



## ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

### Transforming culture in the critical care environment - the building block of the journey

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#### Abstract

*Purpose:* External facilitators were approached by a newly appointed acting nurse unit manager (A/NUM) to provide support and facilitation expertise, in her quest to engage with her new critical care nursing team. The intent was to work towards creating an effective workplace culture in a cardio thoracic intensive care unit (CTICU).

*Background:* The A/NUM position of the CTICU is based on a four bedded unit with 19 full time equivalent (FTE) staff at a major metropolitan teaching hospital in Sydney, Australia. The hospital has, over the past seven years, been working towards the development of an emancipatory culture of nursing. The hospital nursing shared vision statement being; 'for nurses to embrace a culture that enables all persons to flourish'. This programme of work has focused on developing key groups of staff (mainly leadership groups) to adopt ways of working that enable staff participation, facilitate critical conversations and promote collaborative action towards improved person centred outcomes. Shared governance principles of engagement are critical to the development of an emancipatory culture. The new A/NUM was keen to inspire a sense of team spirit in the unique shared environment of public and private healthcare. She had the vision to look beyond the barriers and insular ways of working and advocated a model of shared governance, providing nurses with a voice within the wider organisation that allowed and encouraged them to participate in the decision-making processes that affect their professional practice.

*Process:* The external facilitation provided opportunity for the A/NUM and now permanent NUM to be part of the values clarification and shared values process, this occurred over a number of facilitated sessions. As no adult intensive care unit in New South Wales, had commenced the Essentials of Care (EOC) Programme, it provided an opportunity to introduce the framework and propose the potential for further work.

*Discussion:* Using the values clarification process, the external facilitators were able to progress to an action planning phase of work. The CTICU teamwork has significantly improved overall as they have a sense of belonging to the unit. They shared how they felt the working environment had already improved half way through the process. The external facilitators used various tools and practice development principles to engage the unit, working inclusively and participatively. Circles of concern were reduced and influences increased throughout the action planning phase.

*Future scope:* The action planning phase continues. The future vision to commence the EOC Programme in CTICU in 2011 has been realised; they continue to work collaboratively with the

general intensive care unit to refine the critical care domains of EOC. CTICU have reengaged with the Nursing Person Centred Shared Governance Framework, having representation on Nursing Councils and the specialities Community of Practice.

**Keywords:** Facilitation, shared governance, values and beliefs, workplace culture

### **Introduction**

In May 2010 the Nursing Education and Research Unit was approached, to provide external facilitation, to consult and lead work around workplace values and culture within the cardio thoracic intensive care unit (CTICU) at a major metropolitan teaching hospital in Sydney, Australia. The purpose being that a new acting Nurse Unit Manager (A/NUM) had recently been appointed, and there was a need to provide external support and leadership to enable her to function in this new role and further develop her transformational leadership skills. The secondary intent was to work towards a more collaborative and inclusive team, demonstrating leadership sophistication in 'modelling the way' and also achieving a 'shared vision', two of the five leadership practices identified by Kouzes and Posner (2007) following their twenty five years of observing leadership excellence.

### **Background**

The hospital is a 440 bedded major teaching hospital based in the eastern suburbs of Sydney and serves all of New South Wales, Australia. The hospital initially began working with practice development principles in 2006; a Nursing Professional and Practice Development Model was conceptualised with the introduction of a Nursing Person Centred Shared Governance Framework. Shared governance is a structural model through which nurses can express and manage their practice with a higher level of professional autonomy (Porter-O'Grady, 2003). The vision for nursing was developed, which is; 'for nurses to embrace a culture that enables all persons to flourish', with the hope that this can occur through the different structures and process that underpin the shared governance framework. Within the shared governance framework are nursing councils and also specialty specific Communities of Practice. A Community of Practice is a group of people who share an interest in or concern about a topic (in case of the CTICU, the practice domain of critical care) and who get together regularly to communicate and learn about it and to take action to change or improve aspects of the topic or domain of interest. Within the context of the shared governance framework, a critical element of the purpose of Communities of Practice is to engage all clinical nurses who deliver patient care in shared governance and emancipatory practice development. A Practice Development Advisory committee also formed part of the shared governance framework, with key nursing stakeholders as members, representation being from each clinical programme and each level of nursing group. Also at this time, an 'Improving Patient Care' working party was established to review the care being provided at the bedside, aspects of care that are fundamental to patient's health and wellbeing. This body of work led into the Essentials of Care (EOC) pilot study; this was undertaken in two clinical units at the hospital. Following successful outcomes of the pilot study, EOC has become a state wide Practice Development Programme (New South Wales Health, 2011) and to date has been implemented in almost 600 clinical units in New South Wales. Practice development is gaining momentum very quickly in New South Wales, as clinicians come to realise the value of using a systematic approach to transforming workbased cultures to deliver person-centred care that is inclusive of the needs of patients, families and staff. The EOC Programme is a two year evaluation framework to support the development and on-going evaluation of nursing and midwifery practice and patient care. Within the EOC evaluation framework, to determine when and where aspects of care occur in day-to-day practice, nine domains of care were established; for example, 'documentation and communication' and 'privacy and dignity'. EOC is underpinned by the principles of transformational practice development. The definition of practice development has developed over the past ten years, the current definition being:

*'Practice development is a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformation of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy' (Manley, McCormack, and Wilson, 2008, p 9).*

Within healthcare there are various workplace cultures, some may welcome health professionals and patient's involvement in decision making in relation to patient care and practice improvements where as others may be opposed to involvement. Practice development methods enable all health professionals to have an opportunity to participate in meaningful dialogue about practice and the workplace to improve patient care. There is a collaborative, inclusive and participatory approach to the continuous change process leading to embedded cultural change (Manley, McCormack and Wilson, 2008).

The principal focus of an emancipatory culture is the enabling of 'human flourishing'. Human flourishing focuses on maximising the potential for all persons to grow and develop (McCormack and Titchen, 2006). In this culture everybody is seen as a leader of something and responsibility and independence is actively promoted by staff at every level. There is a commitment to continuous quality improvements by all staff and a sense of responsibility for high standards of patient care and positive outcomes. With this commitment to quality improvement, a patient-centred approach to practice is undertaken. These beliefs are evident in the way practice is structured, how staff are recruited and the support systems in place for staff and patients. Feedback from patients is welcomed and valued at a clinical practice level and patients are encouraged and enabled to reflect on their healthcare experience. Such feedback from patients is actively used to continuously develop practice. In working with such feedback and quality improvement, clinicians are active participants in evidence generation and utilisation. Working relationships are built on mutual trust and high challenge and high support through paying attention to the whole person, processes as well as outcomes (Titchen, 2009).

### **Methodology**

The aim of practice development is to develop effective workplace cultures that have embedded within them person-centred processes, systems and ways of working (Manley et al., 2008, p 4). Person-centred care incorporates the practice development principles of inclusiveness, respect for each other, valuing individual contributions and connecting. This practice development approach was adopted for the CTICU body of work, to embrace and build upon principles of participation, collaboration and inclusion as recommended by Manley et al. (2008). The external facilitators worked collaboratively to plan and map out the intended process of the CTICU workplace culture work, both being aware that how it would progress depended on the group ways of working and engagement. It is widely recognised in the literature that skilled facilitation is essential for effective practice development work (Crisp and Wilson, 2011; Manley, Sanders, Cardiff and Webster, 2011; Titchen, 2000). Skilled facilitation is a process and an outcome aimed at enabling individuals and teams through critical reflection, high challenge in supportive environments, active learning and transformation of individuals and their practice. The CTICU work was facilitated in small groups by the external facilitators. The A/NUM engagement in the process was apparent throughout; she attended sessions and at other times worked in the CTICU clinically, to enable clinical nurses to be released to attend the sessions.

### **Preparation work**

Prior to setting up the first round of facilitated educational sessions for staff, the A/NUM of the unit was asked to enable all the CTICU staff (n=19) to complete the values clarification questionnaire individually (Warfield and Manley, 1990) in preparation for the first session. Manley (2000) suggests that values clarification is the starting point for cultural change in the workplace, as our values and beliefs influence our behaviour. Making explicit our values and beliefs makes them a reality in our work, practice and workplace. Manley (2000, p 34) also proposes that, 'a match between what we say we believe and what we do is one of the hallmarks of effective individuals, teams and organisations'.

Each of the questions below was asked of each staff member:

*I believe the purpose of cardio thoracic intensive care nursing to be.....*

*If I was a patient in CTICU I would like.....*

*I believe my role as a CTICU Nurse is.....*

*I believe the factors that enable a high standard of CTICU Nursing to occur are.....*

*I believe the factors that inhibit a high standard of CTICU Nursing are.....*

*Other values and beliefs about CTICU Nursing I have are.....*

The benefits of completing the questionnaire individually was explained to all staff, to enable them to each have time to reflect on their own values and beliefs, rather than having to complete at the group session with possible influence of others. Various options of returning the completed questionnaire were made available, either electronically or as a hard copy. This enabled the external facilitators to prepare the returned individual statements, adapted from the Warfield and Manley (1990) values clarification exercise, into sections before they came together for the first round of sessions. Any staff who had not returned their questionnaire were provided with the opportunity to contribute their individual responses at the first and subsequent sessions. Sixteen responses (84%) were gained before commencing the work which provided time to review them and consider how the session was to be facilitated.

### **Phase one- the work plan in action- June 2010**

During June 2010, four sessions were planned by the external facilitators and A/NUM to enable her to allocate staff members to participate on the identified dates. The actual staff who participated over these four sessions was fourteen out of the nineteen. Due to unavoidable circumstances, such as staff sickness and departmental acuity, a number were not able to attend.

Each session focussed initially on introductions to each other and each of our individual roles (i.e. external facilitators and CTICU staff). The staff then shared with each other their nursing backgrounds and length of time spent in the unit, which afforded an opportunity to promote this as a unit specific, clinically led piece of work which was driven by and for them, the clinicians. Clarification around the purpose of the work was provided with a view to progressing ultimately to the EOC Programme which was, at the time, yet to be rolled out in the critical care environment at the hospital. Experiences of working with the EOC framework, from across the hospital were shared, along with examples of creative values statements that clinical units had developed during the EOC process.

To identify themes, each question posed from the values clarification preparatory work was systematically worked through and the themes that appeared to be emerging were captured. This process was repeated a number of times to ensure inclusiveness and participation by all team members, with further clarity being gained.

Surprisingly after the first session working on developing the shared purpose and values statement, a strong draft statement for the unit was collectively developed, and following some minor adjustments read as follows:

‘We believe the purpose of CTICU nursing is to provide a high standard of holistic care that is evidence based to enable optimal outcomes. This will be achieved by supportive, professional and transparent teamwork, within a safe environment.’

Other values apparent to the staff that they wanted to capture were ‘advocacy’ and ‘ethical’.

In the following three sessions, the purpose statement was revisited resulting in some minor editing and word changes following suggestions based on others’ interpretation. An example was the inclusion of values ‘advocacy’ and ‘ethical’; the group were challenged, through facilitation, as to how they were different from ‘holistic’. The general opinion was that the word holistic did actually incorporate these values, and therefore did not have to be included in the statement.

When focusing on the second question; ‘If I was a patient in CTITU I would like ...?’, a suggestion from one group was that it may be beneficial to ask patients pre-operatively what they thought, so contact was made with the Nurse Educator for Cardiothoracic who ran the pre-admission clinic to progress this further. It was highlighted that patient stories were also part of the EOC evaluation process; hearing staff make this suggestion at this early stage of working with practice development methodology was exciting for the external facilitators. It was agreed that twenty patient responses to the following questions would be adequate to provide an idea of whether CTICU assumptions around care needs were in fact correct. The questions were:

1. How would you like to be treated in CTICU?
2. How long are you expecting to be in hospital?

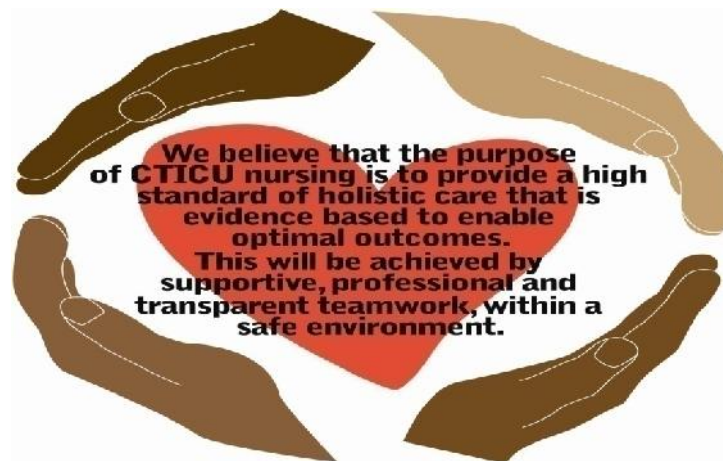
There was a delay in obtaining the twenty responses although six had been collected by week four and all twenty within a week of that. The initial six responses were put to the group on this occasion. All felt that they resonated with what they had proposed as optimal patient care, which was positive. The feedback from the Nurse Educator in the pre-admission clinic was that patients felt grateful for being asked the questions and also had to reflect on their answers somewhat as it took them by surprise.

The themes that emerged from the responses included friendly; fair; professional; respectful; honest; skilful; knowledgeable; competent; reassuring; nice; caring and safe. All of these reflected that the words in the values statement were inclusive of what the patient would expect coming into CTICU.

Each of the first four sessions ended with staff being invited to review examples of creative approaches demonstrating how their values statement could be presented; other units in the organisation had given permission to share theirs. The sessions concluded with thoughts about where the statement could be posted in the unit with suggestions of behind each bed space and also in the staff room.

The creative picture for the values poster was agreed upon following collective consideration of three possible options, with hands and a heart incorporated into them all in various ways. Figure 1 represents the final choice; this is now proudly displayed behind each patient’s area and a larger version in the staff tea room.

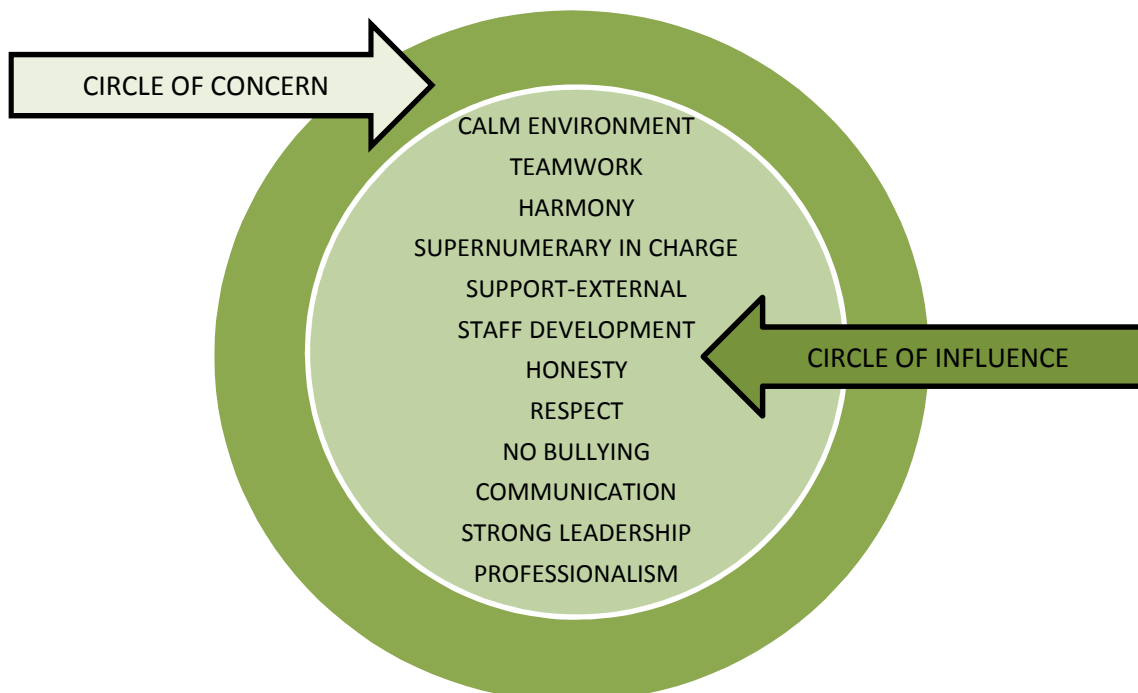
**Figure 1.** Creative shared values statement



**Phase two - July/August/September**

During the next phase, further education sessions were facilitated and other invited external consultation took place. Work progressed to theme the 'enablers' and 'inhibitors' again in small groups during in-service times. Covey's 'circle of concern, circle of influence' (Covey, 2004), was utilised to highlight to the CTICU staff how much energy can be consumed through a reactive response rather than a proactive response to an inhibitor; ultimately a concern that would not be within their scope of influence, over which they have no control. It also demonstrated to the staff what could be achieved easily and fairly quickly and those aspects which would involve a longer process. Figure 2 represents the work produced by the CTICU staff during the facilitated session alongside a diagram of Covey's model to illustrate how it was depicted. An action plan was then formulated from the themes represented in the circle of influence, things they were able to do something about.

**Figure 2.** Circle of concern and influence adapted from Covey, 2004



One of the emerging themes was that the staff in the unit wanted to become more skillful at having conversations that were both supportive and challenging. The Clinical Nurse Consultant for Leadership and Facilitation co-facilitated an education session focusing on effective communication with the team; some salient points were raised through capturing the conversation that occurred. They recognised that for this to happen the culture would need to be supportive of this; individual skill development is necessary but insufficient as a standalone measure.

In terms of developing an effective workplace culture, there were some encouraging signs, such as support from the A/NUM and the Nursing Co Director, the good progress of work to date includes values clarification, identification of 'enablers' and 'inhibitors' during this process, and facilitating an action plan development from these. The challenges faced, and potential threats to this work, were identified in the fact that the A/NUM was a temporary role, the CTICU Clinical Nurse Consultant position remained vacant and there was no educator in position. Part of the initial culture they shared was that practices generally had a slow uptake, staff relationships had traditionally been hierarchical, and there had not been a history of high support and high challenge in the unit. There was also the logistical challenge of getting more than a few staff together, at any one point in time, to facilitate such activities due to the model of care and patient dependency needs.

What CTICU staff also recognised was there was a need to consider the many different approaches to enable skill development (for example, but not limited to: staff being released to attend the Coaching and Facilitating Excellence (CAFE) Programme, clinical supervision, reflective practice groups, e-learning, 1:1 or small group active learning on the unit, 45min 'in-services').

Other aspects of the action plan included a twelve hour shift proposal to gain a work life balance for the staff and also as a recruitment and retention strategy, establishment of the Clinical Nurse Educator position for the unit, need for a permanent NUM, development of unit specific business rules around patient acuity and the communications in and out of the unit after hours.

### **Phase 3 - ongoing support and development**

In February 2011 two further workshops were arranged in order to evaluate where the unit currently was with their action plan and evaluate the workplace culture. Creativity was used to enable staff in two groups to create a collage of how they perceived the look and feel of the unit workplace culture, nine months into the process. Critical dialogue followed around aspects of workplace culture aspects which enabled changes to be identified and shared. Staff were challenged on the fact that without the internal struggles so much apparent, the external issues prevail. It was evident from the collages that there was cultural change in the workplace. They described the harmony in the team, whilst remaining cognisant around the fact that there was still work to do. Figure 3 is a photograph of one of the created collages.

The A/NUM and newly recruited on the unit will be involved, with other key stakeholders and in collaboration with the General ICU, in shaping the 'specialty critical care' domains for the ICU EOC implementation (New South Wales Health, 2011). The CTICU will be one of the first critical care units in New South Wales to undertake this piece of work, in collaboration with General ICU staff. The Clinical Nurse Educator will also participate in the ICU Coaching and Facilitation Excellence (CAFE) Programme to develop her facilitation skills, as skilled facilitation is essential for effective practice development work. This will enable her to take a lead facilitation role with the implementation of EOC in CTICU scheduled for 2011/2012.

**Figure 3.** Example of group creative evaluation of workplace culture 'then and now'



Below, the CTICU NUM has captured her journey, reflecting and sharing how she felt throughout the stages of the facilitated work in this critical care area.

### Reflection on the journey

*'Obtaining the role of Acting Nurse Unit Manager (A/NUM) was a significant mile stone in my nursing career. This unit was where my critical care career had begun some seventeen years earlier, and although I had ventured into other roles to further my career, the CTICU always held significant meaning to me.*

*The unit had undergone significant changes in the two to three years prior to my appointment. For political reasons the unit was under threat of closing, and a proposal to amalgamate the unit with the adjacent private hospital Intensive Care Unit was eventually realised after years of discussion. This change also coincided with the previous Nurse Unit Manager retiring after some forty years in her role. The journey through these massive changes were extremely stressful for all staff involved, and over time resulted in many resignations due to unhappiness and disharmony among the team, to the point that there was not enough staff to provide the required service. There was only 55% of the required full time equivalent (FTE) staff when I commenced.*

*Arriving as the new A/NUM I was met with much suspicion and scepticism from the staff - some who I had previously worked with and been junior to, and others who did not know me. The team desperately wanted a better working environment, but due to disharmony there were alliances among some staff, with exclusion to others. To them their problems seemed insurmountable. I was in fact told "you can try and change things, but it won't work".*

*After a period of three months, the Nursing Co-Director consulted facilitators within the Nursing Education and Research Unit to provide external facilitation. We met to discuss the team dynamics and the issues at hand. A number of sessions were planned to enable everyone to attend and I allocated "aligned" staff into small groups to ensure everyone felt comfortable to contribute in a constructive way.*

*The facilitators navigated the staff through the values clarification questionnaire, and the staff were all pleasantly surprised that they predominantly shared the same values as each other. This was the first step toward meaningful dialogue, and this created the foundation*



*for a collaborative and inclusive workplace. Further, this allowed the team to easily develop their Values Statement. All staff agreed the Values Statement, which has been placed behind each bed space so that all Registered Nurses look and work with it on every shift. The hope being this would support and enable them to effectively communicate with each other and ultimately create the working environment that they desired, not only for themselves, but in delivering exceptional care to their patients.*

*Another effective exercise was the Circle of Influence/Circle of Concern. Based on the nature and level of the political decision making process around the co-location, the staff felt extremely disempowered with situations they were forced to work within. This frustration and anger at external issues spilt over into the way that day to day problems within the unit were also handled. What this exercise made possible for the staff was the realisation that some problems could easily be solved, and in fact some issues had already been solved in the short time between phase 1 and phase 2. The issues that needed more time to address and ultimately solve were also identified, and staff realised, and for the first time accepted, there were processes to be followed to enable such solutions.*

*Over the last twelve months I have been permanently appointed as the permanent NUM, as the Local Health Network (previously Area Health Service) agreed the Public and Private units were to co-locate as individual units, rather than amalgamate. There has also been a Clinical Nurse Educator appointed, who has provided invaluable support and education to the team, ultimately providing an even greater sense of direction and value to their work. An example of the positive impact having an Educator has meant, that staff are now proficient with Intermittent Dialysis which has resulted in us no longer having to send patients requiring dialysis to the Adult ICU. Twelve hour shifts have been introduced and have meant a much better work/life balance for our staff. Our FTE is now at 85% of the expected FTE. The barriers that once existed between staff have been broken down, and we even see an improved attendance at social events.*

*This work, in collaboration with me participating and completing the Coaching and Facilitation Excellence (CAFE) Programme, facilitated by the Nursing Education and Research Unit, has enabled me to be in a far more confident place than I was 12-18 months ago. I am able to direct the team in a supportive manner, and am more confident in having difficult and challenging conversations with staff, to which they are receptive rather than reactive. Through meaningful and constructive dialogue, and the significant commitment to change by the staff, we have been rewarded with a collaborative and inclusive team.*

*The staff would like to thank the Facilitators for working with them and helping them achieve a more productive and harmonious unit. I would personally like to thank the Facilitators and the Nursing Co-Director for giving me the tools I need which has enabled me to effectively lead the team, for which I have been rewarded with significant job satisfaction.'*

## **Summary**

A dual strategy of developing a more effective workplace culture and the development of behavioural skills in having high support/high challenge conversations was identified as the best outcome for the CTICU. Prioritisation of culture development afforded the context for people to have more quality conversations with each other. This was also achieved through encouraging strong transformational leadership by the A/NUM, her setting the tone and expectation for high support/high challenge, with external support coming from the facilitators through individual mentoring, coaching and active learning. It was recognised that executive support was critical

throughout the project and to gain their agreement to actively support the A/NUM in leading the culture development work and expectation for high support/high challenge conversations.

What has been established through the course of this work is that the A/NUM has finally been appointed to the substantial position. The Clinical Nurse Educator is now in post twenty four hours a week, to carry on a facilitation role with the work, since completing the Coaching and Facilitation Excellence Programme. There is a sense of a clinical leadership team in existence with the NUM and Clinical Nurse Educator engaged collaboratively with the wider critical care community, such as General ICU to shape the next phase of EOC development which is the roll out into ICU. The leadership team have reengaged with the Nursing Person Centred Shared Governance Framework, representing CTICU on councils and at the specialty specific Community of Practice, enabling stronger engagement of the CTICU nurses with the shared governance and providing the communication cross-way for their voice. The unit is also currently trialling twelve hour shift roster and continue to work on other aspects of their action plan.

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**A commentary on this paper by Theresa Shaw follows on the next page.**



## COMMENTARY

### Transforming culture in the critical care environment - the building block of the journey

**Theresa Shaw**

The opportunity to read about practice development work in action is always thought provoking because of the opportunity it creates to reflect on both the use and impact of the approaches and activities. From experience, cardio-thoracic intensive care environments can at times make it hard to achieve the kind of person centred care we strive for as nurses, because of the critical nature of health issues, the involvement of a wide range of stakeholders in care and service delivery and the necessary dominance of highly technical equipment. We know from the background of this paper, that this unit was also experiencing organisational changes, which were having a significant effect on staff.

In relaying the experience of using an emancipatory approach to practice development to transform the culture of the unit, the author very much focuses on the 'practice' of practice development, showing the steps taken to progress a journey of developing an effective workplace culture alongside the implementation of the Essential of Care Program within a shared governance framework. As I read over, I found my attention drawn to a number of theoretical principles and processes that I believe are central to enabling the development of an effective workplace culture and are worthy of further thought. These include, the role of critical theory in emancipatory practice development, working with values and beliefs, enabling facilitation and commitment to human flourishing.

Making a commitment to use emancipatory practice development indicated the clear intention to transform practice by working with staff and patients within the unit. Emancipatory practice development, according to Manley and McCormack (2004) draws on critical theoretical perspectives and can be aligned to emancipatory knowledge interests (Habermas, 1972), where acting collaboratively, collective decision making and transformation are firm commitments. Working with people is valued and the 'messiness' of practice context and culture (Schon, 1987) is acknowledged. Whilst committed to adopting the Essential of Care Program, in keeping with an emancipatory approach, knowledge and ideas for practice change also came from practice. Reflection and critique were also valued as a means of achieving outcomes.

One of the most significant activities in starting to look towards culture transformation is to understand the values and beliefs of those within the workplace. According to Manley (2004), 'values determine what people think ought to be done' (p 55) and can be linked to moral and ethical codes. Beliefs refer to what 'people think is true'. A number of opportunities were created within the cardio-thoracic ICU to explore values and beliefs with staff and patients. In combination, the themes that emerged reflected the real world of practice for these people along with aspirations for how the unit could be. Achieving this is an important step in the journey toward transformation because of the commitment that can ensue from participating in the development a vision for the

future. Outcomes can remain tentative but as suggested in this paper, ongoing support and challenge can continue momentum towards emancipation and culture change.

The external facilitators were described as having an enabling role, an approach which Fay (1987) suggests can be more effective within a team as it can create a climate for enlightenment and empowerment (Fay, 1987). Shaw et al., (2008) attempted to expand understanding of enabling facilitation from the literature and experiences of others. Their work suggests enabling is a form of complex expertise in facilitation, which is:

- centred around the concept of person-centeredness
- built on a set of knowledge and skills about facilitation
- can only be fully acquired and synthesised by a continuous commitment to facilitation concerned with transformations and emancipation for others in the workplace
- enhances and integrates further the four modes of being a person (social relationship, place, time and embodiment)

(Shaw et al., 2008, p 165).

Whilst in many instances the facilitator(s) are internal to the team or unit, in this work, external facilitators were appointed to work with the team. Taking account of the fact the unit had a newly appointed Nurse Manager, it seems that this approach worked well to support both the Nurse Manager and helped the team to engage and participate fully in activities.

The final aspect of this work which I believe is important to highlight and add to, is the commitment to human flourishing. In the last decade, practice developers have also begun to explore the role of artistry and creativity. Most notably, theoretical work led by McCormack and Titchen (2006) presents new thinking around the integration of critical theory and creative imagination resulting in the articulation of 'critical creativity' as a new theoretical perspective underpinning practice development. To further refine critical creativity, McCormack and Titchen (2006) interrogated the framework developed by Fay (1987) which enables the journey through from enlightenment to emancipation. Focusing on sub-theory 10, social transformation, they argue that there is an underestimation of the complexity of transformation. Rather, McCormack and Titchen (2006) argue that for practice to be transformed, activity needs to focus and draw on a theory of 'creativity' which blends artistry, reflexivity and human flourishing. Refining the work, Titchen et al. (2011) express critical creativity as a worldview, the strengths of which extend beyond the confines of critical social science; they argue when coupled with skilled facilitation critical creativity results in human flourishing. This is significant for practice development because of the commitment there is for the development of people. As this paper suggests, working in such a way as to enable people to flourish has tremendous implications for maintaining the quality of contemporary healthcare delivery.

In conclusion, I have enjoyed reading what these authors have shared of their experiences of practice development and culture transformation in a critical care environment. They have highlighted the value of engaging stakeholders, including staff and patients, and through the Nurse Manager's reflections have shown how progress on the journey of transformation has begun. Their experiences are not unusual and other readers may recognise synergies with their own work. With this in mind there are some additional questions about the process and impact that it may be useful to reflect upon further:

- To what extent if any, does having a shared governance framework in place enhance the opportunity for development and transformation?
- Does having a focus, such as the Essential of Care Programme help or hinder culture change?

- What are the relative merits of internal/external facilitator roles in enabling others?

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