed exploration of the existing perceptions.

With this detailed exploration comes a detailed reporting in the findings section. Rich details, “thick descriptions”, and the use of many extracts supply the reader with their own database of findings. This supports the transferability of this research. Thus, the responsibility for generalisation lies with the reader, that can apply the specific knowledge that is generated (Flick, 2017, p. 541; Bryman, 2012, p. 392). Confirmability was considered during inter vision sessions with fellow master students, where the themes and potential biases from me as a researcher were discussed. Confirmability and dependability were also enhanced by taking rich notes of experiences, decisions and observations, that later could be discussed with other students and reflected upon. When alterations occurred in the inquiry, because of emergent topics, these were noted in the research notebook to make decisions retractable and therefore also ensured dependability (Bryman, 2012, p. 392; Guba & Lincoln, 1989, p. 242).

As it is an integral aspect to qualitative research, I have had attention for reflexivity. This improves the transparency of the study. As it is inevitable that I, as a researcher and a person, have an influence on my research outcomes. As discussed, constructivism emphasises my own embedded construction of meanings. I therefore make my own values and preferences explicit, so that its influence can be understood (Corlett & Mavin, 2017, p. 278; Grandy, 2017, pp. 175-176).

Considering the embeddedness, another crucial point to be reflexive on, is to acknowledge my own position in the context of the organisation and the broader societal context (Cassell & Symon, 2004, pp. 181-182). Since the research subjects operated in different levels of the organisation, I must take into consideration that there are different power relations and imbalances. The effect this has on this study depends on the position of

the subject and how they perceive my position (Cassell & Symon, 2004, p. 181). I put effort into levelling with the research subject, with attention to assuring their anonymity and responding understandable and emphatically. Even though, it is likely my university background (Organisation, Change and Management) and collaboration with the communication adviser at the organisation has consequences for me being perceived as an extension of the management. Conversely, at management level, knowing of the goal of the study to include multiple layers could perceive me as an advocate for the health care workers or a judge of their work and therefore have some apprehension to share everything.

Another influence of my own embeddedness in society, is the preference for person-centred care. Growing up in an increasingly individualised Western society, that heavily values autonomy and free choice, I am biased towards person-centred care. There must be considered that two of the three locations accommodate non-western elders. their construction of person-centred care can therefore be entirely different from mine. This must be acknowledged. Therefore, I must stress I do not know what is best for these elders, and do not promote nor do I want to impede person-centred care.

In the light of the vision on responsibility that comes with person-centred culture, I must admit to a personal preference for autonomy over control. This stems from my general perspective on the human nature. As many motivation theories suggest, there is a natural willingness to fulfil a purpose in life. People generally want autonomy over their work and desire the mastery of what there are doing (Bolman & Deal, 2008, p. 121). However, it would be naïve and short-sighted to view the world only from my own predominant conviction. During this study, I try to remain open towards perspectives that might prove that perspective wrong. Nevertheless, I am aware this might have implications for how I perceive my findings. In making my preference and thought process explicit, I hope to overcome a blurred vision, be reflective about my interpretations and remain critical and receptive for alternatives during my research.

5. Findings

The chapter begins with a comprehensive summary table of the most important findings, as can be seen in Table 5. After which the major themes will be discussed more elaborately. The major theme is the negotiation of emerging person-centred values within organisational culture, that influences the change perception within organisational culture (with residual and dominant components). The interaction of values can lead to a more positive or negative perception, these will be discussed separately. The influence that leadership can have on the negotiation of person-centred values will be discussed after that. At last, societal influences on this negotiation will be discussed, and of course the impact that Covid-19 has had.

Table 5. *Summary of findings*

Theme and subthemes	Main codes	Meaning	Example
Negotiation of change related values within organisational culture		Overall, it became apparent that the residual and dominant culture were often influential on the perception of change, by bringing its values forward in the negotiation. Vice versa, the emergent values interacted with the perception of the residual and dominant culture, therefore colouring perceived change.	Rx = Respondent talking about: C = Campanula H = Helleborus V = Viburnum X = information left out to guarantee anonymity
Residual culture	• Past culture Campanula • Past culture Helleborus • Past culture Viburnum	The residual cultures of Campanula and Helleborus are influenced by the former hierarchical leadership, family culture and values from Turkish and Indonesian culture. By many respondents at Helleborus, these values were perceived as involvement with clients. At Campanula the Turkish(/family) residual values were as well. Past focus on disease-centred values was found at all locations, like the prioritisation of medical care. Viburnum was ascribed residual convent values: like structure and serenity. As they described lacking leadership, they valued clear rules to abide by to guarantee quality. Respondents at all locations pointed out person-centred care was already valued to some extent in the past.	• "An appeal was made (by clients) on the caregivers their Turkish norms and values" (R1-C) • "Before, we had the feeling we were the stepsister of Helleborus. If we needed something, it was done with sighs and groans" (R13-C) • "With a big pitfall of not addressing each other. Talking about thing without coming to actions. Those were recognisable pitfalls of a family culture". (R1-H) • "The previous director walked his rounds through Helleborus every day […] he had the tendency to say yes, I hear what you say, but it's going to happen like this". (R4-H) • "We got a big correction of the health care inspection in 2013. From then on, we started with all the protocols and rules". (R10-V) • "Catholicism. Those nuns are very structural, of course. […] you don't just go off the beaten track". (R5-V)
Dominant culture	• Current culture Campanula • Current culture Helleborus • Current culture Viburnum	All three dominant cultures seemed strongly rooted in the residual culture, still espousing residual values and corresponding artefacts. For example, residual family culture that valued sociability, resulted in not giving feedback and a lack of rules. At all locations person-centred values were espoused more prominent, but often disease- and task-centred underlying assumptions and artefacts could be discovered.	• "Person-centred care is important for the resident. On that account, I think it's always positive at Helleborus […] Actually from the beginning that has been the case". (R9-H) • "Perhaps they don't address things that don't go well here as much, perhaps they don't dare to say things because they think they will hurt someone". (R3-H) • "If you touched Helleborus, you touched the former director […] many people felt that was a support, but some

		For example, while espousing value for responsibility and autonomy, underlying assumptions or behaviour ascribed more value to following protocol or responsibility higher in the hierarchy. This negotiation of values resulted in the fact that giving feedback was a responsibility that was rather avoided, while person-centred care was espoused to be very important, respondents described that under time pressure, this often could not be prioritised. This indicates conflicting values are still part of the negotiation and can get prioritised if there is a lack of means. It can also indicate that the emphasis on person-centred values, enforces selective tradition of certain (diluted) values and highlights them. Resulting in more person-centred perceptions of past culture, but also of the perception of delivering person-centred care already.	(C) felt it was a rejection. Those will experience the changes in their own kind of way". (R4-H/C) • "There was a sense of fear. Like oops, unfamiliar, what should I do? Can I carry that responsibility? […] There are still people that value hierarchy and call me mister". (R4-C) • "A new resident is a blanc piece of paper for me. Here you go, go do activities with her. I don't know who she is, what does she enjoy?" (R13-C) • "I think Helleborus is more focussed on relations and less on rules. Viburnum, I think, relation I cannot judge, but by all means they are more focussed on rules". (R6-H/V) • "Because you work with more people on one group of residents, you don't have to work as hard. Then you have the space (to deliver person-centred care) […] it's more about wellbeing than care. Although, that's difficult still, because they're all care people". (R10-V) • "You couldn't deliver person-centred care in the morning, because you were alone […] someone gets out of bed quite troubled, because we are rushing – what of course is wrong of us, but it happens because of time pressure". (R7-V)
Emergent culture	• Amount of change perceived • Positive change perception - e.g. involvement, positive prospect, pro-change person • Negative change perception - e. g. scepticism, setback, workload, unclear	The perception of the emergent person-centred culture and recent changes varies depended on the outcome of negotiating residual, dominant and emergent values. For example, a negative perception of being set back by unclarity, perhaps influencing quality, that results from spreading responsibility. Or perceiving a positive prospect or necessity for changing the current situation. Or a faulty perception of change, since person-centred care was already perceived to be applied. The amount of change perceived could also be a combination of the incremental changes in the	• "In some way, they are going to do what they always did. But then labelled as cluster role". (R7-V) • "I cannot always make time for person-centred care for the residents – I try, but with much effort – but if I look around me, I see my colleagues doing a good job. I think it's going the right way". (R13-C) • "At some point we got a debit card for all resident groups, where money is deposited on each month, so you have the freedom to buy some things each month for the residents. So that you're not always dependent". (R7-V) • I scheduled a couple extra meetings, to convey the story to them. […] And now, I also hear things like: Well, when are

	• Person-centred values	primary process and perception of already delivering person-centred care.	we going to change then? So that actually worked out good, people see the added value now". (R6-H)
Influence of leadership on negotiation		The organisation seems to rely on leaders to have an exemplary role and espouse person-centred values, that then got negotiated by employees. Depending on credibility, effect, feasibility these could be adopted.	
	• Person-centred values - e. g. giving responsibility, espousing values • Characteristics perceived important - e. g. credible, being there, capable, communication • Change in leadership • Role of director	In the current dominant culture, leadership is perceived to further include the giving of responsibility and deliberation. Positive perceived leadership that effectively negotiated these values was ascribed credibility, capability, open communication and being there for employees. This reinforced the belief employees had in the values the leader espoused. Especially the director, that reflected espoused values in behaviour, was a cause for appreciation and inspiration. However, a prerequisite for this was often being in the proximity of the director. It was perceived as a negative influence when the leader lacked insight in what feasible, or did not put espoused values into practice.	• "People need time with each other to think: oh right, it's actually true what is said: the smaller the group, the more time I can spend on our group of residents […] Incorporating each other into that story. I think that has succeeded as well". (R6-H) • "When I try to promote that autonomy. Well, the moment they experience a problem, convey them in the thought: well, what did you thought of yourself?" (R1+H) • "I have the feeling that X does not realise things. X expects things of me (doing activities with residents), and I think: don't you realise I have X hours, how in the name of god will I make all that happen?" (RX-X) "(If management says no to a request) you often hear back from it. But well, sometimes it's communicated with a sense of: you don't have anything to say about that. So that was a source of resistance then. […] But now we are increasingly more involved in decisions". (R7-V)
Societal influences on negotiation		The values within the organisation proved to be no closed off system from external influences, as societal values and shifts were seemingly entering the negotiation.	
Influence of societal culture	• Individualism • Market-values • Disease-centred values	It became apparent that the dominant societal culture at the time had influence on the residual culture and the dominant societal values. Making the current dominant culture more prone to the emergent person-centred culture. Because in	• "Values that get increasingly important here are knowledge, competency and expertise […] because you see a different demand in that area". (R6-H)

		society, agreeable values were increasingly incorporated. This could lead to more selective tradition of person-centred values. Valuing individuality led to an emphasis on autonomy (of client and employee) and more articulate demands. Specifically, market-values presented itself in all levels of culture as well. Such as efficiency and a demand-focus that valued quality and therefore person-centred care. This reinforced the negotiation. On the other hand, residual disease- and task-centred values came out in the dominant culture, when prioritising medical tasks or in structures like documentation or lay-out of the building.	• "Then, on a group of 30 feathers (light care), you had 12 employees. Of that you can only dream now, the deployment decreased". (R10-V) • "Elderly have become more vocal. And it's a good thing, too. Back in the days it was all: yes. And now it's: no, I don't want that. And that's allowed I think, it's their life". (R11-V) • "Every resident that comes here is an individual. Of course, you want to adapt the care to them, what they are used to, what they find important". (R2-V) • "It's their life, their house, I need to respect that. […] I worked at a place where they had timeslots. You go to someone, 5 minutes there, 2 minutes there […] before it was like that, I did not care for it". (R12-C) • "Family members […] they really demand a lot. They think: it's my mother and you need to take care of them". (R14-C)
Complexity of health care	• Work load • Neurogenerative disease	The increasing complexity of care was associated with work load and lack of means. It was also stressed this causes different needs, emphasising the tailoring of care to specific demands of clients.	• "The complexity was different that time [15 years ago], the more that has increased, the more specialisation and expertise is needed". (R6-H) • "What kind of person what your mother? […] they cannot tell them yourself, 90% here has dementia". (R13-C)
Covid-19	• Smaller work load • Focus primary process • Change in leadership	Covid-19 foremost contributed to the renegotiation of person-centred values. Emergent values and new norms within society seemed to result in the primary process being the focus, resulting in less workload and the experiencing of more means for person-centred care. Leadership is perceived to be more facilitating and credible, since the positive outcomes regarding Covid-19.	• "You're searching for all kinds of alternatives. […] All the trees are shaken loose, all the roots are a bit loosened – you see that all the processes they were stuck in, are effortlessly discarded right now. Because you just have to". (R1-H) • "By all means, we have to provide that they, whatever it takes, can carry on with their health care work. The rest is second". (R8-C/H/V) • "I think Corona secretly contributed to the trust in the knowledge and capability, in particular that of the top management". (R3-C/H/V)

5.1 Negotiation of change related values within organisational culture

5.1.1 Residual and dominant culture

The three different locations have different dominant organisational cultures, that influence the negotiation by defining what values are perceived as important and so on what changes are valuable to the different locations. An analysis based on Scheins' (2010) three levels of culture is made in Table 6. Thereafter, all locations will be separately discussed, incorporating Williams (1980) lens of residual and dominant culture.

Table 6. *Three levels of culture at three different locations*

	CAMPANULA	HELLEBORUS	VIBURNUM
Artefacts	• Traditional one big living room lay-out • Lack of protocols • Turkish decorations, but in moderation • Closed-off location • Supervisor present • Fluidity in tasks • Being checked upon by family • Strong team bonds • Not giving feedback	• Traditional one big living room lay-out • Lack of protocols • Lots of colourful Indonesian/Mollucan decorations • Lots of socialising • Office set-up with many separate offices • Focus on own task • Not giving feedback • Elaborate but separate complementary care	• Small-scale departments • Clean environment • Working hard • Elaborate security system • Big communal office (and some separate offices) • Lots of protocols (e.g. household book) • Focus on quality of care
Values and beliefs	• (Residual) disease-/task-centred values • Family values • Turkish values • Hierarchy values	• (Residual) disease-/task-centred values • Family values • Indonesian/Mollucan values • Hierarchy values • Task-centred values	• (Residual) disease-/task-centred values • Rational values • Valuing of structure • Valuing of rules and regulation
Assumptions	• Turkish elders have authority over care-givers, and should be respected and listened to • Our priority is care and then wellbeing • Providing care is a collective team effort • Making exceptions is allowed if elders ask • Informal bonds are important • Feedback is hurtful	• To be polite/modest is more important than being truthful • It is important to belong in the collective, informal bonds are important • Our priority is care and then wellbeing • Providing care works best if everyone performs their task • Feedback is hurtful	• Our priority is care, wellbeing is extra • Providing care works best if protocol is followed • Frameworks of rules provide feedback • Quality of care depends on good protocols • Exceptions and stepping out of protocol can lead to worsening the quality

Helleborus has a dominant hierarchical family culture, valuing (informal) relations and respecting hierarchy. This seemed to have roots in the residual culture, that respondents associate with Indonesian and Mollucan culture. These cultures put a strong emphasis on the importance of family and the collective, being (too) modest and friendly, and being respectful towards elders and hierarchy: *"You know, what's said when you come in here: 'plan, plan', (Indonesian for) 'take it easy'. Yes, that is adopted quite quickly. And the residents are of course also like that, they dare not ask for things. Say it's as good as in our DNA". (Respondent 1)*
The focus on informal relations became apparent in artefacts within the residual culture, such as informal gifts. Like flowers on employees' birthdays and a yearly "*envelope with dirty money*" (Respondent 3). *"to give a bouquet of flowers is peanuts of course, but it's the feeling behind it […] the feeling of being appreciated". (Respondent 5)*

The residual culture was also associated with the leadership of an outspoken patriarch: the former director, that made most decisions top-down. Negative consequences of this hierarchical family culture were associated with not taking responsibility and being passive. Respondent 5 commented: *"people were trying to operate under the radar and sort of hide. They did what they had to do and especially not much more than that, to not stand out"*. Not giving feedback was noted as a pitfall of this culture as well. The latter was by some respondents associated with residual influences of the Indonesian and Mollucan culture as well: *"They want to avoid a painful subject. Something that, I think, plays a big part in the Indonesian culture is pleasing a little bit".* (Respondent 4)

The focus on relations also extends to the clients, which results in emphasising certain person-centred values, like making meaningful contact and wellbeing. Since family was often involved, this was also emphasised as an aspect of applying person-centred care.

Similar tendencies were reported at Campanula, where the respect for authority is mainly ascribed to the Turkish and Islamic culture, that is present in the dominant culture and even more strongly rooted in the residual culture. The respecting of authority of Turkish elders, also seemed to result in making exceptions, which was associated with person-centred care. There is however, been less exposure at Campanula to the hierarchical leadership and more emphasis on taking responsibility, due to being *"a small house that is very independent and does their own thing, nobody really interferes with"*, as respondent 3 said.

The reason for not giving feedback seems to have roots in the residual family culture, as well as the valuing of close relations in the dominant culture. Respondents highlight the effect of being checked on by family members, that could enforce the fear of compromising close relations within the team with giving feedback. Respondent 13 commented: *"A lot of colleagues are like me, they want to keep it friendly. Then we just keep our mouths shut, that saves us the drama. There is enough drama as it is with the family".* This and the scale of location Campanula resulted in a very close team, as respondent 13 stated: *"We are more like a big group of friends, that's what keeps me here"*. This made for strong bonds to Campanula and a willingness to go the extra mile for each other.
The implied drama with family members is ascribed to be a consequence of Turkish culture, because family members are in conflict with their values about taking care of your own family members: *"Some family members will complain, complain and complain. In our (Islamic) culture you are not allowed to put your family here. So, I can understand them. […] There are Muslim, their parents are here, they are fighting with themselves".* (Respondent 12)

At Viburnum, the residual culture is described by many respondents as the convent culture. Respondent 5 commented: *"The nun-culture is quite apparent still at Viburnum. Rest, regularity and rules".* As a consequence, dominant culture still puts an emphasis on structure and clarity, but less than the residual culture. Respondent 2 commented: *"The fact that we still work here according to norms like 'a deal is a deal' and norms from the quality framework – that we think that's important – that does fit that (nun) culture".* Respondent 10 ascribed less influence to the convent and more on a significant need for change, namely a bad inspection report in 2013: *"From then on, we started with all the protocols and rules. Before that, there were no rules. Then, it was more – more like Helleborus now – all based on that culture, but no rules"*.

Rationality, structure, clarity and professionality are valued. Downsides of this rational culture, as it will be called from now on, is that it leaves less room for autonomous thinking, experimenting and subjectivity. Customising care to subjective needs can therefore be difficult. Respondent 8 stated: *"It is a challenge to not think in terms of rest and regularity and 'this is how we do things around here', because that's also a type of hierarchy. […] The processes, protocol, that's how we do things around here and we abide by that"*. Respondent 10 offered a metaphor: *"Imagine you are at a roundabout. Nobody is around, and there is a traffic light that is red. Well, then you should be allowed to make your own decisions. I don't need that traffic light, I can look around for myself. Now we are so fixed on the traffic light, we forget to look around for ourselves".*

However, the strong focus on quality due to professional values and market-values made the dominant culture prone to accepting person-centred values, as they were ascribed to improve quality.

5.1.2 Emergent culture

To address differences in perception on changes and, it is necessary to understand what management aspires the changes to achieve. The idealised emergent culture is described in twofold. First of all, the change from the residual disease- and task-centred culture towards the emergent person-centred culture, described by respondent 8:

"The place where hospital care and nursing home care comes from is of course: we know what's best for you. And at the moment you are sick, and the moment you end up here in bed, we close the doors behind you […] And somewhere down the line we said we were going to turn that around, because it's about quality of life and not only about care. And the family matters. And that person's personality, that asks something else from us than saying: that's how we do thing around here. Well, that's a major cultural change of course, and asks for other behaviour". (Respondent 8)

A professional attitude is described as a prerequisite. This includes feeling responsible for delivering person-centred care and making sure others do so as well. This caused a focus on learning and giving feedback, that was also apparent in the change programme.

Respondents espoused many person-centred values. The emergent culture was often perceived as not that different from the way people administered care now. This was reflected in respondents their perception of how much of an adaption it would be to prioritise person-centred care. Respondent 11 stated: "*I think it's going well at Viburnum actually. With the care plans as well, that's also targeted and person-centred care. All the targets are about the*

same, but the actions are all person-related. Then you actually already are operating person-centred".

Respondents often already ascribed their location a person-centred approach in the past. When asked if they noticed a shift from the more traditional elderly care to person-centred care, Respondent 11 answered: *"Actually I think we already were doing that quite a bit. Because here, we have small scale care. Now you are with two employees for eight residents. I think that's quite a luxury".* Respondent 9 commented on another location: *"I think it's always positive (person-centred care) at Helleborus […] Actually from the beginning that has been the case, certain flexibility".* Small scale care, staffing ratios and flexibility are regarded as artefacts of person-centred care.

5.1.3 Positive change perception

Therefore, it is no surprise that findings indicate that there was an overall fairly positive attitude towards implementation of policy striving towards more person-centred care and professional autonomy. Respondents agreed with individualistic values, resulting in values and assumptions that care should adjust to that. Respondent 12 stated: *"I am a guest here, this is their home, their life. I should respect that. Even if they cannot speak. Still I let them know, you are here, you have a say".*

Especially respondents in management or policy positions were positive about the prospects of change. Respondents often mentioned a personal preference for change. Their underlying assumption that change is good, also seemed to contribute to the negotiation of new values. As Respondent 1 stated: *"Once every couple of years, I have a need for some novelty*". But this personal preference was not restricted to management. Respondent 15 stated: *"I live off changes. Every change also means renewed attention, and looking at our clients with new eyes".*

Most health care administrators were moderately positive. The vision behind the change was said to be supported, and was congruent with the person-centred values they espoused. Respondent 9 commented: *"Samen Kleurrijk. With that I just agree, you know. The part of together we're colourful and the residents central and person-centred care. Yes, if you don't support that you should go look somewhere else"*. However, sometimes they were hesitant to believe everything that management espoused to aim for would become reality, like giving more responsibility. Respondent 13 commented: *"We all hear it, you know, that we will become a self-managing team, but I don't recognise any of it to be honest".* Even though the values espoused by management were perceived positive, they could be seen as less credible.

Findings showed that the lack of unrest, as a consequence of subtle negotiation, was of influence on the positive perception of change. Especially employees often stated at first, they did not notice much change. After further inquiry, it became clear there were changes. These were not perceived as intrusive or undesirable change, because of overlap in existing and emerging values. This contributed to the positive negotiation of person-centred values. Top-management had emphasised artefacts and values that already matched person-centred care. Because of this, changes were often perceived as further improvements rather than rigorous turn arounds. Respondent 5 commented: *"Also we looked at what was going well, and then especially keep on doing that. Not at all like everything is wrong or everything needs to be done differently. That was an eye-opener for people".*

5.1.4 Negative change perception

When the negotiation was between conflicting values, change was often perceived more negatively. The challenge of embeddedness in conflicting disease- and task-centred culture was identified in the findings. Several respondents suggested that in the present, there were still employees operating from other values. Such as the disease-centred values or valuing control or efficiency. Respondent 9 commented: *"It still needs to grow on the residents and the employees. Of course, you have those kinds of people that still are in it like: at 10 we have to be finished and ready, dressed at the table. Or at this and that time everybody should go to bed".* Respondent 10 adds: *"it's more about wellbeing than care. Although, that's difficult still, because they're all care people"*. Respondent 15 stated she noticed that some colleagues were just checking off tasks, but expressed this often resulted from a lack of means: "*Those are often the people who have things going on at home as well […] person-centred care asks quite something from the employee".*

No respondents explicitly prioritised disease- or task-centred values over person-centred ones, but in some behaviour and structures it became apparent it was. Respondent 13 commented: *"I almost have no time to give someone individual attention or something like a hand massage or make small talk at their rooms about how there are doing and what they like".* More often, a lack of means like time, energy or structures for person-centred care was mentioned. This resulted in the perception that change was not feasible, even if person-centred values were espoused. More feasible values tended to gain the upper hand in value negotiation.

This lack of means also challenged person-centred care by consequently leading to a lack of prerequisite meaningful relations with clients. Many respondents stressed that time and energy enabled these relations with clients and their loved ones. Respondent 15 stated: "*I myself have a privileged position, I can work one day and rest one day, so I can deliver it. I think health care can only fully make this change if the contracts are modified. The same salary, but a maximum of working 24 hours per week. Only then you can reload and use that energy to really make a connection".*

Traditional structures from residual culture often were at the root of this challenge. Respondent 12, commented: "*Before (the Covid-19 outbreak), it was like a market, way too busy […] they couldn't do anything with the residents, way too busy […] Now we have two living rooms […] more attention, more one-on-one attention. This is ideal".* The lay-out of the location Campanula was perceived as an obstacle for this. Respondent 13 mentioned another problem with structure: *"When new residents arrive, their prehistory is always missing. They don't incorporate that enough in the anamnesis, I think".* These statements imply that certain structures prevent employees from delivering person-centred care. Since these structures are often embedded in traditional cultures, they cause to re-enact conflicting values and therefore undermine person-centred values in the negotiation.

Next to this embeddedness in disease- and task-centred culture, other aspects of the residual culture arose as challenges of embeddedness. Residual values that were re-enacted in dominant culture seemed to block the incorporation of values seen as a prerequisite for person-centred care, such as responsibility and feedback. For example, family culture prioritised being friendly over giving feedback on person-centred care, while the rational culture seems to value the clarity of protocol over the flexibility to apply person-centred care. At Viburnum, a dominant value at the root of negative perceptions of responsibility seemed to be the belief that it could lead to doing things wrong. Respondent 7 commented: *"At the same time I think it's kind of hard sometimes, because you just don't know how far you can go*

with your ideas. What is right and what is wrong?", assuming there is a right and wrong. Respondent 4 spoke about this fear from a leadership perspective: *"I don't get the impression that it's like people don't want to do things because of it. But perhaps I am mistaken, I don't know. Perhaps I'm thinking too lightly of it, because I'll be like: guys, making mistakes is allowed"*.

Overall, leaders seemed to value responsibility more than employees, making this a negotiation between organisational levels. Managers often saw responsibility and autonomy as a prerequisite for person-centred care, which was not recognised by employees as much. Respondent 2 stated: *"It's nice that for employees, their work gets to be more fun, because they are more challenged,"* while Respondent 9 commented: "*I do miss that, that there's not a sort of… like that particular person is responsible […] Of course it's good that a team is thinking on their own – I mean it's not like we are all awaiting – but I do miss that. A real, permanent, yeah, where you can go to"*. This could be linked to leaders personal valuing of responsibility. Respondent 4 commented: *"We did after all choose for the role of supervisor for a good reason. I think we do have something inside of us that wants to make the decisions"*.

it emphasised the presence of different interests among stakeholders, as managers wanted to share their own responsibility and employees often desired someone to be responsible for them. These varying perceptions provide more proof that the values of person-centred culture, and its prerequisites, are still under negotiation within the organisation and between organisational levels. This negotiation was often between employees and managers and could also be about what person-centred values to prioritise. Respondent 7 mentioned: *"There was a lot of resistance […] In the mornings you could not deliver person-centred care, because you're alone. And so, if people don't want to get out of bed, you still get them out of bed because you don't have time for that afterwards. […] We get it, you (the organisation) want person-centred care, but person-centred is not only offering freshly cooked meals. It's also all about how you get someone out of bed in the morning"*.

Residual values that kept getting reaffirmation within the value negotiation, could also lead to certain tainted expectations of emergent changes. As they were not met, they contributed to unrest and a negative perception of change: *"I underestimated it a little, my new position. […] So yeah, I was a bit surprised. At the beginning, that also gave my quite some stress. Like ow, this is actually quite a lot of work"*. (Respondent 3). At Helleborus, there also was a negative perception towards change because of other expectations. It was mentioned by several respondents that at Helleborus, the former director had explicitly said nothing would change. Respondent 5 stated: *"The tone was set by the former director who kept calling, namely here at Helleborus: the merger has no consequences at all, nothing will change, for no one".* This could have enforced the confirmation that residual values were valid and that negotiating them was not necessary and thus, change was unnecessary.

The restructuring of the organisation was seen as another cause for unrest about change, but often did get recognised as a necessity. As was seen in the new organogram, the new structure was built on person-centred values. Helleborus' and Viburnums' past organisational structure was a traditional pyramid scheme with the director on top. The clearly conflicting values of these artefacts were negotiated and seemed to cause unrest. However, being in line with other espoused person-centred values, this example was soon accepted as the norm.

Many respondents recognised a demand-driven and quality-driven impulse from societal values. As so, they often did not blame changes on behalf of these values on the new management. Rather, it was often mentioned that the necessity for the abundance of changes

was caused by former management, by not responding to shifting societal values. Respondent 13, mentioned: *"the new director is very strict. And well, that's what Helleborus and Campanula need. From all those years of being that casual and easy. […] Sometimes I think it's a little… 'why like this, why like that?'. But if you think about it, this is the right way, the better way to make a company work".* Employees who stood further away from the management were often more sceptical, but expressed their understanding for change to adapt to societal demands and ensure survival of the organisation.

The most negative reactions seemed to arise when dominant values were negotiated with clearly contrasting values, while this was not considered necessary. For example, if changes involved values or artefacts that espoused contrasting values. Values were clearly negotiated in a battle between prioritising culture-centred care or person-centred care. This clash between collective values and individual values was described by respondent 8: *"Here, you're also dealing with culture-specific care. It was about to be a war when I came here. A war between people who put culture-specific care first, like: that's our thing. And a group of people who say: no, our thing is person-centred care".* Another example was that emergent values that emphasised more formal agreements seemed to clash with the informal values of the family culture, and therefore had a negative influence. Respondent 5 commented: *"People had made arrangements, but those arrangements weren't put on paper. And the person who they made the arrangements with were gone […] as a family, you put a certain trust in one another".*

Several times an example was made of the bouquet of flowers that formerly would be received if one worked on their birthday at Helleborus, that was cut due to budgetary choices. Respondent 5 commented: "*People did really feel a certain way about it. And were actually showing up on the doorstep of their supervisor at the beginning of this year, when they did not receive their bouquet of flowers. Then I really thought to myself, oh, okay, so that's a sensitive issue".* The unrest about this seemingly small change is an example of the meaning behind the artefact, the *"focus on relations, rather than rules"* (Respondent 1). Cutting on this artefact could therefore be perceived as a breach of their relation-centred values. This also indicates there were different interests. Employees have a big stake in an appreciative and friendly workplace for themselves, while management has stakes in running a financially sound organisation.

5.2 Influence of leadership on negotiation

Many respondents suggested leadership played a big part in steering the value negotiation. They had a central role in making the objectives of the change clear. As values are expressed within objectives, this clear communication contributed to arguing why person-centred values were preferred. Some respondents stressed that this could be done more thoroughly and with more incremental steps that guide them true the negotiation. Respondent 3 commented: *"I think the communication is a point of attention. Because for long, it was like 'there will be a plan, there will be a plan', and meanwhile you are in anxious anticipation. And then: 'this is it!', I don't know, some more communication".* This need was often acknowledged by leaders, such as respondent 5: "*We just need to keep communication with our people, keep talking to them. And also, really listen. […] And not only consult them and think: 'yes, that's nice, but we won't do anything with it'. […] Yes of course, you don't always do something with everything they say, but very often you can explain why you don't. And that they do think is important".*

Respondent 5 also stressed that employees value being listened too and involved in decisions. Respondent 7 stated: "*Sometimes it's quite pleasant I think, because you get the idea that you may contribute in the thought process. That you can generate ideas*".
At first this respondent commented that there were not many changes in the way the managers acted around this, while later in the interview, she stated: *"They are trying to stimulate you to think for yourself, about what you could do or try […] before that was less, indeed".* If managers clearly behaved according to their espoused values, this seemed to contribute to the reliability. Since listening and involving often was associated with getting responsibility, this behaviour contributed to the negotiation of these values.

Moreover, respondent 5 commented: *"You do notice that managers are trying to be more involved themselves. Visit the resident departments more".* More respondents highly valued the leaders to be there for them mentally, which was often linked to being there in proximity. Respondent 2 mentioned: *"We notice that employees value short communication lines with the cluster managers, they have the need for someone to fall back on".* A consequence of being there physically, could be that more dialogue on values was created. Thus, creating more negotiation, which enforced person-centred values. Moreover, person-centred values, like individual attention, could get re-enacted by leaders. Respondent 6 commented: "*I try to do that a couple of times a week. To see people one-on-one. And 'how are you today, is everything going alright?'. Those kinds of things, very basic, but it is well received*". Respondent 3 perceived this tendency as a positive change: *"Because of the new positions we have performance reviews. Those we didn't have before. […] Now they really ask: 'how are you? What are your development goals?'. So that's something I think is very good".*

This enactment by leaders could potentially have an exemplary role. Being in proximity also seemed to enable acting as an example. About the assumption that mistakes can be made, respondent 10 stated: "*If I make a mistake, I will admit to making a mistake. I think that sets an example"*. It was also mentioned that employees adopted person-centred values that other employees espoused and enacted. Respondent 10 mentioned an example, involving an increasingly incontinent client that goes to the toilet independently: *"Then an employee said: 'she's got a sensor, what if we put that on the chair? Then, if she stands up, we can check if she is going to the toilet' […] three years ago, that answer would have been fine. Now, immediately two or three colleagues said: 'well, and then? If she only stands up to get a pair of scissors out of her drawer, we barge in there with our big mouths to ask if she is going to the toilet. […] And then the other one said: 'Right, that's true, you can't do that.'".*

Explicit values, espoused by the director especially, also seemed to have a positive influence on negotiation. If employees agreed with her values, they often showed a positive perception of change. The "Samen Kleurrijk" policy, written by the director, also had an exemplary role. Respondent 5 said: *"I believe the document says the tail follows the head of the organisation and not the other way around […] for a long time it has been normal that the back office decides what the front office should do, so to say. But no, of course it has to be about the residents […] I need to facilitate for the health care administrators the best I can, so they can care for the residents".*

Furthermore, person-centred values were re-enacted by consistently focussing on these values in artefacts leaders created, like policy and documents. It is mentioned that this was a conscious decision, by respondent 8: *"I think everything is connected now. So, people understand that this belongs with this and, oh yeah sure, because we are doing this right now. Instead of all sorts of new things surfacing. People think: 'yes, we are working on person-centred care here*'". Respondents seem to perceive this consistency in values as a good thing.

Respondent 3 stated: *"It ("Samen kleurrijk" policy) did not came as a surprise, because it was in line with the things she previously announced and communicated. So, I really thought to myself: finally, nice, clarity. Something like, I know where she wants to go"*. Respondent 5 mentioned another example that promoted the consistency of person-centred artefacts: *"The organisation chart was altered so that the director wasn't on top, but the residents were on top, and after that the health care administrators that care for them. […] People were like: what's this? […] Yes, that was new to them. But that's the way it should be, right? This is what we propagate, so we should act like it and adjust our structure to it".*

Consistency in leadership also seemed to have an effect on the credibility of the leaders, and therefore on the values they bring to the negotiation. Respondent 4 mentioned: *"It's a whole other way of managing (from the director). It also gives more freedom. And that, I think the teams feel that. And her way of working, in my opinion, seamlessly fits in with the "Samen Kleurrijk" concept they describe. […] That she really practices what she radiates and what she puts into words".* By being consistent, this leadership re-enacted the values and assumptions that are espoused, like the valuing of autonomy. A perceived expertise or capability also had an effect on values being perceived as reliable: *"You know, it's so great that they (coaches) are people outside of the organisation. Who bring their knowledge back into the organisation and help us. […] For me they have a certain expert status. It's something they have done before"*. This possibly contributed to the change being perceived as a (future) success, which contributes to the reliability of values: *"That's why I think that's going to have the most impact, at the end of it all*".

This capability was also ascribed to leaders within the organisation, mostly to the director who envisioned the person-centred changes. For example, respondent 13 stated: *"I think she's a pleasant woman to listen to. And the things she tells. I think by myself: well, see, that's something we can benefit from as a team, you know. As an organisation"*. Or respondent 10: *"She knows when something has priority. She is a person who is obviously grounded, that's what we need right now. So I do have faith in it. Even though I don't see much of her […] but she really stands for the clients"*. The expressed faith in the director seems to contribute to a positive perception of change, because it contributes to the reliability of the values espoused and enacted by her.

5.3 Societal influences on negotiation

As is discussed, organisational culture can be nested in societal values and structures. This became clear when respondents talked about reasons to adopt person-centred care. They often mentioned that elderly care is getting increasingly severe, due to an increased life-expectancy and more severe health issues towards the end of life. Respondent 6 stated: *"The complexity was different that time (15 years ago), the more that has increased, the more specialisation and expertise is needed".* The consequences they described seem to confirm the tendency towards demand-driven care as well as a tendency towards custom care and an emphasis on individual needs. These are values that are in line with person-centred values, so these societal values enforce person-centred care in the negotiation.

Respondent 6 commented: *"Values that get increasingly important here are knowledge, competency and expertise […] because you see a different demand in that area. […] but there is more needed. And I do see the development to more professionality*". These developments put an emphasis on different needs from health care administrators. Care is expected to be specialised to the physical needs, as well as the mental needs of every individual client. Respondent 5 commented: *"First it was all about the quality of care, instead*

of quality of life. But people are more than the care they receive". Respondent 9 stresses there are different structural needs as well, now that clients often have complex problems: "*First, we had one big living room where everybody could sit. But for all the unrest and stimuli the clients were getting, the situation wasn't ideal".*

The valuing of tailored care is enforced by individual demands being more commonly vocalised, by the client or often their loved ones. The vocalisation of individualistic values contributes to the justification that person-centred care is good quality care, leading to the satisfaction of clients. This causes person-centred care to be perceived as successful, and therefore corresponding values as more credible. Respondents seemed to value the vocalising of individual demands. Respondent 12 states: *"I often talk about person-centred care with the quality assurance employee. That's a part of my own culture, that is a must for me. Even if I don't want to. You have to, those people also have a voice".* Respondent 11 describes this tendency as well: "*Elderly have become more vocal. And it's a good thing, too. Back in the days it was all: yes. And now it's: no, I don't want that. And that's allowed I think, it's their life".*

Even though there seem to be higher demands, the staffing ratio has decreased according to respondent 10, due to budgetary cuts in health care: *"Back then, on a group of 30 feathers (light care), you had 12 employees. Of that you can only dream now, the deployment decreased".* This development does not seem to combine well with the desire to administer person-centred care, as many respondents have mentioned lack of time and sufficient staffing as a barrier for the success of person-centred care. Making person-centred values less feasible and therefore less reliable, this had a negative effect on the negotiation and thus, perception of person-centred changes. Efficiency, being a market-value, could potentially re-enact a residual (or dominant) task-centred culture. Respondent 15 stated: "*Yes if look around you, you also see colleagues that are just checking of tasks*".

Respondents also indicated that certain market-values like top-down control and efficiency were diminishing. Respondent 5 said: "*for a long time it has been normal that the back office decides what the front office should do, so to say. But no, of course it has to be about the residents*". And respondent 12 stated: "*I worked at a place where they had timeslots. You go to someone, 5 minutes there, 2 minutes there […] before it was like that, I did not care for it".* This seemed to have a positive effect on the negotiation of person-centred values, as it reinforced the need for taking responsibility and taking time to establish meaningful relations with clients. However, since market values are still very much present in the current capitalistic western society, these values can still be re-enacted in the current organisational culture and thus, undermine person-centred values in the negotiation.

5.3.1 Influence of Covid-19

A unique influence, characteristic for this time, is that of the global Covid-19 pandemic. The outbreak in The Netherlands has caused a complete lock-down of elderly care facilities. This meant the organisation had to refrain from having visitors and most office staff had to work from home. As a consequence of that, much of the communication was done through online videocalls. Further, residents had to abide to the 1.5-meter rule amongst each other and were split up into smaller groups for activities and sitting in the living rooms.

Although respondents commented that the outbreak was an encroachment on the resident's lives and had awful consequences for people who got sick, they also reported some silver linings. Respondent 1 stated: "*You're searching for all kinds of alternatives. […] All the trees are shaken loose, all the roots are a bit loosened – you see that all the processes they were stuck in, are effortlessly discarded right now. Because you just have to".* The necessity to

change and re-evaluation of all norms and values, with only Covid-19 to blame, seemed to have a positive effect on the perception of change. It seemed to made negotiation easier. Some respondents even mentioned it brought people together due to having of an external common enemy. Leaders were not blamed for imposing changes, but praised for facilitating needs of employees during this time.

The emphasis on facilitating leadership, born out of necessity, contributed to the renegotiation of values. The emergent value that the primary process should be the focus of the organisational efforts, seemed to be confirmed by this process. It was mentioned people at the office at Helleborus – jokingly called "*the golden hall instead of ivory tower*" by respondent 10 – even came to help feed clients. Respondent 8 commented: *"By all means, we have to provide that they, whatever it takes, can carry on with their health care work. The rest is second".* This message was reflected in society, heavily espousing value for the hard work of health care workers and loving care they administered now that the loved ones of residents could not come visit. The absence of family and lack of their person-centred attention could also have been a moral consideration to perceive person-centred care as a necessity, and therefore lead to greater incorporation in the dominant culture.

The Covid-19 outbreak also enforced person-centred behaviour from certain leaders. Respondent 3 stated: *"Because of corona, there is not much room for meetings, so I tried to find my way in that by asking more things one-on-one. Like 'how are you? What else have you got?'".* And respondent 4 stated: *"Certainly after corona went off, I'm there about every day. I walk in there and I discuss some things with X or with another person that's there. […] So they see me a lot. They also ask quite a lot now*". These re-enactments of person-centred values, like taking time to give one-on-one attention, could reinforce the emerging person-centred culture.

A behavioural change on the work floor was having less meetings and therefore having more time to administer person-centred care. This change greatly contributed to the ability of health care workers to provide person-centred care. Thus, it seemed to contribute to the negotiation of person-centred values. This could possibly lead to the incorporation of more person-centred values in underlying assumptions, since this increases their feasibility, successful outcomes and thus reliability.

Moreover, the reliability of person-centred values could be further enforced by the growing overall trust in the capability and credibility of the management, that several respondents mentioned. Credibility can provide management with a solid position to negotiate values from. Respondent 3 commented: *"I think Corona secretly contributed to the trust in the knowledge and capability, in particular that of the top management".* This was also reinforced by their clear communication during the pandemic. Respondent 8 stated: *"We also hear things from people like: it's so nice, clear communication, to know where we stand"*.

6. Discussion

The organisation Helleborus-Viburnum has gone through turbulent times, experiencing lots of change the past year. The beginning of the changes was marked by the merging of three diverse locations and the arrival of new management for this colourful mix. The new director came along with a new vision, “Samen kleurrijk”, that focussed on person-centred care and, by extension, the importance of professional autonomy. The extensive change programme, called “Waardigheid & Trots op Locatie”, was deployed to reinforce person-centred care at all three locations. Even amid a global pandemic, change was not put on hold at Helleborus-Viburnum. On the contrary, born out of necessity, change was ever so present in the organisation. With diverse change efforts going on, within an organisation characterised by diversity in the first place, this main question arose:

How are person-centred changes perceived at the organisation Helleborus – Viburnum, and what is the relation of this change process with the organisational culture at the three different locations?

At Helleborus, the former hierarchical and patriarchal leadership resulted in a culture that required less autonomous thinking. This way of working was reinforced by Indonesian and Mollucan cultural values, like being modest and prioritising being friendly. The intended change promoted responsibility for person-centred care, and giving feedback on it, since this was identified as a prerequisite for person-centred care. These changes could be perceived undesirable due to conflicting values about responsibility and feedback, that were still present in the residual and dominant culture. The traditional health care values that conflicted with person-centred values were disease-centred and task-centred values. The underlying assumption that the disease demands priority can be associated with residual societal values in elderly care. Therefore, that residual culture was present at all locations. The prioritisation of the task could be an effect of the hierarchal culture and might be enforced by market values still present in society. These other prioritisations might explain the perception of person-centred change being challenging to realise with the means available to them. Apart from this prioritisation, the means and structures of Helleborus are quite often not sufficient for person-centred care. The lay-out of the building and limited time that re-enact conflicting values can therefore be very substantial reasons for not perceiving changes as positive.

At Campanula, that was led by the same former director, they had experienced the leadership differently. Because of his absence at and perceived disinterest in their location, they perceived the change in leadership as positive to start with. This could contribute to the negotiation of values, by giving management more credibility. Furthermore, their organisational culture seemed to value responsibility more, since they felt more independent from the overarching organisation to begin with. So, even though they still had a supervisor at the moment, they perceived this as a positive change. Giving feedback however, another change that was promoted as a prerequisite for person-centred culture, was perceived as a change that was difficult to achieve. The Turkish culture that was prominent in residual and dominant culture, put a strong emphasis on family as well. Therefore, it was considered more important to remain friendly with colleagues. This value was enforced by many troubles with family members. Originated from Turkish and Islamic culture, assumptions about the need to respect elders seemed to contribute to the fact that employees espoused person-centred values. Employees said that because of this, they already made an effort to administer person-

centred care. The emergent values of the person-centred culture could have interacted with the perception of the residual and dominant culture, therefore colouring employees' judgement into thinking person-centred care was more prominently carried out. However, artefacts like anamnesis, lay-out and behaviour did not always reflect these values. This was often due to the embeddedness in a disease-based value system, that was prominent in residual and dominant culture. These structures that prohibited changes, made employees perceive person-centred care as less feasible.

At Viburnum, the residual and dominant culture emphasising protocol and structure were based in residual convent culture and a residual valuing of rules after a negative inspection. The effects of this in the dominant culture provided some challenges for person-centred change, because of conflicting values. A strict following of rules and protocols did seemingly not promote professional autonomy and responsibility. Thus, changes towards these values were perceived as more difficult. The need for structure and a supervisor who is accountable was continually expressed, and therefore it could be assumed that values about responsibility were still up for negotiation, which influenced the change perception. The emphasis on giving feedback during the changes however, was perceived more positive. This coincided well with the valuing of accountability and guaranteeing quality. Certain artefacts associated with person-centred care, such as small-scale groups and staffing ratios, were already in place. Therefore, certain person-centred values did not have to be negotiated. This made employees perceive person-centred care as positive and changes as very feasible. The pitfall of this is that, possibly because of these artefacts and espoused values, employees think they are already giving person-centred care, while in fact they are still administering disease- or task-centred care. At this location, these types of care are still embedded in their dominant culture, because of their residual culture and societal influences. However, because of the focus on quality of care at Viburnum, there was an overall willingness to work on person-centred improvements, leading to a more positive change perception.

Overall, findings indicate that the difficulty at all three locations might not be convincing employees of values associated with person-centred culture, but convincing them that they are not administrating person-centred care sufficiently, and are still acting according to conflicting underlying assumptions. Behaviour and other artefacts often seemed to be still based on other values, such as disease- or task-centred ones. Therefore, not all artefacts reflect their espoused values. The interaction of current values with residual and dominant culture tends to act as a blind spot. By partially incorporating or diluting person-centred values, this becomes part of the lens through which health care administrators view their own behaviour. When espousing person-centred values, it is reassuring to think that you practice what you preach. This makes employees perceive the care as more person-centred than their behaviour and underlying assumptions give away. This faulty perception of practising person-centred care can act as a challenge for the emerging of person-centred culture, since it reduces the perceived necessity for change.

This blind spot also occurred at management level and in how they applied leadership. Management espoused values about leadership that are associated with person-centred care, like promoting autonomy and facilitating needs. Most of the time they made conscious efforts to apply this in practice, but this did not always succeed. Most of them were aware they still needed control and could undermine employees' autonomy, especially when being under pressure.

Mainly the embeddedness in disease- and task-centred culture formed a challenge for person-centred culture. On top of that, family culture, hierarchical culture and rational culture

all hold values that were contrasting person-centred values. These organisational cultures were also embedded in the disease- and task-centred cultures that created another challenge. Strong contrasting values of the residual cultures still get re-enacted daily in the dominant organisational cultures at the organisation, in behaviour and structures guiding this.

Findings indicate that change is perceived more negatively if the values of the change conflict more strongly with values in the dominant culture. Since matching values of residual cultures are often opposites of person-centred values, change requires a comprehensive value shift. Conflicting values were often embedded in traditional structures and means, which resulted in a challenge of lacking means for person-centred care. Time constraints, staffing ratios, documentation and structural lay-out of the building were mentioned as challenging. This could result in another challenge for person-centred care, namely the lack of meaningful relations with the client (and their loved ones).

The overall drivers towards person centred culture can be associated with concurrent values. Next to person-centred values, positive values about change, in general, can help with a positive perspective towards change. Not being forced to shift values immediately was also a cause for positive perception. Incremental value shifts seem to contribute to the negotiation of values. Selective tradition might an explanation for this. Values that do not contrast dominant values too much are more likely to be incorporated. If changes require significant value shifts and the condemning of dominant values, emergent values are more likely to be excluded.

As leadership is strongly tied to organisational culture, it proved to have its influence on value negotiation and the perception of change as well. An exemplary role, espousing person-centred values and matching behaviour and other artefacts with it, was supporting for the negotiation of person-centred values. Especially when the exemplary behaviour was perceived to have a successful outcome. For example, when the employees appreciated a person-centred approach of the management towards the employees, such as having one-on-one conversations. The perceived capability and credibility of leaders also had a boosting effect on the perception of change, in part due to the greater capacity to negotiate their espoused values.

For all locations, it became apparent that organisational culture is an open system, incorporating values from society that interact with values present in the organisation. The biggest influences were individualism, an increasingly demand-driven society and concurrent market-values. These values were often reflected in structural artefacts like the lay-out of the home, documentation or staff ratios. Covid-19 had its impact on this open system as well, by renegotiating values. It did so by emphasising a facilitating role of management and reinforcing their credibility and therefore reliability of values espoused by management.

Societal tendencies that emphasise individualistic values, demand-driven values and quality values seem to be a driver for the incorporation of person-centred culture. These values legitimised person-centred values in the negotiation process. Already being part of our dominant societal culture, these familiar values could also cause a selective tradition in favour of person-centred values. However, organisational culture is no one-on-one depiction of societal culture. The fact that person-centred values are not yet fully incorporated, underlines that organisational cultures have their own specific dynamics as well.

The three themes emphasise that the perception of person-centred change depends on the outcome of the negotiation of values within the organisational culture, and that this process can be enforced by corresponding values, or inhibited by conflicting values, from the organisational culture, societal culture and values leaders espouse and practice. Furthermore,

the dynamics of the negotiation are influenced by residual, dominant and emergent values, that can be implicated in artefacts, espoused values or underlying assumptions behind them. Thus, the perception of person-centred change is influenced by the dynamic between all these phases and levels of culture. Therefore, when aspiring person-centred change, the complex dynamics of this change process should be considered.

6.1 Strengths and limitations

This study is far from a complete portrayal of either the perception of change or the organisational culture. However, adopting the framework of dominant, residual and emergent culture has provided a more complex interpretation of organisational culture. This would not have emerged from only researching the current artefacts and values through a descriptive lens.

Williams' (1980) framework provided explanatory depth by emphasising organisational culture as a complex and relative process of social construction. It facilitated the ability to look at a bigger picture beyond organisational boundaries, as well as zooming in on individual perspectives within. It helped understanding organisational culture in the broader context of the western hegemony of values, like individualism and capitalistic market-values. Within the organisation, the same notion of construed and negotiated culture, helped zoom in on a pluralistic whole of different perceptions.

While this study explores a more reflexive account of culture, it is not without limitations. The framework of residual, dominant and emergent culture is useful as a lens through which to question and explain. However, it does not provide a research method or a full-blown analysis method. However, it does enable the generation of new insights by adding explanatory depth and breadth to organisational analysis in a number of ways.

The dynamic negotiation of organisational culture is highlighted by the findings of this study. Findings seem to provide proof that the overarching organisational culture is negotiated throughout the three locations as well as the organisational culture within the location. This explains the impact of a credible narrative, such as the "Samen kleurrijk" vision narrative that puts an emphasis on the primary process of care and the importance of person-centred care, thereby increasing the responsibility and autonomy of health care administrators. This coherent and consistent story of change seems to compete with other truths in the organisation, therefore making people receptive for the change perception that it promotes and changes that are consistent with this story. An important notion is that this story of change did not derive from an instrumental intention to tempt employees. Instead, the organisation has put an emphasis on the dynamic nature of culture by respecting the diverse identities and different values of the three locations.

In-depth longitudinal data would be preferred, as this could reveal how the perception of changes and values get renegotiated over time. This study only provides a snapshot of the unfolding changes and associated perceptions, with retrospective accounts of residual culture.

Due to Covid-19, an ethnographic approach with more emphasis on participatory observation was not possible during the time of this study. Therefore, the study was limited to data mainly from interviews. A second limitation of Covid-19 was the limited time spent at the organisation. Therefore, this study gives a very limited snapshot of the dynamic negotiation process going on at the organisation.

6.2 Implications for further research

To provide a more substantial view of this ongoing negotiation, longitudinal research is suggested. For example, mapping the negotiation at several different moments in time would be interesting to test certain theories that came up during this study.

Furthermore, since this study mainly focussed on the perception of change, it only brushed the surface in what is needed to sustain person-centred changes. Establishing change seemed to depend on the interaction of values that were brought up in these negotiations along with experiencing putting person-centred values into practice. The perceived success of artefacts then became a prerequisite for incorporation of its corresponding value in the underlying assumptions. Further research can specify what is needed to implement and maintain person-centred change.

Another influence this study briefly encountered was that of personal values about change in general. Further research could elaborate the impact of this on the perception of change and value negotiation in general.

Furthermore, since Williams' (1980) theoretical model proved itself as a useful lens to create a complex and multi-layered view of organisational culture, further research could further employ this framework. Next to proofing the use of this framework, the negotiation about organisational culture at the organisation seemed to provide evidence to the notion that an organisation *is* culture. More research on this perspective is therefore suggested, to achieve more academic consensus on this stance on culture.

6.3 Practical implications for organisation

Findings indicate challenges that are often structural of nature. Checking existing structures for embeddedness in contrasting values is, therefore, a recommendation. If documents, lay-outs, staffing ratios and other structures are adapted so they espouse the same person-centred values, these can contribute to enforcing person-centred values in the negotiation.

By providing an understanding of different perception, the findings also promote being considerate of different perceptions and experiences. Therefore, the findings highlight the existence of multiple truths in an organisation, and the importance of not incriminating employees on "wrong" perceptions during the negotiation of values. Additionally, viewing a location only from one perspective might downplay the possible needs that still arise due to the residual culture. Being reflexive about residual and dominant culture draws attention to the history of employees and possible futures, justifying varying perspectives. Thus, it can be a ground for consideration.

7. Conclusion

In conclusion, the main question is answered based on the 15 interviews conducted at Helleborus-Viburnum, backed up by observations from participant observation and an extensive literature review on the subject of organisational culture and person-centred change. Overall, it became apparent that the residual and dominant culture of the elderly home locations, manifested in artefacts and values, often influenced the perception of change. Existing person-centred values in residual, dominant and societal culture, led to a more positive perception of change. Conflicting values, such as disease- and task-centred values, undermined person-centred values in the negotiation process. This led to a more negative perception of change because when core values are under negotiation, this causes unrest. After all, it shakes up the way we perceive the world. The analysis along this theoretical model of culture has provided insight into how values within an organisation are negotiated. The result of this value negotiation seemed crucial in determining the perception of change. Findings indicate that there are multiple inhibiting or enforcing factors within the negotiation, namely the interaction of embeddedness in residual organisational culture, societal shifts and leadership. Dominant values acted as a lens within these interactions, highlighting or excluding certain values through the process of selective tradition. If person-centred values proved to be successful in practice, in either health care administrators' behaviours or in the exemplary behaviour of others, this validated the credibility of the values and associated changes.

The identified challenges in negotiating person-centred values were overall concurrent with the literature, and provided further proof and concrete case-specific examples that were often lacking in the literature. Moreover, this study added in-depth explanations of how these challenges arise, by employing a complex and dynamic viewpoint. As such this research contributes to the discussion on person-centred change, by acknowledging the contested nature of change and perception, that is often still approached in research with an instrumental or descriptive manner. Furthermore, it contributes by supplying a theoretical framework, that could serve as a steppingstone towards more research that focusses on embedded, dynamic and interactive value negotiations in change processes. As it proved itself useful to analyse organisational change in the health care sector, it might be useful to employ this in other sectors as well.

8. Appendix

Appendix A. Topic list

Perception of changes
- Sketch of changes
- Reasons for change
- Influences on change
- Results of change
- Influence on function/role

Previous culture/values of location(s)
Explanation "culture": collective values and beliefs of organisation
- Sketch of previous culture/values
- differences culture/values locations

Context culture
- Community
- Target group
- Society

Current culture
- Sketch changes organisational culture/values
- Influences of change on culture/values
- Differences/ similarities in locations

Changing of values in practice
- Espoused values
- Matching artefacts
- Perception of cause

Connection of changes with culture
- Similarity in changes and culture

Resistance
- Differences teams/locations/values
- Cause of resistance

Room for topics that inductively pop up
- Role of leadership

Appendix B. Code tree template

Theme	Second order category	Third order category	Fourth order category
Change perception versus	Residual culture	Past culture Campanula	Islamic culture
organisational culture			Turkish culture
			Controlling family
			Top-down decisions
			Turnover
			Stepsister of Helleborus
			Little involvement of director
		Past culture Helleborus	Indonesian/Mollucan culture
			Family culture
			Patriarch director
			Top-down decisions
			Hierarchy
			Culture-centred
			No feedback culture
		Past culture Viburnum	Structure and rules
			Focus on care
			Convent culture
			Little involvement of director
			Fear of inspection
	Dominant culture	Current culture Campanula	Islamic/Turkish culture
			Controlling family
			Close team
			Still left out

			Difficult giving feedback
			Espoused person-centred values
		Current culture Helleborus	Indonesian/Mollucan culture
			Family culture
			Task-centred
			Culture-centred
			Difficult giving feedback
			Espoused person-centred values
		Current culture Viburnum	Structure and rules
			Focus on care/disease
			Small-scale
			Work ethic
			Espoused person-centred values
	Emergent culture	Amount of person-centred change	Perception of little difference
			Perception of much difference
		Negative change perception	Setback by changes
			Sceptic of goals
			Work load
			Unclear goals
			Not used to responsibility
			Rather keep old ways
		Positive change perception	Involvement in decisions
			Positive prospect
			Pro-change personal preference
			Meeting expectations
			Necessity for change

			Valuing responsibility
			Having support
Societal influences	Societal culture	Individualism	Individual needs
			Vocalising needs
			Respect for individual
		Market-values	Efficiency
			Focus on demands
			Focus on quality
		Disease-centred	Focus on medical care
			Task-centred
			Disease-centred structures
	Complexity of health care	Work load	
		Neurogenerative diseases	
	Covid-19	Smaller work load	
		Focus on primary process	
		Change in leadership	Clear communication
			Facilitating attitude
			Appreciative
Role of leadership	Supporting person-centred values	Exemplary role	Focus on individual employees
			Giving responsibility
			Deliberation
		Espousing person-centred values	
		Characteristics seen as drivers	Credible
			Being there
			Capable
			Open communication
		Negative	

		Role of director	Match behaviour espoused values
			Exemplary role managers
			Trust in organisation
		Changes seen in leadership	Promoting autonomy
			Closer proximity
			Listening and involving

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