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The relationship between teamwork and sustainable quality culture in transitional care

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Abstract

Purpose: To explore how teamwork and sustainable quality culture relate to each other in transitional care from the perspective of intensive care personnel.

Methodology: The questionnaire 'Assessing Quality Culture Health Care edition' (Sten et al., 2021) was used to measure teamwork and sustainable quality culture within an ICU setting. This questionnaire consisted of 50 statements and 16 factors.

The results were statistically analysed using SPSS. Initially, no significant differences in scores were found between the two ICUs. Consequently, the results were treated as one set of data. Pearson's Product-Moment Correlation was used to compare the measured factors for team collaboration within and between hospital units (6 factors) and the measured factors for sustainable quality culture (10 factors) to determine whether the factors correlated with each other. Correlations with an *R*-value above 0.50 (significant level 0.01) were considered high and treated as a correlation.

Findings: All means for the factors measuring teamwork within hospital units were higher than the factors measuring teamwork between hospital units, which could indicate a lack

of system view. The results also showed that it was only the factors measuring teamwork within hospital units that correlated to four of the sustainable quality culture factors, namely ‘AI’, ‘Pride’, ‘System view’ and ‘Continuous improvement’. The sustainable quality culture factors, ‘Leadership commitment’ and ‘Participation of everybody’, did not correlate with any of the factors concerning teamwork. This result suggest that these factors might need to be adjusted in the questionnaire to fit within the healthcare context.

Research limitations/implications: This research is limited to intensive care personnel’s perceptions of transitional care at two medium-sized hospitals located in rural areas of Sweden.

Originality/Value: No studies have been found that investigate the relationship between teamwork and sustainable quality culture within transitional care from the perspective of intensive care personnel. A sustainable quality culture can have an impact on teamwork and therefore also on patient safety. Insights from this study may have practical implications for the development of teamwork and sustainable quality culture within health care aimed at increasing care quality and patient safety.

Keywords: ICU transitional care, Sustainable quality culture, Teamwork

Paper type: Research paper

1. Introduction:

Due to the increasingly unstable and competitive environment of organizations today, achieving successful collaboration is critical within and among organizational teams as well as with their external partners to ensure organizational performance and competitive advantage (Boughzala & de Vreede, 2015). This applies, in particular, to health care in which patients are often fragile with needs that require high care quality and patient safety.

The increasing demands on healthcare services is leading organizations today to struggle to maintain the focus on creating value for patients, while, at the same time, saving costs, adapting to new needs and achieving equity of access to health care (Gualandi et al., 2020). Rosen et al. (2018) argue that coordination and delivery of safe and high-quality care demand reliable teamwork and collaboration, which involves teamwork within as well as across organizational, disciplinary, technical and cultural boundaries. Previous research has shown that effective teamwork is crucial for providing optimal patient care in an intensive care unit (ICU) (Reader et al., 2009). Team leadership, in particular, appears crucial for guiding ICU team members when interacting and coordinating with others. Similarly, Weller et al. (2014) argue that senior champions, department heads and individual clinicians must recognize the importance of interprofessional collaboration and teamwork in creating safe and efficient patient care. Richardson et al. (2010) identified four principles for improving the effectiveness of teamworking in intensive care: engender professional efficacy, create stable teams and leaders, develop trust and participative safety, and enable frequent team reflexivity.

The results of a study by Körner et al. (2015) underpin the importance of interprofessional teamwork in healthcare organizations and that investigating organizational culture and its impact on interprofessional teamwork and team effectiveness in health care is important for future research. According to Borrill et al. (2000), healthcare organizations should seek to create a culture of cooperative interdependence and collaboration between teams that emphasizes shared goals and focuses on delivering high-quality care and patient safety. Gaps in continuity of care can be life-threatening for patients transferred between hospital units. Findings from a study by Häggström et al. (2009) showed a perceived a gap in the care cultures between ICU units and general wards. This gap appears to be caused by differences in the level of care, which contributed to difficulties for nurses encountering an overlap during transitional care.

In summary, the way multiprofessional teamwork in transitional care is performed, along with the existing sustainable quality culture, is likely to affect performance and delivery of care quality and patient safety. It is therefore interesting to further study how teamwork and sustainable quality culture relate to each other.

The purpose of this study is consequently to explore how teamwork and sustainable quality culture relate to each other in transitional care from the perspective of intensive care personnel.

2. Theoretical background:

2.1 Teams, real teams and pseudo teams

A team can be defined as a 'real' team (e.g., Hackman, 2002). A real team has a higher performance impact and team effectiveness than a potential team or a working group (Katzenbach & Smith, 1993). According to Katzenbach and Smith (1993), a real team incorporates five elements: size, purpose and goals, skills, working approach and mutual accountability. Other requirements for being a real team, mentioned in previous research, are the members identifying as being part of the team; the team's task requiring members to work closely and interdependently towards a common objective; the team having clear and specified roles and a mandate to decide how to carry out team tasks; and the team holding regular meetings to reflect, communicate and review team processes (Lyubovnikova et al., 2014; Richardson, 2011). Co-workers often report that they are working in a team when they have the same supervisor (Lyubovnikova et al., 2014). However, having the same supervisor does not necessarily mean that you work in a real team. Hackman (2002) argues that if the task does not require them to work collectively and interdependently with others towards a common goal, they are not members of a real team (Wageman et al., 2012). Such collectives of individuals have previously been identified as "pseudo teams" (e.g., Katzenbach & Smith, 2016; West & Lyubovnikova, 2012).

2.2 Organizational culture and sustainable quality culture

Almost all parts of organizational interactions are affected by the culture of the organization (Henri, 2006), and understanding and developing the culture can be challenging in terms of both effort and time (Gimenez-Espin et al., 2013). According to Santos-Vijande and Álvarez-González (2007), the organizational culture consists of a cluster of common norms and values formed over a long time and affecting the way an organization works. The culture of an organization can be understood through the perspective of three levels: artefacts, espoused values and underlying assumptions (Schein, 2009). Artefacts are described as visible organizational structures and processes. Espoused values are strategies, goals and philosophies that exist in the organization and create an image of the organization. Underlying assumptions constitute a deeper level of culture that is grounded in the history of the organization. This level includes the essence of culture in the form of common learned values and beliefs that are now taken for granted. The second level, espoused values, is the core values that form a sustainable quality culture.

Quality management (QM) is often seen as a philosophy or culture and/or a set of methods and tools used in order to create an organizational culture '… characterized by increased customer satisfaction through continuous improvements, in which all employees in the firm actively participate' (Dahlgaard et al., 2002). According to Sila and Ebrahimpour (2002), customer orientation, leadership commitment, participation of everybody, continuous improvements, management by facts and process orientation are the most common values mentioned in QM literature.

Bergman et al. (2022) present a theoretical model consisting of six core values or cornerstones forming the base for a sustainable quality culture: focus on customers, base decisions on facts, focus on processes, improve continuously, let everyone take an active part and develop

committed leadership. The quality core values are mutually dependent on each other and function as a system in combination with working methods and quality tools (Bergman & Klefsjö, 2020). As QM initiatives often focus on solving problems and are thereby seen as a deficit-based approach, a more strength-based way of approaching problems and culture change can add new perspectives. One way of doing this is by using appreciative inquiry (AI) and thereby, as Cooperrider and Srivastva (1987) state in their research: focus on increasing successful experiences instead of problem detection. AI is a theory and mindset aimed at influencing creativity and organizational learning (Watkins & Cooperrider, 2000).

Ingelsson et al. (2018) summarize the important values to create a sustainable QM culture as follows:

- 'having a committed leadership;
- giving all co-workers the opportunity to contribute and participate;
- having a focus on our customers;
- adopting a more holistic view on the organizations and society; and
- continuously working with improvements.'

Zooming in on health care as a context, there are some challenges that need to be addressed when it comes to organizational culture, which, to some extent, are unique to health care. Establishing a sustainable quality culture within health care organizations can be one way to meet these challenges. According to Khatri et al. (2009), there is a need to move away from a 'blame culture', which is often present within health care, to a 'just culture'. To move from a blame culture to a just culture, 'health care organizations first need to move away from an overly compliance-driven, regulated management system to a commitment-based management system that encourages employee participation and involvement in decision making' (Khatri et al., 2009, p. 320). This is something that teamwork and a sustainable quality culture could help to accomplish. In addition, de Souza and Pidd (2011), identified a number of barriers when studying the implementation of the QM initiative Lean in healthcare. Barriers that can affect the success in changing the organisational culture, i.e. professional and functional silos and hierarchy and management roles (ibid).

2.3 ICU transitional care

Patient transfers between hospital units are common and can be life-threatening for the patient, depending on their health condition. One critical patient transfer process is ICU transitional care (Chaboyer et al., 2005). This process involves care before, during and after the transfer of an ICU patient to another care unit and aims to minimize disruption and optimize continuity of care for the patient. In a study by Häggström et al. (2012), the researchers revealed the importance of a healthcare organization that provides the possibility for delivering coordinated, strengthening, person-centered transitional care. Organizing and performing such patient transfers is part of the continuum of care by multiprofessional healthcare teams (Häggström & Bäckström, 2014). Healthcare teams working in this process often consist of ICU nurses, acute care nurses, physicians and other healthcare professionals (Chaboyer et al., 2005).

3. Methodology:

This study was part of a three-year research project named ‘Increased quality and efficiency in patient’s transfers’ that was initiated in January 2018 and ended in December 2021. The project was financed by The Kamprad Family Foundation and was a joint research project between two research subjects: Nursing Sciences and Quality Management.

The overall aim of the project was to gain new knowledge of how quality and efficiency in patient transfers within health care can be improved, with emphasis on leadership, continuity of care, safety culture, learning and teamwork. The focus of the project was ICU transitional care.

This paper focuses on presenting results from a questionnaire used to measure teamwork and quality culture in the two ICUs that were part of the project.

3.1 Ethical considerations

The Swedish Ethical Review Authority (Ref. 2018-159-31M) has evaluated the project ethically. Since the result from this study can be used to measure and improve ICU transitional care, the positive effects are considered stronger than any negative ones. Before answering the questionnaire, all respondents were informed about the study, both in writing and verbally, and about confidentiality and their rights to withdraw their participation without giving any reason.

3.2 Settings

Two medium-sized hospitals located in rural areas of Sweden took part in this study. One hospital had 3 000 employees and approximately 440 beds, and the other hospital had 2 500 employees and approximately 400 beds. All the participants worked in two medium-sized intensive care units with 6-8 intensive care beds and additional beds for postoperative care. 39 health care professionals at the ICU at hospital 1 and 45 ICU health care professional at the ICU at hospital 2 responded to a questionnaire. The participants were nurses, physicians and assistant nurses.

3.3 Questionnaire

The questionnaire used in this study was named ‘Assessing Quality Culture Health Care edition’ and developed and tested by Sten et al. (2021). The questionnaire used a seven-point Likert agreement scale where seven corresponds to ‘totally agree’ and one to ‘totally disagree’. There was also an opportunity for the respondent to answer ‘Do not know/do not want to answer.’ The questionnaire started with questions about the co-worker’s hospital unit, profession, number of years at the specific unit and education. There was no question about

gender, as few men were eligible to answered the questionnaire and, therefore, including gender could have risked anonymity.

The questionnaire consisted of 50 statements and 16 factors. Six factors measured perceived team collaboration within and between hospital units and ten measured sustainable quality culture. Of these ten factors, six were seen as underlying dimensions of the health-related QM values 'Leadership commitment' and 'Participation of everybody' (Bäckström, 2019), see Table 1. In this paper, these dimensions are seen as equivalent to the other factors and will from here on be referred to and treated as factors.

In total, 152 ICU co-workers received a questionnaire, and 84 out of these 152 co-workers answered, giving a response rate of about 55%. The questionnaire was handed out and answered at staff meetings for nurses, assistant nurses and physicians at the two ICUs. All of the co-workers that joined the staff meetings answered the questionnaire, which was approximately 35% of all the co-workers. The staff who did not participate in the meetings received the questionnaire from their leaders (65%).

Table 1. Areas and factors measured in the questionnaire

Areas	Factors
Sustainable quality culture	Appreciative Inquiry (AI) Pride System view Continuous improvement Empathy Presence & communication – Leadership commitment Integrity Development Influence – Participation of everybody Being informed
Team collaboration within a hospital unit	Person-centred care within a hospital unit Continuous learning within a hospital unit Prerequisites for successful patient transfers within a hospital unit
Team collaboration between hospital units	Person-centred care between hospital units Continuous learning between hospital units Prerequisites for successful patient transfers between hospital units

3.4 Analysis process

The results of the questionnaire were analysed using SPSS and carried out in four steps:

1. An independent sample *t*-test was performed to assess whether the means from the two ICU units differed significantly. Depending on the result of this test, further analysis would be carried out as one or two populations.

2. The mean and standard deviation were calculated for all factors in the questionnaire.

3. The internal consistency reliability was tested. This was done by calculating the Cronbach's alpha coefficient for each of the factors. For the factors consisting of three statements, a value

of 0.6 or more was seen as acceptable and for factors consisting of four statements, a value of 0.75 or more was seen as acceptable.

4. Finally, the correlations between the factors within the area sustainable quality culture and the two areas measuring team work were investigated using Pearson's product-moment correlation. In addition, Spearman's coefficient of rank correlation was calculated to see if this generated any other results. Correlations with an *R*-value above 0.50 (significant level 0.01) were considered high and thereby seen as correlations.

The result is presented in accordance with this process.

4. Results:

4.1 Independent sample *t*-test

In order to investigate if the two hospital wards differed from each other, the results from the two ICU units were tested for statistically significant differences using an independent sample *t*-test. This showed no differences between the results (ranging from 0.06 to 0.98). The results from all 84 questionnaires were therefore treated as the same population. Further analyses were conducted with this assumption.

4.2 Cronbach's alpha, mean value and standard deviation

Table 2. Cronbach's alpha, mean value and standard deviation for the measured factors for both ICUs

Factors	Number of statements	Cronbach's alpha	Mean value	Standard deviation
Appreciative Inquiry (AI)	3	0.74	4.07	1.36
Pride	3	0.74	6.08	0.78
System view	3	0.79	5.33	1.27
Continuous improvement	3	0.73	5.30	1.05
Empathy	3	0.78	4.99	1.28
Presence & communication	3	0.66	5.41	1.06
Integrity	3	0.83	5.46	1.20
Development	3	0.84	5.27	1.24
Influence	3	0.45	4.90	1.04
Being informed	3	0.54	4.83	0.81
Person-centred care within a hospital unit	3	0.78	5.77	0.79
Continuous learning within a hospital unit	3	0.60	5.33	0.87
Prerequisites for successful patient transfers within a hospital unit	4	0.86	5.23	1.02
Person-centred care between hospital units	3	0.77	5.04	1.09
Continuous learning between hospital units	3	0.74	4.14	1.13
Prerequisites for successful patient transfers between hospital units	4	0.85	4.53	1.08

All factors except two reached the desired value when calculating Cronbach's alpha. The two factors 'Influence' and 'Being informed' were therefore not used in further analysis of the result (see Table 2). Analysing this further by calculating 'Cronbach's alpha if item deleted' shows that the factor 'Influence' reaches a value of 0.60 if the statement 'I can adjust the working hours if necessary' is deleted. The factor 'Being informed' reaches a value of 0.65 if the statement 'The communication between units works well' is deleted.

4.3 Correlations

Pearson's product-moment correlation was used to compare the measured factors for team collaboration within and between hospital units (6 factors) and factors measuring sustainable quality culture (10 factors) to determine whether the factors correlated with each other. The Spearman's coefficient of rank correlation was also calculated and generated the similar results. This paper presents the correlations that were considered high, i.e. with an *R*-value above 0.50 at significant level 0.01 (see Table 3).

Table 3. Correlations between factors measuring teamwork and sustainable quality culture that were considered high and significant at the 0.01 level (2-tailed)

	AI	**Pride**	**System view**	**Continuous improvement**
Person-centred care within a hospital unit	-	0.667**	0.556**	0.672**
Continuous learning within a hospital unit	0.559**	0.582**	0.528**	0.649**
Prerequisites for successful patient transfers within a hospital unit	0.511**	0.618**	-	0.575**

** Correlation is significant at the 0.01 level (2-tailed).

Only factors aimed at measuring team collaboration within hospital units were found to correlate with four of the factors measuring sustainable quality culture. The factors measuring sustainable quality culture were 'Appreciative Inquiry (AI)', 'Pride', 'System view' and 'Continuous improvement'. They correlated with the factors measuring team collaboration: 'Person-centred care', 'Continuous learning' and 'Prerequisites for successful patient transfers **within** a hospital unit'.

5. Discussion and findings:

The purpose of this paper was to explore how teamwork and sustainable quality culture relate to each other in transitional care from the perspective of intensive care personnel. This was an interesting case to study as previous research shows that effective teamwork is crucial for providing optimal patient care when handling critically ill patients (Reader et al., 2009) and that the quality of teamwork has a direct impact on the quality of an organization's outcomes and performance (Boughzala & de Vreede, 2015).

There were a number of main findings from the analysis. First, all means for the three factors measuring teamwork within hospital units were higher than the factors measuring teamwork between hospital units. This could indicate a lack of a system view when looking at the factor 'Person-centred care' in the study, as the patients and their relatives are those in the transitional care that should be focused on when it comes to creating value in the form of care quality and patient safety. This is in line with results from Häggström et al. (2012) indicating that transitional care between intensive care and wards was not always person-centered and adjusted to the needs of the patient, although the nurses wanted improvements, but the organisation did not always make this possible. Working in silos within hospital units in a patient transfer process does not benefit the patients and their relatives, nor the co-workers within the process and is seen as a major barrier for implementing QM initiatives (de Souza & Pidd, 2011). Häggström and Bäckström (2014) argue that collaboration intertwines the healthcare chain and is a foundation for ICU transitional care. Results according to teamwork also showed that the factor 'Continuous learning' as well as 'Prerequisites for successful patient transfers within a hospital unit' had higher mean values than the corresponding factors *between* hospital units. Like 'Person-centred care', this indicated that more focus should be placed on building team abilities of how to learn and communicate between hospital units as well as how to coordinate, structure and make fact-based decisions for safe patient transfers.

Other main findings from this study were that only teamwork within a hospital unit correlated with some of the factors related to sustainable quality culture. These factors measuring sustainable quality culture were 'AI', 'Pride', 'System view' and 'Continuous improvement'. Correlations between teamwork and organizational culture have been found in previous research. In a study by Körner et al. (2015), the authors investigated the relationship between organizational culture, interprofessional teamwork and job satisfaction and found a significant correlation ($p < .01$) between organizational culture and interprofessional teamwork, as well as that the effect of organizational culture was completely mediated by interprofessional teamwork. From this result, Körner et al. (2015) assumed that it could be most important to establish good interprofessional teamwork in order to increase job satisfaction in health care. Improving teamwork can also increase care quality and patient safety and the satisfaction for patients and their relatives, by decreasing the gap between intensive care units and general wards (Häggström et al., 2009). Previous research also emphasizes the importance of interactions with patients, relatives, environment and other team members for ICU transitional care (Häggström & Bäckström, 2014). Häggström and Bäckström (2014) argue that this process should be seamless and transparent for all persons involved, as well as include a multidiscipline approach and a family perspective.

A final main finding was that none of the four remaining factors[1] measuring sustainable quality culture correlated with teamwork within or between hospital units. This is surprising when it comes to the three factors aimed at measuring 'Leadership commitment'[2], as previous research emphasizes that team leadership is crucial in guiding how ICU team members interact and coordinate with others (Reader et al., 2009) and that strategies are needed to improve healthcare

[1] That reached an acceptable Cronbach's alpha value (Empathy, Presence and communication, Integrity and Development)
[2]Empathy, Presence and communication and Integrity

teams at the level of individuals, patient care teams and organizations (Weller et al., 2014). Nurses have an important role as leaders of their health care teams. Nursing competence of managers and leaders at all levels is necessary to identify needs for quality development and improvement work in nursing and to lead this development (Svensk Sjuksköterskeförening, 2018). Häggström et al. (2009) argue that leaders in organizations must take responsibility for encouraging and building a collaborative environment and a culture that improves ICU transitional care. It is also interesting to note that the two factors that did not reach an acceptable Cronbach's alpha value both aimed to measure 'Participation of everybody'. This could suggest that these factors might need to be further studied within this healthcare context.

To summarize, this study aimed to deepening the understanding of how teamwork and sustainable quality culture relate to each other in transitional care from the perspective of intensive care personnel. One suggestion for further research is to investigate how core values such as 'Leadership commitment' and 'Participation of everybody' relate to teamwork aimed at increasing care quality and patient safety. Another suggestion is to study relations between teamwork, sustainable quality culture and performance using the IPO model by (McGrath, 1964) as a theoretical framework.

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REFERENCES:

Bergman, B., Garvare, R., Klefsjö, B., & Bäckström, I. (2022). *Quality: From customer needs to customer satisfaction* (4th ed.). Studentlitteratur, Lund.

Bergman, B., & Klefsjö, B. (2020). *Kvalitet från behov till användning* (Sjätte upplagan). Studentlitteratur, Lund.

Bäckström, I. (2019). Health-related quality management values – comparing manager and co-worker perceptions. *International Journal of Quality and Service Sciences*, *11*(4), 588–603. https://doi.org/10.1108/IJQSS-08-2018-0071

Borrill, C., West, M., Shapiro, D., & Rees, A. (2000). Team working and effectiveness in health care. *British Journal of Health Care Management*, *6*(8), 364–371. https://doi.org/10.12968/bjhc.2000.6.8.19300

Boughzala, I., & de Vreede, G.-J. (2015). Evaluating Team Collaboration Quality: The Development and Field Application of a Collaboration Maturity Model. *Journal of Management Information Systems*, *32*(3), 129–157. https://doi.org/10.1080/07421222.2015.1095042

Chaboyer, W., James, H., & Kendall, M. (2005). Transitional Care After the Intensive Care Unit: Current Trends and Future Directions. *Critical Care Nurse*, *25*(3), 16-28. https://doi.org/10.4037/ccn2005.25.3.16

Cooperrider, D.L., & Srivastva, S. (1987). *Appreciative inquiry in organizational life,* in Pasmore, W.A. and Woodman, R.W. (Eds.), Research in Organizational Change and Development, JAI Press, Greenwich, CT, 1, 129–169.

Dahlgaard, J.J., Kristensen, K., & Kanji, G.K. (2002). *Fundamentals of Total Quality Management.* Nelson Thornes Ltd, Cheltenham, United Kingdom.

de Souza, L.B. and Pidd, M. (2011). Exploring the barriers to lean healthcare implementation. *Public Money & Management*, *31*(1), 59-66. https://doi.org/10.1080/09540962.2011.545548

Gimenez-Espin, J.A., Jiménez-Jiménez, D., & Martínez-Costa, M. (2013). Organisational culture for total quality management. *Total Quality Management & Business Excellence*, *24*(5/6), 678–692. https://doi.org/10.1080/14783363.2012.707409

Gualandi, R., Masella, C., Viglione, D., & Tartaglini, D. (2020). Challenges and potential improvements in hospital patient flow: the contribution of frontline, top and middle management professionals. *Journal of Health Organization and Management*, *34*(8), 829–848, https://doi.org/10.1108/JHOM-11-2019-0316

Hackman, J.R. (2002). *Leading Teams: Setting the Stage for Great Performances,* Harvard Business Review Press, Boston, M A.

Henri, J.-F. (2006). Organisational culture and performance measurement systems. *Accounting, Organisations and Society*, *31*(1), 77–103, https://doi.org/10.1016/j.aos.2004.10.003

Häggström, M., Asplund, K., & Kristiansen, L. (2009). Struggle with a gap between intensive care units and general wards. *International Journal of Qualitative Studies on Health and Well-Being*, *4*(3), 181–192. https://doi.org/10.1080/17482620903072508

Häggström, M., Asplund, K., & Kristensen, L. (2012). How can nurses facilitate patient's transitions from intensive care? A grounded theory of nursing, *Intensive and Critical Nursing, 28*(4), 224-233. https:// doi.org/10.1016/j.iccn.2012.01.002

Häggström, M., & Bäckström, B. (2014). Organizing Safe Transitions from Intensive Care. *Nursing Research and Practice*, *2014*, 1–11, https://doi.org/10.1155/2014/175314

Ingelsson, P., Bäckström, I., & Snyder, K. (2018). Strengthening quality culture in private sector and health care: What can we learn from applying soft measures? *Leadership in Health Services, 31*(3), 276–292 https://doi.org/10.1108/LHS-02-2018-0012

Katzenbach, J.R., & Smith, D.K. (1993). The Discipline of Teams, *Harvard Business Review, 71*(2), 111-120.

Katzenbach, J.R., & Smith, D.K. (2016). *The Wisdom of Teams – Creating the High-Performance Organization*. Harvard Business Review Press.

Khatri, N., Brown, G.D., & Hicks, L.L. (2009). From a blame culture to a just culture in health care. *Health Care Management Review, 34*(4), 312–322. https://doi.org/10.1097/HMR.0b013e3181a3b709

Körner, M., Wirtz, M.A., Bengel, J., & Göritz, A.S. (2015). Relationship of organizational culture, teamwork and job satisfaction in interprofessional teams. *BMC Health Services Research*, *15*(243), 1–12. https://doi.org/10.1186/s12913-015-0888-y

Lyubovnikova, J., West, M.A., Dawson, J.F., & Carter, M.R. (2014). 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology*, *24*(6), 929–950. https://doi.org/10.1080/1359432X.2014.992421

McGrath, J.E. (1964). *Social Psychology: A Brief Introduction,* Holt, Rinehart and Winston, New York.

Reader, W.T., Flin, H.R., Mearns, H.K., & Cuthbertson, H.B. (2009). Developing a team performance framework for the intensive care unit. *Critical Care Medicine, 37*(5), 1787–1793. https://doi.org/10.1097/CCM.0b013e31819f0451

Richardson, J. (2011). *An investigation of the prevalence and measurement of teams in organizations: the development and validation of the real team scale*. Doctoral thesis, Aston University, United Kingdom.

Richardson, J., West, M.A., & Cuthbertson, B.H. (2010). Team working in intensive care: current evidence and future endeavors. *Current Opinion Critical Care, 16*(6), 643–648. https://doi.org/10.1097/MCC.0b013e32833e9731

Rosen, M.A., DiazGranados, D., Dietz, A.S., Benishek, L.E., Thompson, D., Pronovost, P.J., & Weaver, S.J. (2018). Teamwork in Healthcare: Key Discoveries Enabling Safer, High-Quality Care. *American Psychologist, 73*(4), 433–450. https://doi.org/10.1037/amp0000298

Santos-Vijande, M.L., & Álvarez-González, L.I. (2007). Innovativeness and organisational innovation in total quality oriented firms: the moderating role of market turbulence. *Technovation, 27*(9), 514–532. https://doi.org/10.1016/j.technovation.2007.05.014

Schein, E.H. (2009), *The corporate culture survival guide*, Jossey-Bass, San Francisco, CA.

Sila, I., & Ebrahimpour, M. (2002). An investigation of the total quality management survey based research published between 1989 and 2000. *International Journal of Quality & Reliability Management*, *19*(7), 902–970. https://doi.org/10.1108/02656710210434801

Sten, L.-M., Ingelsson, P., Bäckström, I., & Häggström, M. (2021). The development of a measurement instrument focusing on team collaboration in patient transfer processes. *International Journal of Quality and Service Sciences, 13*(1), 45-62. https://doi.org/10.1108/IJQSS-04-2020-0055

Svensk Sjuksköterskeförening. (2018). *Ledarskap för omvårdnad och Magnetmodellen.* Åtta45.

Wageman, R., Gardner, H., & Mortensen, M. (2012). The changing ecology of teams: New directions for teams research. *Journal of Organizational Behavior, 33*(3), 301–315. https://doi.org/10.1002/job.1775

Watkins, J.M., & Cooperrider, D. (2000). Appreciative inquiry: A Transformative Paradigm. *OD Practitioner, 32*(1), 6–12.

Weller, J., Boyd, M., & Cumin, D. (2014). Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare. *Postgraduate Medical Journal*, *90*(1061), 149–154. https://doi.org/10.1136/postgradmedj-2012-131168

West, M., & Lyubovnikova, J. (2012). Real Teams or Pseudo Teams? The Changing Landscape Needs a Better Map. *Industrial and Organizational Psychology, 5*(1), 25-28. https://doi.org/10.1111/j.1754-9434.2011.01397.x