1 **Title:** Person-centred Leadership: a relational approach to leadership derived through action
2 research.
3
4 **Abstract:**
5 *Aims & Objectives:* How does person-centred leadership manifest in clinical nursing.
6 *Background:* Person-centred practice fosters healthful relationships and is gaining increasing
7 attention in nursing and healthcare, but nothing is known about the influence of a person-
8 centred approach to leadership practice. Most leadership models used in nursing were
9 originally developed outside of nursing.
10 *Design:* A three year participatory action research study where participant leaders planned,
11 researched and learned from their practice development.
12 *Methods:* After an orientation phase, four action spirals focused on: critical and creative
13 reflective inquiries into leadership practice change; leading the implementation and evaluation
14 of a new nursing system; facilitating storytelling sessions with staff and annually reflecting on
15 personal leadership change. Multiple data gathering methods offered insight into leadership
16 development from several perspectives.
17 *Results:* Critical and creative thematic data analysis revealed a set of attributes, relational
18 processes and contextual factors that influenced the being and becoming of a person-centred
19 leader. Comparing the findings with nursing leadership literature supports a conceptual
20 framework for person-centred leadership.
21 *Conclusions:* Person-centred leadership is a complex, dynamic, relational and contextualised
22 practice that aims to enable associates and leaders achieve self-actualisation, empowerment
23 and wellbeing.
24
25 **Keywords:** person-centeredness; leadership; nursing leadership; action research

26 **What does this paper contribute to the wider global clinical community?**
27 - This paper offers deeper insight into clinical nurse leadership as a relational and
28 contextual phenomenon.
29 - The participatory action research methodology shows how clinical nurse leadership
30 can be developed and researched in practice, with practitioners.
31 - The conceptual framework offers clinical nurse leaders a reflective tool to support
32 leadership development and the development of person-centred cultures.

33

34 **INTRODUCTION**
35

36 With increasing concerns among service-users and practitioners about the nature, formation
37 and maintenance of healthcare relationships, policy-makers, administrators and scholars are
38 showing greater interest in the concept of person-centred practice. Berwick (2013) advises
39 leaders at all levels to concern themselves more with the realities of frontline healthcare and
40 develop cultures of learning, compassion and continuous improvement. Person-centredness
41 has been identified as a core value of effective workplace cultures (Manley, Sanders, Cardiff
42 & Webster, 2011) and person-centred practice defined as the formation and fostering of
43 healthful relationships with service users and among staff, based on the humanistic values of
44 respect for persons, individual right to self-determination, mutual respect and understanding

(McCormack & McCance, 2017). Whilst nurse leadership has received a lot of attention in nursing literature, the study of person-centredness in nursing leadership is still in it's infancy.

## Background

Industrial age heroic and autocratic leadership, with its hierarchical and linear thinking, compartmentalization, surveillance and control has been criticized as new leadership styles emerge which address complexity, whole system and meta-thinking, outcome orientation, morality and purposefulness (Cook, 2001; Wheatley, 2006). New styles of leadership described and researched in nursing include authentic (Avolio, Gardner, Walumbwa, Luthans & May, 2004); servant (Greenleaf, 2003); transformational (Bass & Riggio, 2006; Kouzes & Posner, 2007) and situational (Hersey, Blanchard, & Johnson, 2001), although none of these originated from nursing research or the nursing context. This is of importance as, from a Bordieusian perspective, ways of being learnt and embodied whilst a nurse will influence leadership practice (Lalleman, Smid, Lagerwey, Oldenhof, & Schuurmans, 2015). Also, many leadership theories, styles and research assume that leaders hold hierarchical positions and achieve outcomes by simply applying techniques, principles and practices i.e. a unidirectional flow of influence causing change (Cunliffe & Eriksen, 2011). However, effective leadership in healthcare is more complex as leaders need to consider "roles, relationships and practices that are made within contexts and through social interactions, while learning with people who share these contexts" (Fulop & Mark, 2013: 257). Inquiring into the work of nurses, DeFrino (2009) argues that it is through their unseen relational work that nurses achieve positive patient and professional outcomes. Such embodied history could flow over into nursing leadership relationships and, in contrast to task-focused nurse leaders, relationship focused leaders have been shown to improve nurses' working life, care environments, productivity and patient outcomes (Cicolini, Comparcini, & Simonetti, 2013; Cowden, Cummings, & Profetto-McGrath, 2011; Cummings et al., 2010; Wagner et al., 2010; Wong, Cummings, & Ducharme, 2013; Lynch, McCormack, McCance & Brown, 2017). However, nursing leadership research predominantly views leadership from a hierarchical perspective and is rarely framed within relational leadership theory.

Relational leadership theory detaches leadership from management and hierarchical roles (Uhl-Bien, 2006) and has been defined as "a practice of caring for colleagues, enabling others to act, acknowledging and learning from one's mistakes and being emotionally authentic" (Binns, 2008, p.601). How relationships and relational dynamics maintain, transform and/or construct social structures, conventions and practices becomes the focus of study (Uhl-Bien, 2006). As a moral and dialogical practice, relational leadership is a way of "being and relating with others, embedded in everyday experience and interwoven with a sense of moral responsibility" (Cunliffe & Eriksen, 2011, p.1432). Several relationship-orientated leadership models and frameworks are described in nursing literature. Transformational leadership is a popular choice and frequently found in person-centred practice literature (e.g. McCormack & McCance, 2010; Beckett et al., 2013). However, neither Bass and Riggio's (2006) nor Kouzes and Posner's (2007) leadership models were developed within a nursing or healthcare context. Also, hierarchical power could be a means of aligning staff values, beliefs and behaviour to that of the organisation or the leader self. Measurement tools for these models do not reveal

outcomes achieved through manipulation, destruction and/or exploitation (Hutchinson & Jackson, 2013). In their critique of transformational leadership in nursing, Hutchinson and Jackson (2013) conclude that there is still much to be explored in nursing leadership, and ethics and values should be given greater attention. Uhl-Bien (2006) also calls for richer methodologies that study the processes involved in the emergence of leadership relationships within the workplace.

## THE STUDY

### Aims

The aim was to study changes in clinical nurse leadership when approached from a person-centred perspective.

### Method

The chosen method was participatory action research (PAR), a rich methodology seldom used in leadership research, but one that longitudinally studies change by and with participants through processes of consciousness raising, collaboration and empowerment. Action researchers (AR'ers) collaborate with practitioners, as co-researchers, to collectively inquire into their past, present and future practice and context, with an intent of bringing about change for the good of all and generating scientifically and practically adequate knowledge (Winter & Munn-Giddings, 2001; Kemmis, 2008). In their natural setting, facilitated by an external AR'er, clinical nurse leaders in this study systematically researched changes to their leadership practice as they individually and collectively reflected on a person-centred approach. Working with principles of collaboration, inclusivity and participation also meant that the study design emerged across time as it responded to individual, community and contextual (need) changes.

### Context, participants and participation

The PAR fieldwork was conducted in one unit of a Dutch urban general hospital between 2009-2011. A general study design was collaboratively agreed with the unit team before the orientation phase and again before the action spirals were started. Initial participant co-researchers were the unit nurse manager (UM Betty) and two charge nurses (CNs Anne and Loes) who responded to an article describing the AR'ers (first author) interest in studying person-centred leadership. During the study, one CN became the unit clinical nurse specialist (CNS Anne), a new CN was internally recruited (CN Fleur), and two primary nurses (PNs Chloé and Tess) joined the group in action spiral 2. Proposed research activities were presented in planning meetings, with the AR'er and co-researchers dialoguing until details were collaboratively agreed. Each co-researcher self-determined the degree to which they would be active as a subject and/or researcher, per activity. The emergent and responsive nature of PAR also accommodated self-determined involvement of staff in various research activities throughout the study, for example, being interviewed post leader observation or co-interpreting results obtained in action spiral two.

## Data collection during the study

PAR generally begins with an orientation phase, the outcomes of which inform core action spirals of planning, acting, observing and reflecting (Kemmis & McTaggart, 1988). Data collected and analysed during the *orientation phase* was aimed at generating a deeper understanding of existing relationships and the context. This was achieved through: a culture workshop with the care team, AR'er participant observation of context and nurse leadership by the CNs and UM, and narratives of care (n=24) and leadership (n=11) collected from patients, staff and a physician (see table 1). Results were presented in a poster gallery event where, after viewing, the team shared claims and concerns about the unit, collectively identified issues for development and suggestions for action. The action research group used these claims, concerns, issues and suggestions to co-design action spirals aimed at collaboratively becoming aware of, and empowered to, lead from a person-centred approach. The action phase design (see figure 1) was structured with a central action spiral influencing and being influenced by three other action spirals (see table 1 for goals and data gathering activities).

**< INSERT FIGURE 1 HERE >**

*Action spiral one* consisted of biweekly, two hourly critical and creative reflective inquiries (CCRI) (Cardiff, 2012), held across the two years. During CCRI's participant leaders supported each other in sharing recent leadership narratives and collectively reflecting on them using Mezirow's (1981) model of critical reflection. Resultant insights influenced future leadership practice and subsequent observations incorporated into new inquiries. Audio-transcripts and photographs of the creative expressions in each session were used for post-fieldwork data analysis.

*Action spiral two* entailed the design and implementation of a new nursing system based on the principles of primary nursing (c.f. Manthey, 2002). Development of the system and enactment of the PN role offered deeper insight into clinical leadership. The CN's adopted a dual CN/PN role and two new PNs were internally recruited. To generate a shared vision on primary nursing, participant leaders engaged in a creative workshop and conducted semi-structured interviews with members of the care- and medical team as part of a second workshop on the PN role. Participant observation of the leaders in practice was conducted by the AR'er shadowing participant leaders at and away from the bedside. Observations sessions ended with a post-observation leader interview, sometimes accompanied by an interview with those being led during the session. This offered insight into individual leader intent as well as follower perceptions. The PNs also held regular meetings evaluating the implementation process and invited staff contributions via various methods, such as, an evaluation journal kept in the staffroom. They used Guba and Lincoln's (1989) claims, concerns and issues framework to structure and document evaluations.

Staff perceptions on culture and leadership change were collected using various methods. Qualitative data on culture and practice change were gathered in a creative culture workshop with the care team. Quantitative data were obtained in a leader designed Likert scale staff

questionnaire, the items of which were based on concerns identified in the (pre)orientation phase: care continuity and coordination, informed families, workload, work satisfaction, unit atmosphere, student supervision and PN leadership of care from admission to discharge. Staff perceptions of received leadership were collected during a workshop facilitated by an external university researcher with no ties to the study and anonymised transcripts member-checked before sharing with the action research group.

In *action spiral three* the CNs facilitated weekly 20 minute storytelling sessions where nursing staff could share narratives and reflect on their care using McCormack and McCance's (2010) framework for person-centred nursing. CN experiences of facilitating these sessions were collected in post-observation interviews, initially by the researcher and later by each other. These too were audio-taped and transcribed.

Whilst action spiral one created reflective space for daily leadership practice, annual reflective inquiries in *action spiral four* provided space to evaluate and reflect on personal growth. Individual creative expressions of leadership and growth were critically peer reviewed and findings compared to those of the previous annual inquiry. Whilst the PNs and CNS chose not to participate in these sessions, they did participate in a mid-term evaluation workshop on the research project. Having re-defined leadership during a CCRI as "a (non-)hierarchical relationship where one person supports individuals and groups in achieving common goals", participant leaders felt that the AR'er was also engaging in (person-centred) leadership. As critical (self-)reflection by an action researcher enhances research credibility (Trondsen & Sandaunet, 2009), it was agreed that the traditional researcher 'facilitator' role (c.f. Winter & Munn-Giddings, 2001) would be viewed as a 'leader' role. Data from the AR'ers annual inquires, alongside the AR'er journal, audio-recorded supervision sessions and notes from his own action learning set, therefore contributed to the data pool. The AR'ers leadership was also evaluated by participant leaders in a workshop facilitated by the external researcher.

**< INSERT TABLE 1 HERE >**

**Data analysis**

Data gathered in the orientation phase was analysed before action spiral planning. Data on (the growth of) person-centred leadership was gathered and sometimes analysed during the action phase as data interpretation during field work is inherent to PAR. Researchers and participants reflect on recent observations and narratives to inform change (Winter & Munn-Giddings, 2001). Two years of action spirals yielded 250+ hours of audio-recordings, 23 participant observations and documents from various workshops. To reduce the data corpus to a size feasible for post-fieldwork analysis the whole was divided into two data sets. The primary data set (see table 2) was used for the initial thematic analysis. The remaining collected data was used to support and/or challenge themes emerging from primary data set analysis.

**< INSERT TABLE 2 HERE >**

A six phased thematic analysis (see box 1) was conducted by the AR'er, based on the analysis frameworks of Braun and Clarke (2006) and van Lieshout and Cardiff (2011). Transcripts from the primary data set were used for phases 1-5. Transcripts from the secondary data set were included during phases 4-5 in order to expand the scope of evidence supporting or challenging emerging themes.

**< INSERT BOX 1 HERE >**

## Ethical considerations

The study was approved by the ethics committee of the university supervising this doctoral study. The study aims and plans were presented to the whole unit team for critical dialogue before fieldwork commenced and after the orientation phase. The co-researchers gave informed written consent at the beginning, all data gathering was overt and individual informed verbal consent obtained before commencing data gathering activities. Participation was voluntary and care taken to respect confidentiality and anonymity. As researchers investigating their own leadership practice there was a concern for the wellbeing of others and self. Posing 'how to behave' questions to self and one another became common practice. In line with McCormack's (2003) framework for person-centred research, the orientation phase and weekly presence of the AR'er was conducive to researcher socialisation within the setting; regularly held dialogical spaces helped prepare and engage people and boundaries were (re)negotiated; research activities were planned with participants so as not to disrupt patient care or unwillingly impinge on private time and member-checking all written documentation ensured authentic representation of participant voice.

## Findings

Thematic analysis of the data revealed themes and sub-themes for the 'being', 'becoming' and outcomes of person-centred leadership (see figure 2). 'Being' a person-centred leader entailed a set of six leader attributes and seven processes. 'Becoming' a person-centred leader was influenced by four developmental and four contextual themes and eight outcomes were identified. Person-centred leadership was defined as a style of leadership in which a leader tries to enable associate coming into own whilst working towards a shared vision/common goal. Participants chose to replace the traditional term 'follower' with 'associate' as they felt this better reflected the humanistic values guiding their practice.

**< INSERT FIGURE 2 HERE >**

**Attributes for being a person-centred leader:** Essentially, participants felt that leaders need to want to become person-centred and should be *authentically other-centred and caring.*

> CN Loes: *"… you can't learn them all. You have to want to be other-centred … Others have their 'feelers', don't they? That authenticity must be felt by the other. "* (CCRI 4)

Although they felt this could not be learnt, *self-awareness* emerging from reflecting and working with one's own values, beliefs and preferences fostered relational connectedness, as

did daring to *show one's own vulnerability.* Vulnerability could be professional and/or personal. For instance, one CN who initially believed that leaders should be a constant pillar of support for staff, discovered that daring to show vulnerability, whilst grieving the death of her father, can foster reciprocal support.

Being *open, patient and optimistic* fostered a sense of tranquillity as leaders listened attentively to associates, seeing them as valued and distinct individuals moving collectively towards a common goal. Students, like staff, also experienced equity when working alongside CN's and PN's.

> Student Joanne*: "… a bit like an equal really, not as if I'm just another student. No, very honest, very open, explaining things thoroughly, and letting me talk first and then looking at, "Yes, that's right," or not."* (Post-observation interview)

*Reflexivity*, reflecting with moral intent, on large and everyday small dilemmas required inquisitiveness, analytical thinking, heeding and questioning intuition, as well as considering (potential) consequences. Leaders used their *interpersonal intelligences* to move through different levels of engagement and share rather than sell or impose their vision. Examples included inviting associates to share their views/narrative before responding, and matching offers of task participation with associate desire and ability. CN Loes articulated this movement between nearness and distance without loss of connectedness, in a narrative about a staff nurse who was failing to progress whilst on sick leave.

> CN Loes: "*You also have to be careful that you don't get sick of it, because then we'd be doing her an injustice … you have to be sympathetic, but not lose your objectivity, and you have to keep trying to see the bigger picture."* (CCRI 9)

**Processes in being a person-centred leader:** The leader attributes manifested in all processes of person-centred leadership. Core processes of s*ensing, balancing, contextualising, presencing* and *communing* were identifiable in all situations, at different moments, in different configurations and intensity. Engagement generates information, helping the leader position themselves in relation to associates (*stancing*). *Creating safe and critical (learning) spaces* also aided the creation of shared visions and/or goals.

*Sensing* was the continuous engagement of the senses to gather information about self, associates, performances and context. Alternative information sources, such as accounts from other staff members, personnel records or a leader's history with the person, sometimes supplemented what was being sensed, but verifying interpretations was important.

> CN Fleur: "…*I saw that she wasn't coping well. I saw it on her face and in her eyes … I asked, "How are you coping?... You come across as being a bit muddled … I noticed it again in you." And she said, "Yes, it's not my morning this morning." But, she didn't want to take it any further."* (Post-observation interview)

*Contextualising* was the process of seeing associates as more than colleagues or nurses. Each person has their own narrative, including social roles and contexts outside the workplace which influence their being and performance within the workplace. Recognising this, alongside contextual factors such as policy, time and resources, meant that leaders constantly found themselves *balancing* needs.

> CN Loes: *"I have to do something… It's not good for anyone… She isn't really going to get any better under these circumstances… we need to look critically at where we can help her… Are we doing the right thing? because it really is something if you have to say to someone, "You're not functioning adequately, so, you'll have to leave here."* (CCRI 14)

*Communing* with associates entailed communicating at a more intimate level to find a common ground, shared vision and/or collectively deciding how to act. Conflict situations in particular revealed how destructive an authoritative stance, or use of hierarchical power, could be for relationships. Lifting discussions to a higher level of abstractness helped identify the common opinion/goal and from here they could gradually work down to concreter details and tackle divergences in opinion as they emerged, one-by-one. Self-awareness aided this, as unearthing own expectations and identifying shared understandings/goals reduced defensiveness and persuasion.

> CN Loes: *"What I have learnt from this is that my own stance, my own insecurity, can come across as aversion and that in doing so I maintain her* [hierarchical] *stance… On the other hand, I have to find a way to build a collaborative relationship* [with her] *and I could achieve that by agreeing a common goal, among other things, and by stating beforehand that I want to discuss the common goal. I need to be aware of that myself* [own goal] *and to discuss that with her."* (CCRI 7)

Observations and narratives of *presencing* showed a move from participant leader doing/resolving issues 'for' associates to being and thinking 'with' associates. Attentive listening and sympathetic/non-judgemental understanding preceded offering alternative perspectives, hope, shared responsibility, plausible explanations or practical and concrete advice. This was creatively expressed in a CCRI about a staff nurse who was experiencing difficulties balancing her work-home responsibilities.

| | |
|---|---|
| CN Loes: "*It shows an opposing balance to the loneliness depicted in the other pictures, that there is someone there who puts an arm around you and says, "You're not alone. We want to think with you and help." That doesn't mean to say that you can completely take the despondency away … sometimes just listening and showing understanding is enough and people then undertake action* | **< INSERT FIGURE 4 HERE >** |

| | |
|---|---|
| *themselves to resolve a problem.*" (CCRI 4) | |

These processes helped leaders decide how to position themselves in relation to associates (*stancing*), each moment anew. Four basic stances were identified: leading from the 1) front, inviting leader role modelling or 'doing for' associates; 2) side-line, offering instruction or reminders; 3) alongside, balancing challenge with support to enable action; 4) behind, stepping back and observing when comfortable with associate ability or enabling experiential learning. Initially, participant preferred/habituated stances were to lead from the front or side-line and more directive than invitational. The invitational approach proved to be effective in respecting self-determination and leaders became more responsive, moving reflectively and fluidly through different stances in any situation. Leading from behind was the most alien and challenging, requiring calculated risk-taking at times.

> UM Betty: *"I tried to connect with where she was at … where she is in her role, so to speak, but, I didn't take over. A year ago I would have taken over and it would have been long sorted … now I think, "Ok, that is a choice you have made, that's possible. May also be a good thing, or at least there may be some good elements to it." So, I pick it up more easily, where she is at, in that moment, in her situation … and I can continue from that point … I also intervene now and again, to give them the feeling that they are not left swimming* [alone] *either."* (Post-observation interview)

Leadership had been nurturing associate dependency on leader direction, but focusing on *enabling associates to come into their own* nurtured reciprocity. The idiomatic expression was frequently used to describe leaders wanting to help associates feel good, reach their potential, become more active and self-determinate. In time, they started to experience reciprocity and feel good themselves, that things were right and working life was becoming easier.

> CN Loes: *"I notice a difference. I must say I'm calmer now … I think that I do it* [leadership] *better now, that I'm more confident about the things that I do … I'm accepted and people understand that my choices are often reflected upon and it's easier … I'm myself now … I have chosen for myself to stay as charge nurse for the time being. And I like that."* (Post-observation interview)

Engaging in this AR exposed participant leaders to new ways of learning. They started to experiment in *creating safe and critical (learning) spaces* where multiple perspectives could be shared, horizons broadened, interpretations balanced, as well as shared power and responsibility nurtured. The PN's, in particular, started to see and capitalise on learning opportunities around them, matching opportunities with associate need and readiness to learn.

> PN Chloé: *"I think she comes into her own because she said that she wanted to do it* [administer medication] *a few times under supervision. And then I created the space, so that we make sure she feels safe ..."* (Post-observation interview)

**Developmental processes in becoming a person-centred leader:** When asked for advice on becoming and/or researching person-centred leadership, participant leaders unanimously replied: "*take the time needed* to ensure sustainable change". It required constantly working around/with existent structures, processes and workloads to foster participation and build safe, trusting relationships.

> CN Loes: "*... despite our enormous work pressure we took time to listen to what people were saying, to really hear the team ... and adjust yourself to them first. Look at where there is a need and try to focus on that ... So, take your time ... and look at the tempo they can work at. Some are quicker than others."* (Midway evaluation with CN's and UM)

Engaging in research activities enabled them to become acquainted with the researcher and re-acquainted with one another. *Creating safe, critical and creative communicative spaces,* one of the AR'ers philosophical principles, enabled deep and sometimes challenging self-inquiry. These spaces supported change momentum, honest and critical debate, living with uncertainty, problem resolution, perspective transformation and group cohesion. Working creatively was catalytic in opening minds and explicating thoughts and feelings which may otherwise have been suppressed, or emerged later in disguised/deconstructive ways.

> UM Betty*: "Feeling uncertain about things has actually helped me change ... I now believe in collectiveness, which has come from being open ... We were open, but now that we explicitly ask each other to say what we're thinking, it's more* [in the] *present! ... The challenging discussions help me think how to move forward ..."* (Participant leader annual reflection)

There was a strong preference for experiential learning and leaders only engaged superficially with the literature offered. By *role modelling* how he used theory to explain experiences the AR'er triggered curiosity, as did re-presenting the person-centred nursing framework (McCormack & McCance, 2010) in the form of a Dutch windmill.

> CN Loes*: "... it's only now that I feel that I'm starting to understand it* [ person-centered nursing framework] *for myself ... it was too abstract and far off for me ... now I'm starting to notice and feel what we're doing, that it's great what we're doing, and the windmill is starting to come to life, and I'm starting to use it more often and can stick more things on it and name them by myself."* (Midway evaluation with CN's and UM)

*Reflecting on evaluations and observations* of leadership practice assisted participant growth. Evaluative data from staff was fed back to the leaders and the AR'er consciously

1 tried to role model being person-centred as he worked alongside in reflecting on the
2 evaluations. The use of post-observation interviews also raised leader awareness to their
3 being and context, something left unexplored beforehand.

4 CN Fleur*: "I have never really had to reflect on what I was doing with*
5 *someone really watching what I was doing … It's an eye opener and a*
6 *development that is really great to experience. Shadowing is very direct,*
7 *the questions afterwards and the evaluation."* (Post-observation
8 interview)

9 **Contextual influences on becoming a person-centred leader:** Leader development was
10 influenced by personal factors and commitment, organisational culture and the crises
11 encountered en route. Each leader arrived with a *personal history, ability, values and beliefs*,
12 some of which were conducive to person-centred leadership, whilst others underwent
13 transformation. For instance, having led the unit for longer and through some difficult
14 periods, CN Loes' values and beliefs about leadership underwent significant change. In
15 contrast, CN Fleur was a staff nurse on the unit during the orientation phase and applied to
16 become CN as she believed in the concept of person-centredness. Her person-centred
17 leadership was quickly observed and acknowledged by staff.

18 *"More than the others she radiates warmth … you experience the*
19 *engagement … Fleur can feel what people mean, put her finger on the*
20 *salient point … She's also comfortable admitting when mistakes have*
21 *been made or that the situation is difficult. In doing so, you feel*
22 *acknowledged when you raise an issue."* (Staff evaluation workshop on
23 unit leadership)

24 The hospital organogram showed two operational managers of equal status per unit: a UM
25 for the care team and medical manager (MM) for the physician team. However, traditional
26 professional status and power was evident in the *organisational culture*. Despite invitations,
27 the MM and physician team did not actively participate in the study. They were kept
28 informed via UM-MM meetings, but, as change within the nursing system and culture
29 emerged so did MM resistance. The changing nurse leadership was viewed negatively: "too
30 many people involved in decision-making processes and too much sharing of
31 responsibility". This culminated in the MM expressing a lack of faith in the UM's
32 managerial competency, despite a lack of concrete examples of poor performance and a
33 positive, independent, formal competency assessment. Finding herself in conflict with no
34 support from higher management, the UM decided to resign. Her departure heightened
35 awareness among the remaining leaders to the role tradition and power play in
36 multidisciplinary contexts.

37 CN Fleur*: "… With Clive* [MM] *I notice as well that I'm easily talked*
38 *around to his way of thinking and afterwards I think, "It wasn't supposed*
39 *to happen like that." That means that I'm still susceptible to power and*
40 *hierarchy."* (Halfway evaluation, March 2010)

Events such as this were initially perceived as *crises,* but, not necessarily detrimental to leader development. For instance, UM Betty's decision to move her office away from the unit, or Anne's decision to be CNS instead of CN, created new spaces for others to come into their own, do things differently and take on new roles and responsibilities.

> CN Loes*: " … the real breaking point came for me when Anne left. On the one hand I thought, "How are we going to do this now?" But, on the other hand I thought, "Now I can be myself." I started to change … I learnt more about myself then …"* (Midway evaluation with CN's and UM)

As the participant leaders experienced the benefits of person-centeredness, so did their *commitment* to the research activities. This was further helped by *comparisons of self to others* in similar posts within the hospital. Participant leaders were evolving in a direction they self-choose and found rewarding.

**Outcomes of being and becoming a person-centred leader:** With commitment came outcomes at a personal, relational and cultural level. All participants described *personal changes*, feeling transformed, proud of what they had achieved and embodying their new leadership style.

> CN Loes*: "… it's* [person-centred leadership] *under your skin … you can't be any different, you've become so."* (Final evaluation with CN's)

A *positive leadership change* was experienced by the nursing team who now saw five individuals leading from within, rather than from above/outside the team. They felt strategic decisions were well thought through and supervised support was balanced with freedom to experiment. Where the leaders were parental, protective and directive, they moved *from managing to leading* staff, becoming focused on 'doing the right thing' rather than 'doing things right'. The leaders themselves experienced more self-worth, relaxation and work satisfaction, as well as *relational reciprocity and equity*.

> CN Fleur*: "The more we lead like this, the more we get back. The more person-centered we are the more person-centered they are to us …"* (Participant leader annual reflection)

*Workplace culture change* emerged alongside relational changes. Leaders described greater collaboration, inquiry and less resistance to change. There was greater staff willingness to take on more responsibility and/or become involved in decision-making. There was a noticeable decline in call-bells, response time and greater tranquility on the unit. The evaluation questionnaire revealed that staff tended to agree that there was a better atmosphere on the ward, better continuity and coordination of care, better mentoring of students and improved work satisfaction, despite no changes in workload/pressure or staffing levels. Photos from the culture workshop supported these findings, and expressed improvements in being caring yet critical and transparent towards one another.

Participant observations revealed leaders *using the same strategies and processes* of the research in their daily practice. For example, narrative interviewing skills when communing with staff, or the claims/concerns/issues framework to structure evaluations. *Leader reflectivity* was evident as the acted on intuition combined with cognition, connecting their 'thinking' with their 'doing' and articulating the 'why'.

> CN Fleur*: "I don't just act from gut instinct now … The gut feeling is usually OK, it's just that you need to be able to reason it and place it somewhere. Gut feeling alone is not enough."* (Annual reflection, July 2010)

## Discussion

Whilst the thematic analysis framework of this study could be interpreted as a linear flow of attributes, processes and influences causing outcomes, the thematic descriptions reveal how complex person-centred leadership is in clinical practice. For instance, supervising a staff nurse (SN) during a phased return to work after sickness, in a context/organisational culture pressing for reduced sickness rates, CN Fleur's leader attributes (interpersonal intelligence, self-awareness and reflexivity) supported her engagement in relational processes (sensing how the SN was coping, being mindful of the SN's difficult home context, balancing needs of the SN to feel functional with patient safety needs) from which she decided which stance(s) would most likely enable the staff nurses', and her own, coming into own. Consequently, she frequently led from alongside, encouraging and supporting the SN's engagement and perseverance in nursing care. At times she also led from behind, to show acknowledgement and trust in the SN's growth, and observe her progress. Person-centred leadership now becomes a complex relational and contextualised practice. As a relational practice, leader attributes support relational processes, which inform stancing aimed at enabling associate and leader coming into own. As a contextualised practice, contextual structures, practices and conventions influence leader-associate relating. Activation of leader attributes and relational processes, as well as contextual factors, is particular and dynamic. This means that each leader-associate relationship is unique and in a constant state of flux.

The (sub)themes show congruency with a person-centred practice theory. Being authentically other-centred, caring and reflexive, engaging in relational processes such as presencing and communing, as well as being focused on the coming into own of associates and self, demonstrate the enactment of the humanistic values (mutual) respect, right to self-determination and understanding. As well as portraying relational leadership as a moral and dialogical practice (c.f. Cunliffe & Eriksen, 2011), the themes resonate with Binn's (2008) description of relational leadership as an authentic, caring practice that enables others to act whilst acknowledging and learning from one's own actions. The findings thereby contribute to knowledge on relational leadership theory in nursing. However, the process of leader development was relatively long and contained to leaders on one unit. When the study started, besides the person-centred nursing framework (McCormack & McCance, 2010), there was also no conceptual framework or model for person-centred leadership. This has encouraged

the development of a conceptual framework for person-centred leadership (see figure 3) where thematic findings and compared to existent nurse leadership literature.

## A conceptual framework for person-centred leadership

The conceptual framework for person-centred leadership offers a graphic and narrative representation of clinical nursing leadership as person-centred relationships that are healthful (McCormack & McCance, 2017) and growth-fostering (Jacobs, 2014). It contains themes from the findings, inductively ordered and supported by propositions to describe relationships between the themes. The framework is circular with a relational and contextual domain separated by a permeable border (dotted line). This represents leadership as a constantly evolving phenomenon emerging from intrapersonal, interpersonal and contextual interactions. The findings show how leaders were consistently and increasingly aware of self, self in relation and context. They developed and used attributes for relational being, and core processes for relational connectedness. Knowledge derived from being and relating influenced stancing, intended to foster associate and leader coming into own. The assumption here was that when people felt good at work, optimal performance and commitment were likely to follow. This is in line with Cummings et al.'s (2010) finding that relationship-focused leadership has greater positive influence on the nursing workforce and nursing environment than task-focused leadership.

**< INSERT FIGURE 3 HERE >**

**The relational domain:** The relational domain of the framework holds leader attributes and core processes informing leader positioning of self (stancing) in relation to associates. Nurses want honest, positive, receptive, moral and facilitative leaders (Anonson et al., 2013; Wieck, Prydun, & Walsh, 2002; Stanley, 2006). Being *authentic, other-centred and caring*, the leaders respected unicity and sought meaning in "I-Thou" relationships with associates. Leader authenticity has been shown to aid subjective well-being at work among public organisation managers (Ménard & Brunet, 2011) and self-reported vitality among nurses (Mortier, Vlerick, & Clays, 2015). The caring disposition so familiar among nurse leaders, requires *intra- and interpersonal intelligence* and can lead to ad hoc or fragmented work if not balanced with an investigative stance (Lalleman, 2017). *Reflexivity* and *willingness to show vulnerability* helped the leaders balance the caring and investigative dispositions as they acknowledged their fallibility and tried to understand first, second and third person perspectives in context. Studying intergenerational leadership, Wieck et al. (2002) also conclude that today's leaders need to be aware of differing needs in order to respond appropriately. Whilst nurses value decisive leaders in times of crisis (Anonson et al., 2013), they also need to trust leaders. Avolio et al. (2004) use the term commensurability (the sharing of self-aspects in dyads) to explain the building of such trust. The reciprocity experienced by the person-centred leaders in this study, is indicative of trust emerging from relational connectedness.

The leader attributes support continuous engagement in the five relational processes providing a constant flow of information to guide stancing. *Sensing* (using one's senses to gather information about associate being, and verifying interpretations) is described in nursing

(Bundgaard, Nielsen, Delmar, & Sorensen, 2012; Sellevold, Egede-Nissen, Jakobsen, & Sørlie, 2013; Martin, O' Connor-Fenelon, & Lyons, 2012), but not leadership research. Hersey et al. (2001) describe leader assessment and diagnosis of 'follower' competency and willingness, but this is a more reductionist (task-orientated) than holistic (whole person-orientated) approach. *Contextualising* (understanding how associate embeddedness within differing contexts, past and present, can influence present and future being) is also a concept not described in leadership literature but was demonstrated by the leaders as they, for instance, lead associates reintegrating into work life after sick leave. In contrast, *balancing* needs and *communing* (action-orientated dialogue) are frequently described in nurse leadership literature. However, where publications on leader communication skills usually describe a unidirectional (leader-to-follower) flow of information, person-centred leaders are more dialogically orientated, thereby lowering the potential for manipulation as they balance needs and commune. Utilising the narrative interview skills learnt in CCRI's helped reduce perceived power differences and enhanced authenticity, shared understanding and shared decision making as they engaged in communing and ordinary 'person-to-person' conversations (c.f. Groysberg & Slind, 2010). Also, *presencing* (being and thinking with an associate) fostered relational connectedness. The presencing demonstrated and described showed greater similarity to McCormack and McCance's (2010) sympathetic presence (appropriately responding to another's cues so as to maximise coping) and Baart's (2001) presencing (beneficent attentiveness), than Senge, Scharmer, Jaworski, & Flowers' (2004) presencing as personal and contextual mindfulness. Alongside the other processes, this being and thinking with associates helped the leaders decide on a stance they felt most likely to enhance associate coming into own.

Whilst the process of *stancing* was broken down into four basic stances, observations and narratives demonstrated that different stances occur within any leader-associate encounter, reflecting responsiveness to own and associate being, as well as contextual changes. Leading from the front entailed offering directive support, such as role modelling or 'doing for' the associate. When leading from the side line, leaders offered instruction or advice. Leading from alongside or behind was less directive as associates were encouraged and supported in becoming more self-directive. Where leading from alongside showed more intense interaction, with high challenge and high support. Leading from behind was far less interactive as leaders stepped back and observed. These four stances could be confused with Hersey et al.'s (2001) four modes of situational leadership, however, there are differences in discourse and leader intent. Situational leaders are primarily concerned with follower performance, whilst person-centred leaders focus first on associate wellbeing, empowerment and self-actualisation (coming into own). Situational leaders 'tell' followers what to do in S1 mode, rather than 'offer' direction, 'selling' and/or 'persuading' followers to psychologically buy in to what the leader wants in S2 rather than offering advice. In S3, situational leaders support follower confidence and involvement in problem-solving, using praise and compliments, and in S4 they delegate, convinced of follower task competency (Hersey et al., 2001). Person-centred leaders may choose to lead from behind even when associate competency is not evident. For instance, aware of the CNs' learning needs and preferred learning styles, the UM Betty restrained from intervening and stepped back, observing how

they solved challenging issues, thereby creating a safe learning space as she could change stance if and when needed. Calculated/considered risk-taking is characteristic of empowering care environments (McCormack & McCance, 2010) with benefits including heightened associate self-awareness, empowerment, self-confidence, job satisfaction, professional development and organisational innovation (Crenshaw & Yoder-Wise, 2013) i.e. associate coming into own.

Based on staff and leader positive evaluations, three concepts were associated with the idiom '*coming into own*': empowerment, wellbeing and self-actualisation. The NHS NICE (2009) guideline recommends that front-line leaders focus on staff wellbeing and empowerment. Findings in the orientation phase reflected earlier research that Dutch nurses experience leadership as hierarchical, non-communicative and increasingly 'business-like' (van der Arend & Remmers-van den Hurk, 1999). However, as leadership practice changed, so did perspectives, with coming into own not restricted to associates. Participant leaders sought and developed their own empowerment. This is important as nurse middle-management leaders often do not feel empowered (Patrick, Laschinger, Wong, & Finegan, 2011; Regan & Rodriguez, 2011). Also, the relational approach to leadership meant that empowerment was seen as something that can be enabled (not given), individually experienced and contextualised. The person-centred approach respected that not everyone wanted the same level of responsibility and self-determination all the time. Also, structural empowerment as supporting access to opportunity, information, resources, support and (in)formal power (Kanter, 1977) was accompanied by psychological empowerment as supporting self-determination and self-efficacy in meaningful work (Conger & Kanungo, 1988). Although not empirically measured in this study, working simultaneously with both empowerment approaches has been shown to have a positive impact on nurses and nursing (Wagner et al., 2010).

**The contextual domain:** A leader-associate relationship manifests in context, not isolation. Whilst leadership research has tended to stay clear of studying situatedness and contextual influences (Ashman & Lawler, 2008), this study revealed several factors influencing and influenced by the leader-associate relationship.

*Creating learning spaces* enabled adult cooperative, collaborative and transformative learning (c.f. Cranton, 1996) and opportunistic, facilitated workplace learning can be professionally and personally empowering (Snoeren, Niessen, & Abma, 2013; Merriam, 1996). Facilitated critical and creative reflection on-, in- and before-action in action spiral 1 supported the connecting of thinking with doing, thereby influencing future 'being'. Also, in contrast to traditional leadership development strategies such as educational programmes, the PAR approach provided the positives of work-based learning (self-directing and self-pacing) without the challenges of written assignments and/or portfolio development for academic accreditation. Utilising the development strategies they were experiencing, the leaders created learning spaces aimed at fostering a person-centred culture. Nurses appreciate leader facilitation of professional development (Anonson et al., 2013) and although no evaluative data on care was collected from a patient perspective, Lynch (2015) found that nurse leaders partnering associates from a person-centred approach fostered person-centred care.

There is a danger that person-centredness could be interpreted too individualistically i.e. too focused on own assumptions and the needs of one individual/group. Awareness of, and working with '*differing stakeholder needs*' helps balance such blinkeredness. Reciprocal influencing between the leader-associate relationship and other stakeholder needs was evident in the PAR, for instance: when leaders realised that absent persons could potentially be affected by decisions/actions they made in the here and now with one individual/group, and when PN's started to collaborate more with colleagues each shift after hearing fears that their range of nursing activities was declining. In contrast, the MM's attempt to regain control over nurses and nursing on the unit reflected an individualistic mindset and reflects Fealy et al.'s (2011) finding that interdisciplinary relationships are a potential barrier to clinical nurse leadership development, especially when nurses choose not to play the 'doctor-nurse' game (McMahan et al, 1994). *Organisational culture* refers to espoused values and practices across differing groups within an organisation (Kotter & Heskett, 1992) and whilst many believe this determines 'the way things are done' within organisations, Bolan and Bolan (1994) propose that groups and units within the organisation (idio-cultures) are both carriers and creators of culture. That nurse leaders can be seen as minor strategic players (relative to physicians and higher management), experience positional marginalisation and powerless responsibility has been documented (Fealy et al., 2011) and was evident within the research setting. However, collaborative reflection on such organisational values and practices raised awareness and conscious action. Comparing their leadership vision and development with colleagues of similar positions within the organisation aided this empowerment and the idio-cultural/unit findings support the view that leadership can enable the enactment of person-centred values in workplace cultures (c.f. Manley et al., 2011; Lynch et al., 2017).

Lastly, healthcare practices need *systems of evaluation* to maintain quality and safety, plus, perceptions and leadership practices evolve in time (Krugman, Heggem, Kinney, & Frueh, 2013). Some evaluation systems monitor key performance indicators regularly whilst others are specific and transient/intermittent. All have the potential to influence and be influenced by leadership practice. For instance, based on primary nursing implementation evaluations, the CN's decided to alternate weekly between working bedside and working from the office, so as to meet their clinical and administrative responsibilities.

## Conclusion

Front-line leadership is pivotal to workplace culture evolution and with the increasing interest in person-centred practice it is important that insight is gained into the role leadership plays. This participatory action research study describes how a relational, person-centred approach to leadership influences leaders, associates and context. The conceptual framework derived from the findings portrays person-centred leadership as a complex, dynamic, relational and contextually embedded practice that fosters healthful relationships and growth.

When clinical nurse leaders embody the set of attributes, and engage in the relational processes, they become more responsive and better able to support associate and own wellbeing. Whilst the findings are predominantly based on the leaders' voice, many of the attributes and relational processes affirm existent findings in nursing leadership literature.

Others, such as a willingness to show vulnerability, contextualising and communing, are new. A new perspective of shifting leader focus from primarily aligning 'followers' with their own/organisational vision, higher performance, lower turnover/absenteeism and improved service-user evaluations to associate empowerment and self-actualisation, is also presented. The belief being that associate wellbeing, empowerment and self-actualisation are antecedent to the other outcomes. The framework also makes explicit the interplay between leadership relationships and context.

The developmental journey was long, intense and restricted to the leaders on one unit. However, the participatory action research approach demonstrated how leaders working alongside an action researcher can be active and self-directive in both their leadership development within the workplace and practice research. Engagement in research activities raised awareness to their own embeddedness and helped them remain attentive to the multiple values, needs, structures, conventions and practices influencing and/or being influenced by their leadership relationships. A positive and valuable mindset for contemporary clinical nurse leaders.

## Relevance to clinical practice

The study supports the call for greater relationship-orientated leadership in clinical nursing. It shows how clinical nurse leaders can develop relational leadership within the workplace. Expert facilitators can support them in collectively, critically and creatively reflecting on their own leadership narratives. Where the facilitator is also an action researcher, the step to becoming practitioner researchers is also reduced. Those wishing to develop person-centred cultures now have a conceptual framework to aid their developmental journey too. The framework can assist the deconstruction of leader narratives into present/absent elements in the relational and contextual domains, and help identify areas for growth and development. Because of the relatively limited view from an associate and service user perspective, we also recommend that these perspectives are studied more intensely in future research on person-centred leadership development and practice.

**References**:


Anonson, J., Walker, M., Arries, E., Maposa, S., Telford, P., & Berry, L. (2013). Qualities of exemplary nurse leaders: perspectives of frontline nurses. *Journal of Nursing Management*. doi:10.1111/jonm.12092.

Ashman, I., & Lawler, J. (2008). Existential Communication and Leadership. *Leadership, 4*(3), 253-269.

Avolio, B., Gardner, W., Walumbwa, F., Luthans, F., & May, D. (2004). Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviors. *The Leadership Quarterly, 15*, 801-823.

Baart, A. (2001). *Een theorie van de presentie*. Den Haag: Lemma.

Bass, B., & Riggio, R. (2006). *Transformational Leadership* (Second ed.). Mahwah: Lawrence Erlbaum Associates, Inc.

Beckett, P., Field, J., Molloy, L., Yu, N., Holmes, D., & Pile, E. (2013). Practice What You Preach: Developing Person-Centred Culture in Inpatient Mental Health Settings through Strengths-Based, Transformational Leadership. *Issues in Mental Health Nursing, 34*(8), 595–601.

Berwick, D. (2013). *Improving the Safety of Patients in England: National Advisory Group on the Safety of Patients in England*. UK: Department of Health.

Binns, J. (2008). The Ethics of Relational Leading: Gender Matters. *Gender, Work and Organization, 15*(6), 600-620.

Bolan, D., & Bolan, D. (1994). A Reconceptualization and Analysis of Organizational Culture: The Influence of Groups and Their Idiocultures. *Journal of Managerial Psychology, 9*(5), 22-27.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Bundgaard, K., Nielsen, K., Delmar, C., & Sorensen, E. (2012). What to know and how to get to know? A fieldwork study outlining the understanding of knowing the patient in facilities for short-term stay. *Journal of Advanced Nursing, 68*(10), 2280-2288.

Cardiff, S. (2012). Critical and creative reflective inquiry: surfacing narratives to enable learning and inform action. *Educational Action Research, 20*(4), 605-622.

Cicolini, G., Comparcini, D., & Simonetti, V. (2013). Workplace empowerment and nurses' job satisfaction: a systematic literature review. *Journal of Nursing Management, 22*(7), 855–871.

Conger, J., & Kanungo, R. (1988). The Empowerment Process: Integrating Theory and Practice. *The Academy of Management Review, 13*(3), 471-482.

1 Cook, M. (2001). The renaissance of clinical leadership. *International Nursing Review, 48*(1),
2 38-46.

3 Cowden, T., Cummings, C., & Profetto-McGrath, J. (2011). Leadership practices and staff
4 nurses' intent to stay: a systematic review. *Journal of Nursing Management, 19*, 461-477.

5 Cranton, P. (1996). Types of group learning. In S. Imel (Ed.), *Learning in groups: exploring*
6 *fundamental principles, new uses, and emerging opportunities. New Directions for Adult and*
7 *Continuing Education. No. 71* (pp. 25–32). San Francisco: Jossey-Bass.

8 Crenshaw, J., & Yoder-Wise, P. (2013). Creating an Environment for Innovation: The Risk-
9 Taking Leadership Competency. *Nurse Leader, 11*(1), 24-27.

10 Cummings, G., MacGregor, T., Davey, M., Lee, H., Wong, C., Lo, E., . . . Stafford, E. (2010).
11 Leadership styles and outcome patterns for the nursing workforce and work environment: A
12 systematic review. *International Journal of Nursing Studies, 47*, 363–385.

13 Cunliffe, A., & Eriksen, M. (2011). Relational leadership. *Human Relations, 64*(11), 1425–
14 1449.

15 DeFrino, D. (2009). A Theory of the Relational Work of Nurses. *Research and Theory for*
16 *Nursing Practice: An International Journal, 23*(4), 294-311.

17 Fealy, G., McNamara, M., Casey, M., Geraghty, R., Butler, M., Halligan, P., . . . Johnson, M.
18 (2011). Barriers to clinical leadership development: findings from a national survey. *Journal*
19 *of Clinical Nursing, 20*, 2023–2032.

20 Fulop, L., & Mark, A. (2013). Relational leadership, decision-making and the messiness of
21 context in healthcare. *Leadership, 9*(2), 254–277.

22 Greenleaf, R. (2003). *The Servant-Leader Within: A Transformative Path* (H. Beazley, J.
23 Beggs, & L. Spears Eds.). New York: Paulist Press.

24 Groysberg, B., & Slind, M. (2012). Leadership is a Conversation. *Harvard Business Review,*
25 *90*(6), 76-84.

26 Guba, E., & Lincoln, Y. (1989). *Fourth Generation Evaluation*. California: Sage Publications.

27 Hersey, P., Blanchard, K., & Johnson, D. (2001). *Management of Organizational Behavior:*
28 *Leading Human Resources* (8th ed.). New Jersey: Prentice Hall.

29 Hutchinson, M., & Jackson, D. (2013). Transformational leadership in nursing: towards a
30 more critical interpretation. *Nursing Inquiry, 20*(1), 11-22.

31 Jacobs, G. (2014). *Ont-wikkelen van verbindingen: Persoonsgerichte en evidence based*
32 *praktijkvoering in zorg en welzijn*. Eindhoven: Fontys Hogescholen.

33 Kanter, R. (1977). *Men and Women of the Corporation*. New York: Basic Books.

1 Kemmis, S. (2008). Critical Theory and Participatory Action Research. In P. Reason & H.
2 Bradbury (Eds.), *The SAGE Handbook of Action Research: Participative Inquiry and Practice*
3 (2nd ed., pp. 121-138). London: SAGE Publications.

4 Kemmis, S., & McTaggart, R. (1988). *The Action Research Planner* (3rd ed.). Victoria,
5 Australia: Deakin University.

6 Kotter, J., & Heskett, J. (1992). *Corporate Culture and Performance* New York: The Free
7 Press.

8 Kouzes, J., & Posner, B. (2007). *The Leadership Challenge* (4th ed.). San Francisco: Jossey-
9 Bass.

10 Krugman, M., Heggem, L., Kinney, L., & Frueh, M. (2013). Longitudinal Charge Nurse
11 Leadership Development and Evaluation. *Journal of Nursing Administration, 43*(9), 438-446.

12 Lalleman, P. (2017). *Leadership as blended care: on daily work and habitus of nurse middle*
13 *managers in hospitals.* (PhD thesis), University of Utrecht, Utrecht.

14 Lalleman, P., Smid, G., Lagerwey, M., Oldenhof, L., & Schuurmans, M. (2015). Nurse
15 Middle Managers' Dispositions of Habitus: A Bourdieusian Analysis of Supporting Role
16 Behaviors in Dutch and American Hospitals. *Advances in Nursing Science, 38*(3), 1-16.

17 Lieshout van, F., & Cardiff, S. (2011). Dancing outside the ballroom: Innovative ways of
18 analysing data with practitioners as co-researchers. In J. Higgs, A. Titchen, D. Horsfall, & D.
19 Bridges (Eds.), *Creative Spaces for Qualitative Rsearching: Living Research* (pp. 223 - 234).
20 Rotterdam: Sense Publishers.

21 Lynch, B. (2015). Partnering for performance in situational leadership: a person-centred
22 leadership approach. *International Practice Development Journal, 5*((Supp) [5]).

23 Lynch, B., McCormack, B., McCance, T., & Brown, D. (2017). The development of the
24 Person-Centred Situational Leadership Framework: Revealing the being of person-
25 centredness in nursing homes. *Journal of Clinical Nursing*. doi:10.1111/jocn.13949

26 Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: the
27 attributes, enabling factors and consequences of a new concept. *International Practice*
28 *Development Journal, 1*(2).

29 Manthey, M. (2002). *The Practice of Primary Nursing* (2nd ed.). Minneapolis: Creative
30 Health Care Management.

31 Martin, A., O' Connor-Fenelon, M., & Lyons, R. (2012). Non-verbal communication between
32 Registered Nurses Intellectual Disability and people with an intellectual disability: An
33 exploratory study of the nurse's experiences. Part 1. *Journal of Intellectual Disabilities, 16*(1),
34 61-75.

35 McCormack, B. (2003). Researching nursing practice: does person-centredness matter?
36 *Nursing Philosophy, 4*(3), 179-188.

McCormack, B., & McCance, T. (2010). *Person-Centred Nursing: Theory and Practice*. Oxford: Wiley-Blackwell.

McCormack, B., & McCance, T. (Eds.). (2017). *Person-Centred Practice in Nursing and Health Care: Theory and Practice* (2nd ed.). Oxford: Wiley-Blackwell.

McMahan, E., Hoffman, K., & McGee, G. (1994). Physician-Nurse Relationships in Clinical Settings: A Review and Critique of the Literature, 1966-1992. *Medical Care Review, 51*(1), 83-112.

Ménard, J., & Brunet, L. (2011). Authenticity and well-being in the workplace: a mediation model. *Journal of Managerial Psychology, 26*(4), 331-346.

Merriam, S. (1996). Updating Our Knowledge of Adult Learning. *The Journal of Continuing Education in the Health Professions, 16*, 136-143.

Mezirow, J. (1981). A Critical Theory of Adult Learning and Education. *Adult Education Quarterly, 32*(1), 3-24.

Mortier, A., Vlerick, P., & Clays, E. (2015). Authentic leadership and thriving among nurses: the mediating role of empathy. *Journal of Nursing Management*, 1-9. doi:10.1111/jonm.12329.

NICE. (2009). *Promoting mental wellbeing at work*. Retrieved from London: http://www.nice.org.uk/nicemedia/live/12331/45893/45893.pdf.

Patrick, A., Laschinger, H., Wong, C., & Finegan, J. (2011). Developing and testing a new measure of staff nurse clinical leadership: the clinical leadership survey. *Journal of Nursing Management, 19*, 449–460.

Regan, L., & Rodriguez, L. (2011). Nurse Empowerment from a Middle-Management Perspective: Nurse Managers' and Assistant Nurse Managers' Workplace Empowerment Views. *The Permanente Journal, 15*(1), 101-107.

Sellevold, G., Egede-Nissen, V., Jakobsen, R., & Sørlie, V. (2013). Quality care for persons experiencing dementia: The significance of relational ethics. *Nursing Ethics, 20*(3), 263–272.

Senge, P., Scharmer, C. O., Jaworski, J., & Flowers, B. (2004). *Presence: Human purpose and the field of the future*. Cambridge: SOL.

Snoeren, M., Niessen, T., & Abma, T. (2013). Beyond dichotomies: Towards a more encompassing view of learning. *Management Learning*, 1–19. doi:10.1177/1350507613504344

Stanley, D. (2006). In command of care: clinical nurse leadership explored. *Journal of Research in Nursing, 11*(1), 20-39.

Trondsen, M., & Sandaunet, A. (2009). The dual role of the action researcher. *Evaluation and Program Planning, 32*(1), 13-20.

Uhl-Bien, M. (2006). Relational Leadership Theory: Exploring the social processes of leadership and organizing. *The Leadership Quarterly 17 (2006), 17*, 654–676.

van der Arend, A., & Remmers-van den Hurk, C. (1999). Moral problems among Dutch nurses: a survey. *Nursing Ethics 1999 6 (6), 6*(6), 468-482.

Wagner, J., Cummings, G., Smith, D., Olson, J., Anderson, L., & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: a systematic review. *Journal of Nursing Management, 18*, 448–462.

Wheatley, M. (2006). *Leadership and the New Science: Discovering Order in a Chaotic World* (3rd ed.). San Francisco: Berret-Koehler.

Wieck, K., Prydun, M., & Walsh, T. (2002). What the Emerging Workforce Wants in Its Leaders. *Journal of Nursing Scholarship, 34*(3), 283-288.

Winter, R., & Munn-Giddings, C. (2001). *A Handbook for Action Research in Health and Social Care*. London: Routledge.

Wong, C., Cummings, G., & Ducharme, L. (2013). The relationship between nursing leadership and patient outcomes: a systematic review update. *Journal of Nursing Management, 21*(5), 709–724.

**Figure 1:** Methodological framework

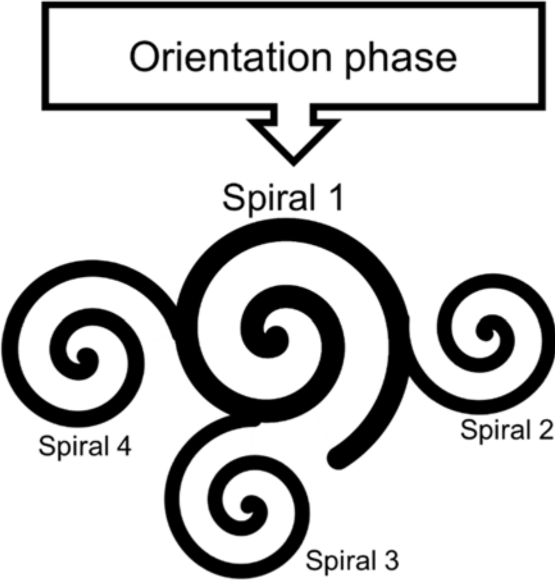


**Figure 2:** Thematic framework of findings

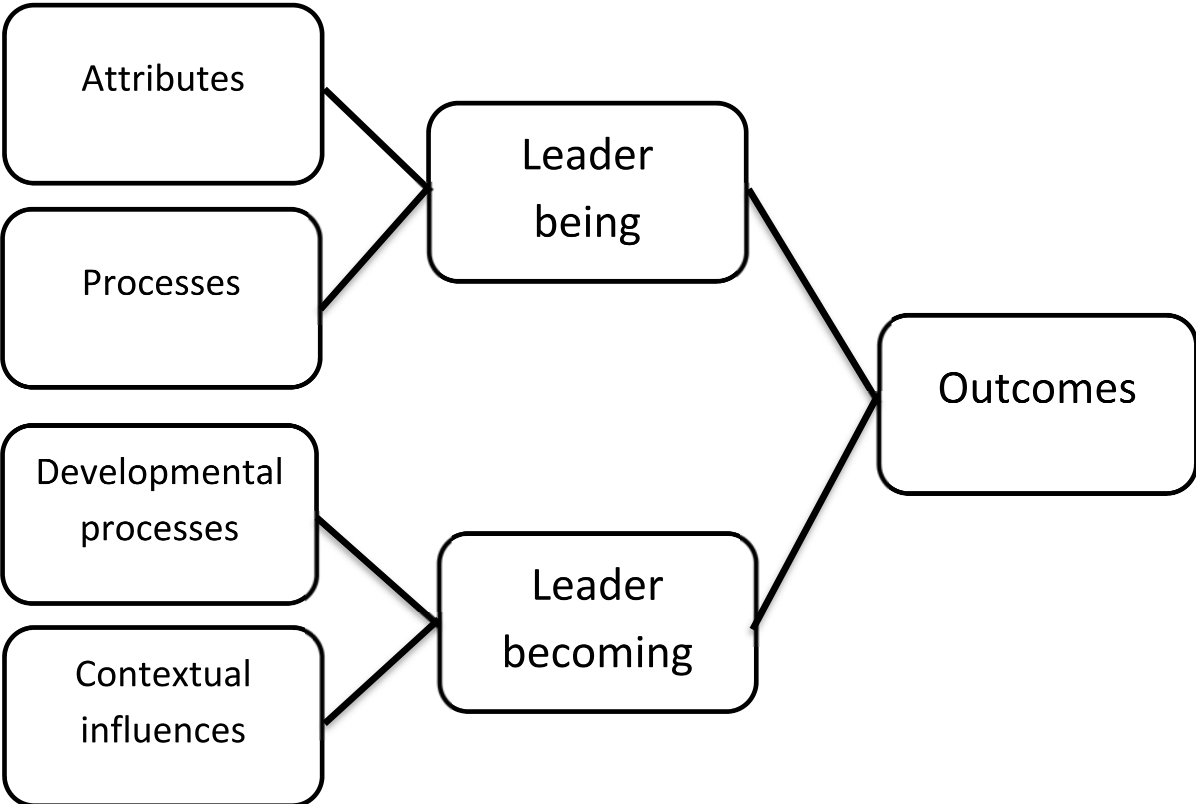

**Figure 4**: Photo accompanying citation 'CN LOES' (CCRI 4)

**Figure 3:** Conceptual framework of Person-Centred Leadership

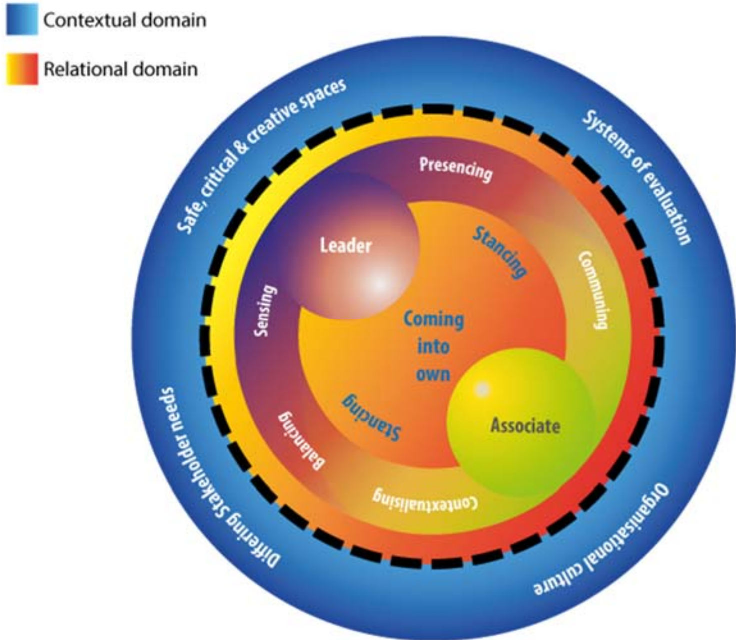

**Table 1:** Overview of research phase/action spiral goals and data gathering activities.

| Phase | Primary goals & activities: | Participants |
|---|---|---|
| **Orientation** | ***Goal: To gain insight into current relationships and context (structures, conventions & practices)*** | |
| | • critical and creative culture workshop | 22 members of staff |
| | • participant observations of context (x5) | Staff & patients |
| | • participant observations of nurse leadership (x3) | CNs / UM / staff |
| | • narratives of care | 8 patients + 16 staff |
| | • narratives of nurse leadership | 11 nursing staff + 1 physician |
| **Action spiral 1** | ***Goal: To gain insight into changing nurse leadership practice*** | |
| | • 19 AR'er facilitated critical and creative reflective inquiry sessions on 15 narratives | 2CNs + 1UM + 1CNS + 2PNs |
| **Action spiral 2** | ***Goal: To gain insight into leading change in the nursing system*** | |
| | • Visioning primary nursing workshop, facilitated by the AR'er | 2CNs + 2PNs |
| | • Primary nurse role analysis workshop, facilitated by the AR'er | 2CNs + 2PNs |
| | • 23 AR'er participant observations of leadership + post-observation interviews with the observed leader (and those interacting with leader) | CNs (16 sessions)<br>PNs (4 sessions)<br>UM (3 sessions)<br>2 staff nurse interviews<br>2 student interviews<br>1 physician interview |
| | • 4 PN implementation evaluation meetings | 2PNs + 2CNs |
| | • (Evaluative) critical and creative culture workshop, facilitated by 1UM + 1CN | 5 staff nurses |
| | • Nurse leadership evaluation workshop, facilitated by an external researcher | 5 staff nurses |
| | • Participatory analysis of a staff evaluation questionnaire (n=15), facilitated by the AR'er | 4 staff nurses + 1CN |
| **Action spiral 3** | ***Goal: To gain insight into leading storytelling sessions aimed at fostering person-centred care*** | |
| | • 13 post-observation interviews of CN facilitated storytelling sessions | 2CNs |
| **Action spiral 4** | ***Goal: To gain insight into nurse leader growth*** | |
| | • 3 annual reflective inquiries into individual leader growth | 2CNs + 1UM + AR'er |
| | • 19 supervision sessions | AR'er + 4 supervisors |
| | • 3 AR'er experiences reflected upon during Action Learning Set sessions with university co-workers. | AR'er ±7 set members |
| | • AR'er leadership evaluation workshop, facilitated by external researcher | 1UM + 1CNS + 2CNs |
| | • Midterm evaluation workshop of action research experience, facilitated by AR'er | 4 co-researchers |

**Table 2:** Overview of primary data set for thematic analysis

| Action Spiral | Primary data set: |
|---|---|
| 1 | • 15 critical and creative reflective inquiries = 23 hours of transcript |
| 2 | • 23 observations of leadership practice + post-observation interviews = 10 hours of transcript<br>• Unit leadership evaluation workshop = 1,5 hours transcript |
| 3 | • 8 post-observation storytelling session interviews = 4,5 hours transcript |
| 4 | • 3 annual reflective inquiries = 8 hours of transcipt<br>• Midterm evaluation workshop of action research experience = 2,5 hours transcript<br>• AR'er leadership evaluation workshop |

**Box 1:** Thematic data analysis framework

1. *Familiarization and submergence*: Reading and scanning data to refresh and enhance understandings gained during the fieldwork, noting relevant events, citations and thoughts.
2. *Creative expression*: Intermittently working on a creative expression of the cognitive and embodied inferences emerging from phase 1. Working on the expression intermittently creates space for contemplation and rest whereby one returns with 'new eyes', reviews and continues. Key words/concepts are then added to relevant/appropriate areas on the final product.
3. *Blending and melding*: Intermittently seeking patterns and connections using the words and imagery, clustering those that can be blended and aligning others for melding. A tentative thematic framework emerges.
4. *Indexing*: Extracts and citations from the raw data are coupled with (sub)themes. New (sub) themes may emerge from re-reading the data, or existent (sub)themes adjusted.
5. *Reviewing and refining*: Thick descriptions are composed for each theme, supported by extracted data. Returning to the data set may be necessary to check the context in which citations were made.
6. *Critiquing*: The thematic framework(s) are member-checked (preferably in dialogue) with participants, and peer-reviewed, until consensus is reached.