

Person-Centred Leadership

What is it, and how can it be developed?

Shaun Cardiff

July 2014

The research for this thesis was conducted under the Faculty of Life and Health Science of the University of Ulster (Belfast, UK) in cooperation with the School of Nursing's Knowledge Centre for the Implementation and Evaluation of Evidence Based Practice at Fontys University of Applied Sciences (Eindhoven, NL).

ISBN:

Printing: Ridderprint BV, Ridderkerk, the Netherlands

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Person-Centred Leadership

A critical participatory action research study exploring and developing a new style of (clinical) nurse leadership

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ABSTRACT

Background: Person-centeredness within care relationships has received considerable attention in nursing literature, research and healthcare policy since the turn of the century. Concept analyses and conceptual frameworks have been developed and it is considered by some a core value that when enacted forms an essential attribute of effective workplace cultures. However, there has been no exploration of person-centeredness within clinical nurse leadership relationships. In an era of competing needs and dwindling resources traditional hierarchical and autocratic styles of leadership have been shown to be inadequate, but continue to persist, especially in healthcare settings. Whilst a relational approach to leadership is being propagated and showing positive outcomes, the majority of models referred to were developed outside a healthcare context. This study set out to explore and develop the concept of person-centred leadership within a nursing context.

Aims and research questions: Having negotiated conducting a three year study with stakeholders, we set out to find answers to the questions: "What is person-centred leadership? How can it be developed?" The primary aim was to explore person-centred leadership as it was developed in collaboration with a nurse leadership team of a ward in a Dutch urban general hospital.

Approach and methods: A critical participatory action research methodology was chosen to enable research done with rather than on leader participants and other stakeholders. The initial orientation phase explored care and leadership relationships using patient and staff narratives alongside participant observation. Narratives were critically and creatively analysed with participants and after combining with other data sets, the whole team reviewed results and identified issues for action. Four action spirals structured the rest of the fieldwork. A critical and creative reflective inquiry method was designed to facilitate leader exploration of the lived leadership experience. A new nursing system based on primary nursing was implemented. Participant leader facilitated storytelling sessions with staff were set up and self-reflective inquiries were conducted. Collected data was thematically analysed post fieldwork and member-checked.

Findings: The findings revealed relational processes and contextual influences on the development and living of person-centred leadership in a nursing context. A conceptual framework was created through blending findings with existent propositional knowledge. The relational domain describes the leader attributes enabling being in relation in a person-centred way, processes for achieving relational connectedness, and positions leaders can take as they aim to enable associate wellbeing and empowerment. Contextual elements which influence and are influenced by leader-associate relating form the contextual domain. An additional framework describes facilitated workplace experiential/transformational learning in safe, critical and creative learning spaces for leaders/learners to connect thinking with doing in order to influence future being.

Conclusions and implications: The person-centred leadership framework contributes to relational leadership theory and offers clinical nurse leaders, educators and researchers a style of leadership congruent with the person-centred movement and developed within a nursing context. As the concept is new to nursing and healthcare, further research and development is recommended.

SAMENVATTING

Achtergrond: Sinds het begin van deze eeuw heeft persoonsgerichtheid binnen zorgrelaties een toenemende aandacht gekregen in de gezondheidszorg en met name in de verpleegkundige literatuur en onderzoek. Er zijn diverse concept analyses en conceptuele raamwerken ontwikkeld voor persoonsgerichtheid binnen de verpleegkunde. Sommigen beschouwen persoonsgerichtheid als een essentieel kenmerk van effectieve werkplek culturen, maar, persoonsgerichtheid binnen klinische leiderschap relaties is nog niet geëxploreerd. In een tijdperk van concurrerende behoeften en afnemende middelen, is een traditionele hiërarchische en autoritaire leiderschapsstijl ontoereikend gebleken, echter blijft deze wel voortbestaan, vooral in de zorg. Terwijl een relationele benadering van leiderschap positieve resultaten laat zien en steeds populairder wordt, zijn de meeste, raamwerken en modellen buiten de gezondheidszorg context ontwikkeld. Deze studie verkend en ontwikkeld het concept persoonsgericht leiderschap binnen een verpleegkundige context.

Doelstellingen en onderzoeksvragen: Nadat overeenstemming was bereikt met belanghebbenden dat er een driejarige studie zou worden uitgevoerd binnen een verpleegafdeling, werden de volgende onderzoeksvragen vastgesteld: "Wat is persoonsgericht leiderschap? Hoe kan dit worden ontwikkeld?" Het primaire doel was om persoonsgericht leiderschap te onderzoeken tijdens het ontwikkelen hiervan, in samenwerking met de unit manager en teamleiders van een verpleegafdeling in een algemeen ziekenhuis.

Methode: Een participatief actie onderzoeksmethodologie werd gekozen om ervoor te zorgen dat onderzoek werd verricht 'met' in plaats van 'voor' deelnemers. De eerste oriëntatiefase onderzocht zorg en leiderschap relaties door middel van patiënt en medewerkers verhalen, naast participerend observatie. Verhalen werden kritisch en creatief geanalyseerd met deelnemers en na het samenvoegen met andere datasets, heeft het hele team de resultaten bekeken en verbeteraspecten geïdentificeerd. Deze werden omgezet in vier actie cycli die het onderzoek in de praktijk richting gaven.

In de eerste actie cyclus werd een kritische en creatieve methode van reflecteren ontwikkeld, om de leidinggevende te ondersteunen bij het verkennen en ontwikkelen van hun leiderschap stijl. Een tweede actie cyclus hield zich bezig met het implementeren van een nieuw verpleegsysteem, gebaseerd op de principes van 'primary nursing', door de leiders. In de derde actiecyclus faciliteerden de teamleiders wekelijkse bijeenkomsten waarin verpleegkundigen reflecteerde op verhalen die ze met elkaar deelden. In de laatste actie cyclus werden methoden gebruikt om de zelfontwikkeling van deelnemers te onderzoeken. Verzamelde data werd thematisch geanalyseerd nadat de cycli doorlopen waren in de praktijken er is een member-check gedaan door de unit manager en teamleiders welke hadden deelgenomen in de actie cycli.

Resultaten: De data analyse liet zien dat relationele processen en contextuele invloeden van invloed zijn op het naleven en ontwikkelen van persoonsgericht leiderschap. Nadat de bevindingen naast de bestaande literatuur over verpleegkundig leiderschap waren gelegd, kon een conceptueel raamwerk voor persoonsgerichte leiderschap ontwikkeld worden. In het relationele domein zijn er negen eigenschappen en vijf kern processen die relationele verbondenheid tussen de leider en de medewerker bevorderen. Tevens zijn er een viertal posities die een leider kan aannemen om medewerkers te helpen 'tot hun recht te komen', binnen de praktijkcontext. In het contextuele domein zijn vier elementen geïdentificeerd die invloed uitoefenen op en worden beïnvloed, door de leider-medewerker relatie. Voor het ontwikkelen van persoonsgericht leiderschap is een ander model ontwikkeld, dat laat zien hoe een facilitator leiders ondersteunt in hun 'denken' en dit overeen laat komen met hun 'doen', om zodoende hun toekomstige 'zijn' als leider positief te beïnvloeden, waarbij rekening gehouden wordt met contextuele invloeden.

Conclusie: Het conceptueel raamwerk voor persoonsgericht leiderschap, draagt bij aan relationele leiderschapstheorie en biedt klinisch verpleegkundig leiders, docenten en onderzoekers een leiderschapsstijl welke congruent is met de persoonsgerichte beweging/tendens en welke tevens ontwikkeld is binnen een verpleegkundige context. Omdat het concept nieuw is binnen verpleegkunde- en de gezondheidszorg in het algemeen, wordt verder onderzoek en ontwikkeling aanbevolen.

ACKNOWLEDGEMENTS

Even though six years may be the statistical or recommended time for a part-time PhD, there is nothing statistical or average about the lived experience. Across the six years many people have contributed directly and indirectly, consciously and unawares to the making of this thesis. The list is too long to name each person here, but I would like to thank each and every one of you for making it possible. Every time I look at this final piece of work I am reminded of you all as each has left their mark in some way or other.

This study would not have been possible without the input from the leaders, staff and patients from the research setting. It was the first time a large piece of nursing research had been conducted within the organisation, and I hope it will not be the last. I was lucky to have worked with a nursing team who were willing to share so many stories with me, more than were referred to in the final thesis, but all of which made an impression on me. The participant leaders in particular were vital to our success. Without their openness, their willingness to jump into the unknown and to persevere through difficult times, I would never have been able to report our journey in this thesis. I will remember primary nurse Chloé for her passion for nursing, which reassured me that there are still nurses who care. Primary nurse Tess taught me that hidden talents can be found in a nursing team if we look closely enough and person-by-person. Anne seemed to have embodied person-centeredness from the beginning and her contribution showed how this work is relevant for advanced practice nurses too. A special thank you goes to Betty, my companion so full of energy and positivity. Loes and Fleur gave so much of themselves too. Loes' decisiveness and Fleur's eagerness to learn were an invaluable source of support. As the epilogue to this thesis shows, each has continued to grow and that makes me feel good.

Support was not restricted to the research setting. It was a privilege to be a member of the Fonty's Knowledge Centre for Evidence-Based Practice throughout the study period. I could not have wished for better colleagues to challenge me to think harder/differently, or support me through difficult times. I hope we can continue to grow together as individuals and a team as we move into a new era. As a team we were led by two unique leaders, both of who were my co-supervisors. Dr. Karen Cox created opportunities for me to come into my own since my initial interview with her at Fontys School of Nursing. Of the many leaders I have worked with, Karen is the one who seems to know me best and never makes me feel like I am being judged. Being led by you has made my working life a pleasure. Prof. Angie Titchen worked very hard with me on many fronts. She taught me the value of creativity and to keep a check on negativity and scepticism. I thank you for this and for being there from the first mud sketches beside the lake at Kapellerput, to the final comma before 'and'!

Being a part-time student at the University of Ulster was a journey in itself, travelling three times a year to Belfast for face-to-face supervision and various activities. Whilst I

won't particularly miss the predominantly wet and cold climate, I will miss the warmth of the people I met. The travelling could have been lonely and tiresome were it not for the companionship of two dear colleagues. Every meal was a 'happy meal' with Donna Frost and I hope we can continue to laugh and eat together for many years to come - because we do it so well! I have very few memories of Belfast without Famke van Lieshout featuring in them somewhere. More than a travel companion, she was a colleague I learnt with and from, and a friend I could share my hopes and fears. We started our PhD journeys together in Belfast and I hope we continue to journey together for many years to come. The same goes for my primary supervisors, Prof. Brendan McCormack and Prof. Tanya McCance. I consider myself extremely fortunate to have met and been supervised by them, and hope we can continue to work together in the future.

Even though I was fortunate enough to be able to combine this PhD with my work at Fontys University of Applied Sciences, it would still not have been possible without support from the home front. I am so pleased with the support from my step-daughter, Gaëlle, who saved the graphic representation of the conceptual framework, and un-awares helped me see how when the time and conditions are right, each and every one of us can come into our own. The final and biggest thank you has been reserved for my partner, Francois, who has stood by me and believed in me throughout: "Now it's time for us again."

Introduction

Chapter 1



INTRODUCTION

This opening chapter presents background information on a doctoral study exploring the concept of person-centeredness within (clinical) nurse leadership. The chapter starts by introducing myself and the inspiration for the study. This is followed by a description of the context in which the study took place and a brief overview of the design. The chapter ends with a short description of subsequent chapters.

THE SELF

As indicated in the title of this thesis, the core concept of my research is person-centeredness. Choosing to conduct a study on person-centeredness says something about me. For me, person-centeredness requires getting to know others as unique people in order to relate with them in a way that is mutually beneficial. This requires knowing 'self'; what makes us who we are, as our 'being' influences how we relate with others. Reflecting on what I value has brought me to conclude that the most important value I hold is 'caring', caring about others and the knowledge I use in practice. The way this manifests in my behaviour is varied, and related to my own biography. Sharing some aspects here will hopefully help you understand/assess how my being may have influenced the research process and outcomes.

I was born in England and raised by caring parents, but, suffered bullying at secondary school which left me with an aversion towards people negatively exercising power over others. I was not the quickest of learners either, but a change of environment when I went on to a sixth form college created space for me to be myself and cultivated a thirst for trying to understand theory. Registered general nurse training created an opportunity to apply what I was learning, as well as appreciate the value of the reciprocal rewards of caring for and about others. Moving into the high-tech world of intensive care nursing taught me the importance of balancing bio-technological with caring science.

My working and private life have never been two separate entities, and have always influenced each other. As my sister-in-law once said, "You carry yourself with you twenty four hours a day." In 1991 my partner and I decided to return to his home village in Belgium, and I started a career in Dutch intensive care units. Experiencing different cultures in both my private and working life reinforced a belief in equity, where difference does not equate to superior/inferiority. In my working life I perceived a culture that valued efficiency, technology and medical knowledge above nursing theory. Integration into the Dutch intensive care culture entailed learning to appreciate what was valued without undermining my own valuing of, and belief in the art and science of nursing. Sharing my narratives of life in UK nursing with Dutch colleagues helped us find the common ground,

build good relationships and start to influence change. A post as clinical nurse educator created further opportunity for me to try and bring more balance into the different forms of knowledge nurses were using in practice. Key words from farewell messages and cards reflect how I was perceived: team player, leader, innovator and implementer of change, being attentive and understanding and having integrity and vision.

Moving from practice into Dutch higher education meant I could continue to contribute to a more theory-based approach to nursing practice. Becoming a member of a practice development and research team, and the way we work, enabled me to retain a practice orientation as I facilitated practice development projects. I interpreted the theory/practice gap spoken of at the time as a gap between educational and practice institutions. I believed then and still do, that with closer partnerships, knowledge generation in practice, 'with' and 'for' practitioners, administrators and service users, will be mutually beneficial and close the gap.

THE INSPIRATION

Traditionally research and knowledge generation has been the domain of academic universities within The Netherlands, with professional education concentrated in universities of applied sciences. In 2001 the Ministry for Education, Culture and Science joined hands with the Association of Universities of Applied Sciences to create the Foundation of Knowledge Development which subsidised the development of knowledge centres within Dutch universities of applied sciences. The goal of the knowledge centres was to generate knowledge, professionalise university staff, disseminate knowledge into curricula and circulate knowledge to and from the economy and society (OCW & HBO Raad, 2001). In 2002, the nursing faculty of Fontys University of Applied Sciences established a knowledge centre for the implementation and evaluation of evidence based practice (EBP). The aim of the knowledge centre was to narrow the gap between theory, education and practice (Cox & Titchen, 2003) informed by the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Kitson et al., 1998; Rycroft-Malone et al., 2002) and practice development theories, approaches and processes (Manley et al., 2008; McCormack et al., 2004; McCormack, Manley, et al., 2013). The PARIHS framework has been shown to be flexible, resonate with practice experience and articulate a holistic view of evidence. A knowledge centre colleague reviewed the use of action research (AR) for the implementation of EBP (Munten et al., 2010) and subsequently used the PARIHS to diagnose practice and context before collaboratively planning change with research participants. His pre-intervention analysis of two Dutch mental healthcare settings showed an absence of factors that would positively contribute to the successful implementation of evidence. The nurses relied heavily on experiential knowledge, had

minimal skills in literature searching and use and the contexts showed few characteristics of a learning organisation. Management and nursing staff held differing perceptions of workload, nurses experienced little investment in nursing innovation, there was a lack of professional leadership and there was hardly any structure or strategy for change implementation (Munten 2012). These findings painted a picture that could easily have been one of the many Dutch workplaces in which I had worked and/or facilitated practice development projects.

Although Munten (2012) was able to achieve a more person-centred approach to care, as perceived by service users, he retained concerns about sustainability as there was still a lack of clinical leadership, limited knowledge exchange among staff and a continued lack of communication between management and nurses. Leadership giving rise to clear roles, effective teamwork and organisational structures is important for the implementation of EBP (McCormack et al., 2002). The PARIHS framework states that all practitioners should be considered potential leaders of something, as this fosters commitment and dynamism at all levels of the organisation. Reference is made to transformational leadership in particular as “transformational leaders can transpose ... individual beliefs and values into collective beliefs and values [so] that these eventually become assumptions because they are seen to work reliably and then become taken for granted ... [and so] bring the ‘science’ component of health care practice (the application of science and technology) together with the ‘art’ component (the translation of different forms of practice knowledge) into caring actions.”(McCormack et al., 2002, p. 99).

The concept of transformational leadership did not seem to have reached our region of the Dutch nursing context, as another colleague of the knowledge centre discovered whilst aiming to develop an effective workplace culture through an action research study (Lieshout van, 2013). During the orientation phase she heard of, and observed, a hierarchical and task driven culture with a “medicalised model of healthcare, in which nurses were subordinate to medical staff and the focus on nursing care was sometimes forgotten” (Lieshout van, 2013, p. 63). Front-line management showed a reluctance to change and the study had to move from an emancipatory to hermeneutic praxis to analyse the relationship between context and facilitation. Key messages derived from the analysis included the importance of achieving consensus on the value of participatory action research with participants, connecting with management and practitioners at a personal level in order to develop partnerships and creating safe communicative spaces for critical and creative dialogue (Lieshout van, 2013).

Munten (2012) and van Lieshout (2013) described leader-staff relationships that seemed to lack a sense of mutual benefit or connectedness, which resonated with my own experiences. I had often encountered leaders/managers criticising nursing staff for not keeping themselves up-to-date with professional (scientific) literature, whilst they themselves did not read leadership/management journals. In many annual appraisals

over the years, I had received performance feedback from various leaders, but seldom been asked to give feedback on their performance. There seemed to me to be a cultural norm that leaders determine what happens and what others do, a unidirectional flow of influence.

Facilitating practice development projects, I had also met leader indecisiveness related to a lack of clear vision. One manager who wanted to collaborate with the university was disappointed by outcomes, but was unable to formulate expectations, a problem statement or goals. It is very easy to criticise formal leaders, but working closely as a clinical nurse educator with a new leadership team who were keen to be more participative also taught me that the expectations of those being led influences leadership style too. The team had been led by strong, directive leaders for many years and this new style was initially interpreted as weak and indecisive leadership rather than inclusive and facilitative. Such experiences left me pondering about how leadership relationships experienced as mutually beneficial can be built.

In 2006, the knowledge centre had proven itself effective in meeting criteria of generating knowledge, professionalising university staff, disseminating knowledge into curricula and circulating knowledge to and from the economy and society and was granted a second period of four years to continue its work. The mission statement was reviewed and now aimed to “involve all stakeholders in the development of innovative ways of increasing the rigour of all types of evidence and in the facilitation, implementation and evaluation of evidence based practice and person-centred care” (Titchen & Cox, 2006, p. 1). Combining ‘person-centred’ with ‘evidence-based’ care was congruent with my own belief that nursing is both an art and science. I had never found a ‘one size fits all’ approach to be effective. Each individual is unique and contextual factors always influence the feasibility of implementing new ways of working. Joining an International Practice Development Colloquium created an opportunity to contemplate the role of person-centeredness in practice settings as the colloquium explored and developed four concepts central to practice development: culture, enablement, evaluation and critical creativity. I discovered how the use of creativity can help surface embodied and preconscious forms of knowledge, expanding the scope and depth of critical dialogue with others. Explorations of facilitation theory and practice revealed the importance of person-centeredness in enabling relationships aimed at the growth and development of individuals and groups. Participating in a workgroup conducting a concept analysis of effective workplace cultures (Manley et al., 2011) my attention was drawn to leadership as an enabling factor. Effective workplace cultures are defined as:

“A local workplace characterised by the experience of three value sets by all who come into contact with it: a focus on person-centeredness, collaborative, inclusive and participative ways of working; and a focus on providing effective care. These values are embedded in lo-

cal formal systems of evaluation, learning, development and stakeholder participation that reflect and sustain them. Effective workplace cultures are recognised by flourishing of all involved, consistent achievement of standards and goals, evidence-based and continuous development, improvement and innovation in practice linked to the needs of patients, and, empowered and committed staff. These cultures are enabled by transformational leaders, skilled facilitation and role clarity and are complemented by organisational readiness with a flattened and transparent management structure and supportive human resource department.” (Manley et al., 2011, p. 17)

Through our concept analysis, we concluded that an enabling approach used by ward managers was an important factor for effective workplace cultures and that transformational leadership was the most frequently found term in the literature. Transformational leaders were considered to be more facilitative than management orientated leaders, focusing on culture, developing a shared vision and role modelling shared values. The analysis demonstrated that effective workplace cultures value leadership development by all who are professionally responsible for leading positive change. These cultures value person-centeredness and the respecting of service users and staff as unique individuals with a right to self-determination. The term ‘self-determination’ was deemed not to be synonymous with the term ‘autonomy’, because we took on McCormack’s (2001) view that as we exist in relation with others we can only ever really speak of ‘negotiated autonomy’.

Contemplating the role of leadership in EBP and effective workplace cultures I started to question what a leadership style that embodied person-centeredness would look like. To me, any organisation and/or leader wishing to develop an effective workplace culture and/or person-centred practices¹ would need to embed/embody person-centeredness. Surfing leadership literature, I only found two references made to person-centred leadership. Two American studies in the profit and non-profit sectors, defined person-centred leadership as:

“...an approach to participatory management and leadership that directs as much attention to the individual as the team, requiring senior leadership to be responsible for empowering people at all levels of the organization, and develop quality through continuous attention to organizational culture and system processes”. (Plas & Lewis, 2001, p. 35)

These studies had not been conducted within a nursing context. Whilst person-centeredness was linked to care and workplace cultures in nursing, there had been no link made to

1 The term person-centred practices is used for any practice, for instance, leadership and care practices. When the term person-centred care is used, this is in keeping with an author’s use of the term and/or only care practices.

(clinical) nurse leadership. Combined with colleague and my own experiences of Dutch nursing leadership, I felt that a study exploring person-centeredness within (clinical) nurse leadership would be more appropriate than another study on transformational leadership in nursing.

THE CONTEXT

Dutch healthcare is a government regulated insurance market system, aimed at combining universal coverage with competition. Whilst the government monitor quality of care through (professional) law and inspection agencies, competing insurance companies translate patient demand/satisfaction into negotiated contracts with care institutions. Each resident in The Netherlands is required to be registered with a general practitioner who acts as a 'gatekeeper' to the rest of the system, as well as offering primary care. Patients enter the hospital system through GP referral or Accident & Emergency visit. Dutch hospitals are required by law to fulfil a care provision role and generate profit as proof of right to exist. Consequently, hospitals are increasingly being managed like a business.

'Nurse' is a legally protected title in The Netherlands. In-service training ceased in 1997. Now there is the option of a bachelor in nursing (level 5) at a university of applied sciences, or diploma in nursing (level 4) at a school of secondary professional education. In 2009 there were 8.4 nurses per 1000 residents in The Netherlands, compared to 9.7 in the UK (OECD statistics). Of the 234,000 registered nurses in 2009, only 75% were in healthcare employment and only 36% of these nurses worked in hospitals. The number of registered nurses leaving healthcare has been rising consistently, suggesting dissatisfaction with professional life. Recent professional responses such as the legally protected title of 'Nurse Specialist' (Advanced Practice Nurse/Nurse Practitioner) have tried to offer nurses more career prospects. Universities of applied science are also being encouraged to collaborate more closely with care institutions to develop curricula, communities of practice and practice orientated research (Westerlaken, 2013).

Hospitals can generally be classified as university, teaching or general hospitals. Organisational structures have become more decentralised in recent years, with a board of directors leading a team of sector managers who in turn lead unit (operational) managers. The sector and unit managers do not necessarily have to have a nursing background, but are responsible for managing the nursing workforce. Local physician and nursing advisory councils liaise with a hospital's board of directors. Nursing advisory boards are not compulsory, their advice is not binding and they often lack political power. There has however been a recent growing interest in developing more active nursing advisory councils locally.

Having decided to conduct a part-time PhD study on person-centeredness in nurse leadership, I needed to find a context and leader to conduct the study with. Publishing an article in the university magazine, outlining my interest in exploring person-centeredness in leadership and care relationships, I was approached by three units. Preliminary discussions resulted in one unit manager wanting to engage in a collaborative research project based on practice development principles. After further discussions with the sector manager, unit manager and head of continuing education, the proposal was agreed by the board of directors and the research project launched in September 2007. The hospital was a 430 bedded urban general hospital, and the setting a 24 bedded ward with 16 FTE (Full-time equivalent) nursing staff: 20 qualified staff; graduate and diploma students, two charge nurses (CNs) and; one (nurse) unit manager (UM).

An imaginary line divided the ward into two identical halves, 'East' and 'West', each with two single rooms, three double rooms and one four bedded room. Although there were two 'teams', each led by one CN, staff would work on both halves. On a typical week day shift, each nurse/student would be allocated four patients. A CN and an experienced member of staff would lead the East and West teams, coordinating logistics of all twelve patients and helping in care activities. The other CN was usually working on 'office duties'. The UM (who was a trained nurse) was stationed on the ward too. She was responsible for managing two out-patient clinics too, one of which was part of the unit and physically located at the entrance to the ward.

THE STUDY

As the concept of person-centred leadership appeared new to nursing and healthcare contexts, the purpose of this study was to explore the concept of person-centeredness within nurse leadership relationships. Two research questions were formulated:

- What is person-centred leadership within a clinical nurse context?
- How can person-centred leadership in nursing be developed?

Exploration was needed to derive a description of person-centred leadership within a nursing context. Development was needed as the term was not found in nursing literature, totally alien to research participants and there were accounts from multiple sources that current nurse leadership did not resonate with a person-centred approach.

My previous experience and critique of quantitative intervention studies, current leadership practices within local Dutch nursing contexts and positive experiences of practice development, led me to use a critical participatory action research methodology (Kemmis, 2008). The criticality of the methodology offered opportunities to explore the

meaning of person-centeredness within leadership relationships, alongside the identification of enablers and barriers to be fostered and overcome respectively. In addition, the participatory element would enable me to conduct research 'with' rather than 'on' practitioners and the action element would create the opportunity for participants and myself to bring about change and learn from it.

The overall design consisted of an orientation phase followed by four action spirals. During the orientation phase leadership and care relationships were explored using patient and staff narratives, accompanied by participant observations. The outcomes of collective analysis identified areas for action, four of which formed interconnected action spirals. The primary aim of the action spirals was to collectively, critically and creatively explore person-centred leader being, thinking and doing. A secondary aim was leader initiation of a more person-centred approach to care. The study ran for a total of three years, the first of which was dedicated to building researcher-participant relationships and orientating ourselves to current leadership/care relationships and culture.

THE THESIS

Having introduced myself, the inspiration for the research subject and the research context in this chapter, I now summarise the remaining chapters.

Chapter 2 is a review identifying four core values and twelve descriptors of person-centeredness in the healthcare literature. The resultant values framework is used to identify and discuss six models/styles of leadership most frequently referred to in nursing literature. The review and discussion conclude that there is a need to explore the concept of person-centred leadership within nursing for the development of person-centred cultures.

Chapter 3 presents the research methodology. The philosophical framework is based on assumptions drawn from critical realism, critical social science and critical creativity. It portrays a spiral of influence between human relating/agency and social context, where transformation is possible through the creation of critical and creative communicative spaces. Description of the orientation phase and four action spirals shows how the principles of criticality, participation and action-orientation influenced research activities. After discussing ethical considerations, the thematic data analysis framework is presented.

Chapter 4 opens with a definition of person-centred leadership as used by the participant leaders. Eight themes are then presented and described, supported by participant citations. Each theme represents a core process of person-centred leadership that was described and/or observed. The eight core processes form a collective whole, but were used individually and in multiple configurations, dependent upon the situation.

Chapter 5 presents leader attributes as well as processes used and contextual influences on the outcomes. The five leader attributes presented are those considered essential for person-centred leadership. The six processes describe what influenced participant leader development, as do the four contextual influences. Eight outcome themes were identified in the data. The development of person-centred leadership was a facilitated process with no end, a constant cyclical of leaders critically and creatively connecting their thinking with their doing in order to affect their future being.

In *Chapter 6* a conceptual framework for person-centred leadership is presented. This was the result of blending and theorising findings from Chapters 4 and 5. A photo and metaphor are used to help visualise the dynamic nature of person-centred leadership before introducing the graphical representation. Leader attributes enabling leaders' being in relation with others in a person-centred way are discussed first. This is followed by a description and discussion of five processes used to enable relational connectedness between leader and follower. The positions a leader takes in relation to the follower, aimed at enabling enhanced wellbeing and empowerment, are then presented and discussed. The mutual influencing between three contextual elements and leader-follower relating is discussed before presenting a framework for developing person-centred leadership.

This thesis closes with *Chapter 7*. Here worthiness of the study is discussed using the person-centred leadership framework. The significance of the researcher-participant relationship, as well as the context, is discussed in relation to knowledge generation. Implications and recommendations for practice, education and research communities round the whole off.

CONCLUSION

In this chapter I have attempted to introduce myself as a nurse, educator and practice developer who values caring about others and theory for practice. Using events that have taken place during the course of my life I have tried to illustrate my belief that the world we live in influences our being and our being influences the way we relate with those around us. As we encounter new people, cultures and traditions, I feel it is important to try and understand differences and find commonalities upon which to build new relations, contexts and ways of being.

I have described how experiences of colleagues and myself, and a lack of nursing literature, were the inspiration for me to study and explore how person-centeredness could manifest in leader relationships. The Dutch context is introduced and how I found a nurse leadership team in a Dutch urban hospital who were willing to join me in a critical participatory action research study. The study design is briefly introduced as an orientation phase followed by four action spirals. An overview of the remaining chapters is also

presented, in which the last two chapters present a conceptual framework for person-centred leadership and discussion on the worthiness of the study. Before going into the research methodology, a literature study on person-centeredness and leadership models is presented in the following chapter.

**Person-centeredness and
leadership models**

Chapter 2



INTRODUCTION

Carl Rogers is often cited as the founder of the person-centred movement. He viewed person-centeredness as “a philosophy, an approach to life, a way of being, which fits any situation in which growth - of a person, group or community – is part of the goal.” (Rogers, 1980, p. xvii). Enabling the growth of individual nurses, and the team as a whole, is often considered an important role of clinical nurse leaders. This raises the question: Which style of clinical leadership is most congruent with the concept of person-centeredness? This chapter presents a literature study to determine the value system underpinning person-centeredness. This would help me determine those leadership models/styles compatible with such a value system. The rationale for this decision lies in a belief that values influence behaviour and a human tendency to treat others as we ourselves are treated. If nurses are treated in a person-centred way, the personal experiential knowledge gained through such relationships could be transferred to relationships with service users.

Person-centred nursing is a phenomenon of the 21st century and has been defined in older person care as:

“an approach to practice established through the formation and fostering of healthful relationships between all care providers, older people and others significant to them and their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.” (McCormack, Manley, et al., 2013, p. 193)

Unlike previous concepts such as individualised/patient-centred care, person-centred nursing and practice focuses on all individuals and relationships within the healthcare context (McCance et al., 2011). The person-centred paradigm of respecting service-user, significant other and care provider individuality, is also key to practice development as a continuous process of developing person-centred cultures (Eve, 2004; McCormack, Manley, et al., 2013). Alongside two concept analyses (Morgan & Yoder, 2012; L. Slater, 2006), a practical framework for person-centred nursing (McCormack & McCance, 2010) has been developed. The enactment of person-centeredness has also been identified as an essential attribute of effective workplace cultures (Manley et al., 2011). Person-centred cultures have been shown to foster lower levels of staff stress, increased job satisfaction, organisational commitment and less intention to leave (McCormack, Dewing, et al., 2010). The development of such cultures requires facilitation and commitment from staff and leaders if ‘moments’ of person-centeredness are to become a ‘culture’ of person-centeredness (McCormack & McCance, 2010). Boomer & McCormack (2007) do not specify which leadership model they used in a programme designed to support clinical leaders in developing attractive work environments and person-centred care. However,

Manley et al (2011) refer to transformational leadership as an enabler of effective workplace cultures.

DEFINING CLINICAL LEADERSHIP

In everyday conversation, leadership is often used interchangeably with management and associated with organizational hierarchy. Although there are no universally accepted definitions (Howieson & Thiagarajah, 2011), leadership and management are differentiable. Definitions of leadership usually focus on social influencing: guiding and supporting individuals and teams in working towards predetermined goals (for examples see Box 1 p.16). However, such definitions imply unidirectional influencing (leader to follower) and fail to recognise the relational aspect of leadership and possibility of interdependency and mutual influencing.

Leadership is ...

"... aligning people towards common goals and empowering them to take the actions needed to reach them." (Sherman, 1995, In: Howieson & Thiagarajah, 2011, p. 8)

"... the ability to identify a goal, come up with a strategy ... inspire your team to join you ... in action." (Rafferty, 1993, p. 3)

"... providing support and motivation to achieve mutually negotiated goals ... may occur in formal and informal settings and structures." (Davidson et al, 2006; 182)

"influencing the attitudes, beliefs, behaviours and feelings of other people." (Spector, 2006 In: Curtis et al., 2011, p. 306)

"unifying people around values and then constructing the social world for others around those values and helping people get through change." (Stanley, 2006a, p. 22)

"setting direction, opening up possibilities, helping people to achieve, communicating and delivery." (Crisp, 2001 In: Millward & Bryan, 2005, p. xiv)

Clinical leadership is ...

"... driving service improvement and the effective management of teams to provide excellence in patient/client care." (Scottish Executive, 2005, p. 5)

"... a dialectical relation between being (aspects linked to a person) and doing (creating a frame for performing the tasks in the clinic) ... an enterprise in which personal character and skills are exercised and where an adequate social practice is created. An important element in this enterprise is the goals of nursing ... moral praxis." (Johansson et al., 2010, p. 2626)

"... authority in the broadest sense of the word, is non-hierarchical and not confined to a specific set of skills, attributes or traits ... reflects all of the complexity of the culture, the organization, the practice setting and situational variables of each clinical nurse leader." (Hyrkäs & Dende, 2008, p. 495)

"... facilitating evidence-based practice and improved patient outcomes through local care." (Millward & Bryan, 2005, p. xv)

"... an expert clinician, involved in providing direct clinical care, who influences others to improve the care they provide continuously." (Cook, 1999, p. 306)

"... a clinician who is an expert in their field, and who, because they are approachable, effective communicators and empowered, are able to act as a role model, motivating others by matching their values and beliefs about nursing and care to their practice." (Stanley, 2006, p. 136)

Box 1: Definitions of leadership and clinical leadership

Clinical leaders are often defined as expert practitioners who, from a hierarchical or non-hierarchical position, facilitate the provision of effective care (for examples see Box 1). At a time when nursing care is being scrutinized and accused of being over-managed and under-led, charge nurses have been accused of being too management focused (Drach-Zahavy & Dagan, 2002). Whilst acknowledging the importance of nurse leadership within the academic, political and managerial domains, Stanley (2010) also feels that bedside leadership is distinctly different from managerial leadership, and calls for more development and research. There is a demand to synthesise management and leadership skills within one clinical role (MacLeod, 2012), although, clinicians do need to differentiate between skills sets if role conflict is to be avoided (Stanley, 2006).

Whereas management is often described as being short-term focused, 'getting things done' and 'doing things right', leadership is more focused on longer-term growth, development and 'doing the right thing'. An ethnographic study by Cook & Leathard (2004), described effective clinical leadership as a synergy of five processes: understanding context and creatively finding new ways of working; actively engaging with others to challenge the status quo; influencing others through the sharing of meaningful knowledge; reading and responding appropriately to individual/contextual signals; and enhancing ownership and learning. These processes take place in the relational space between the leader and those being led.

DEFINING VALUES

Being visionary is a leader attribute found in most contemporary models and visions are based on values. Whilst many definitions of values exist, I give preference to those stating that values 'influence' rather than 'determine' an individual's behaviour (for examples see Box 2 p.17). Values are constructs of what we feel 'ought' to be done, our moral principles. Combined with emotions and personal beliefs of what is (un)true, they form (un)conscious basic assumptions that influence our behaviour (Rokeach, 1973; Schein, 2010; Schwartz, 1992). They are abstract, may be difficult to articulate and can, to a certain

Values are...

"... universalistic statements about what we think is desirable or attractive; they are internalised attitudes about what is right or wrong, ethical or unethical, moral and unmoral." (Yukl, 1998, p. 234)

"... not merely cognitive beliefs but include an emotional or affective component and are enacted in everyday life in multiple arenas. In this way, they also come to constitute one's identity." (Liaschenko, 1999, p. 36)

"... qualities that demand respect and that generate:

- principles that guide us in our thinking and doing
- standards against which we judge ourselves and others." (Talbot, 2003, p. 18)

Box 2: Definitions of values

degree, be inferred from our behaviour (Glen, 1999). However, personal values do not predict behaviour as they evolve and mature over time (Raths et al., 1966). As active, embodied and embedded creatures we are able to reflect on our values, but they are also influenced by social contexts (Fay, 1987; Maio et al., 2001). Value-behaviour discrepancy is well documented in organisational psychology and no direct predictive linear relationship has been demonstrated between values (far-from-action), intention (close-to-action) and behaviour (Szabo et al., 2001).

As we evaluate self and others on the extent to which congruency between espoused values are lived, we experience a sense of success and achievement and create strong idio-cultures (Schein, 2010). The more we are aware of our values, the easier it is to live them (Kouzes & Posner, 2007). Frequently reviewing and generating reasons for, and examples of, our values helps ensure pro-value behaviour as we move from an ideological/emotive level of thinking to a more rational one (Maio et al., 2001).

LITERATURE SEARCH

An initial electronic literature search was conducted using various combinations and spelling of keywords in the Cumulative Index for Nursing and Allied Health Professions (CINAHL) and OvidSP (Embase, Medline and Psychinfo) databases (see Box 3 p.18). Setting time limits to 1998-2012, removing conference abstracts and duplicates, and screening abstracts for research question relevance, reduced the 775 hits to 140 retrievable articles. The majority were research studies (68), literature reviews (16) including systematic literature reviews and the remaining 56 articles were descriptive/discussion papers (see Box 4 p.19).

As the aim of this paper was to determine the values underpinning person-centeredness as it is used in the literature, research articles were not screened for methodological rigour and discussion papers were included too. Analysing the literature was a hermeneutic process of moving between individual papers and the whole collection, seeking patterns in author/research participant interpretations of person-centeredness. Familiarising myself with all the papers, I asked, "What is important in person-centeredness? What are these texts saying ought to happen?" Answers provided tentative descriptors. Returning to individual articles I sought citations and messages that supported the descriptors and

Keyword combinations	CINAHL	Ovid
Person-centered* AND value*	207 hits	568 hits
Person-centred* AND value*		
Person centered AND value*		
Person centred* AND value*		

Box 3: Primary search strategy and hits

Types	Articles (N=140)
Discussion paper	56
Quantitative design	19
Qualitative design	38
Mixed methods	9
Action research	1
Meta-synthesis	1
(Systematic) Review	16

Box 4: Retrieved articles

remained open to any descriptors I may have missed. Some original descriptors were blended (integrated) whilst others were melded (compounded) to each other and the labels refined. Clustering descriptors resulted in themes depicting key values of person-centeredness.

The initial electronic search resulted in papers predominantly referring to caregiver-care receiver relationships. This failed to surface work on person-centeredness as a relational concept for collegial relationships and workplace culture. A new electronic search was conducted (see Box 5 p.19) and books I knew contained relevant information were also added to the data set. Person-centeredness within collegial relationships was never the primary focus of the literature found, and the majority of authors were engaging in emancipatory and transformational practice development. However, the literature did enable me to expand the original values framework to include person-centeredness within collegial relationships and workplace culture.

Keyword combinations	CINAHL Full text	retrieved
Person-centred*		
Practice development		
Workplace culture	46 hits	22 hits
Teams		
NOT occupational therapy		
NOT conference abstract		

Box 5: Second search strategy, hits and articles retrieved

PERSON-CENTRED VALUES FRAMEWORK

Person-centeredness can mean different things to different people in different contexts (Kirkley et al., 2011; Leplege et al., 2007), so identifying core values and descriptors could

help reduce Freeth's (2007) fear that it is becoming the latest 'buzz word' in policy guidelines and mission statements. Its growing popularity is linked to modern criticism of the biomedical paradigm, technology de-contextualising patients and a lack of compassionate care (Cox, 2008), which has brought 'wellbeing' into the public discourse. Practitioners, government agencies and educationalists are looking more closely at care concepts such as identity, autonomy, security, connectedness, meaning, joy and space (Brune, 2011; Koren, 2010). In healthcare, person-centred medicine as "a medicine of the person, for the person, by the person and with the person" (Mezzich et al., 2010, p. 703) has emerged alongside person-centred nursing (McCormack & McCance, 2006). The Royal College of Nursing's eight principles for nursing practice (RCN, 2010) reflect a call for dignity and humanity within healthcare settings and practice development research is starting to demonstrate the value of person-centeredness for effective workplace cultures (Manley et al., 2011; McCormack, Manley, et al., 2013).

Suffering can negatively affect a person's identity, but, experiencing personalisation and empowerment from approachable, available, respectful others helps restore a sense of safety, identity and personhood (Coyle & Williams, 2001). Whilst the 'self' can be seen as located in internal processes such as cognition, memory and emotion, the 'person' is seen as the moral agent embedded within a network of social relations (Swora, 2001). 'Personhood' becomes an existential sense of being, "a standing or a status that is bestowed on one human being by another in the context of relationship and social being" (Kitwood, 1997, p. 8). Acknowledging this dependency on others for our sense of personhood, I conclude that person-centeredness is the enabling of personhood in care, leadership and collegial relationships within healthcare contexts. Themes derived from the analysis of the person-centred literature represent core values influencing a person-centred way of being. These core values of *individualisation*, *relational connectedness*, *blending knowledges* and *creating supportive cultures* are described in more detail in the following sections.

Individualisation

Individualism is not synonymous with individualisation. Whilst individualism emphasises independence, self-reliance and autonomy, individualisation is concerned with interdependency and subjectivity (Nolan, 2001).

Descriptor: Respecting uniqueness and diversity.

Recognition of personhood and respect for individuality are essential attributes of person-centeredness (Morgan & Yoder, 2012; L. Slater, 2006). This assertion is strengthened by McEvoy & Nosowska's (2012) finding that service-users dislike being labelled and feel that carers should understand the need to treat others with respect. When service users feel accepted and valued, mutual respect grows (Connor & Wilson, 2006). Kitson (2004) feels that Kantian ethics of mutual respect and sympathetic benevolence help practitioners

view self and others as subjective persons, which could foster McCormack's (2003b) view that the other should be seen in their own right and not the means to another's ends. This ethical approach could, as advised by numerous authors, help the person-centred practitioner see the person behind the social role/condition, their (subjective) experiences, integrity, rights (to privacy and self-determination), values, beliefs, needs, desires, choices, life patterns, culture, difference, accomplishments, circumstances, strengths and vulnerabilities (Barker & Buchanan-Barker, 2011; Bolster & Manias, 2010; Brune, 2011; Burke & Doody, 2012; Chenworth et al., 2011; Elliott & Greenberg, 2007; Galland, 2006; Gzil et al., 2007; Kirkley et al., 2011; Lawn et al., 2011; Lehluante et al., 2012; Leplege et al., 2007; A. Martin et al., 2012; McCormack, 2003a; McCormack, Dewing, et al., 2010; Mezzich et al., 2010).

Valuing people as individuals is an attribute of effective workplace cultures (Manley et al., 2011) and being respectful can be leant (Kemeny et al., 2004). One does not have to like another person, or what they say, in order to respect them (Freeth, 2007), but trying to engage with 'unconditional positive regard' can help keep personal values and prejudices from diminishing one's understanding of the other's uniqueness (Rogers, 1980). Exercising unconditional positive regard is especially relevant to modern practitioners working in increasingly culturally diverse societies with inter- and intragroup differences (Campinha-Bacote, 2011; Iliffe & Manthorpe, 2004). For instance, whilst the indigenous people of Australia value connectedness to the land and collectivism more than individualisation, aboriginal city dwellers may sway between the values of black and white communities (McMillan et al., 2010). Citizenship Theory could also support person-centred practice as it holds the moral belief that all humans are equal in worth, and diversity is essentially good as it brings about "change, beauty and interest to human life, creating opportunities for meaningful exchange in a way that sameness never can" (Duffy, 2010, p. 259).

Descriptor: Continuously trying to understand the whole person in context

The person-centred paradigm sees people as embodied, with no hierarchy or separation of mind from body, and embedded within a social context in which they interact with structures, processes and other persons (McCormack & McCance, 2006). Each person has a (preconscious) plan of what they want to do in life, reflecting their values and beliefs (McCormack & McCance, 2006). The whole person is more than the sum of the parts (Finlay, 2001) and existing in relation, influences and is influenced by surrounding social and cultural forces (Cox, 2008). For instance, external environmental factors can initiate and sustain psychological symptoms (Simmons, 2012). However, illness can undermine personal identity, especially in contexts that dehumanise, objectify, devalue and disempower (Coyle & Williams, 2001; Wain et al., 2008). Person-centred care encompasses trying to understand the whole embodied person and the social world they are embedded in as they create and recreate meaning (McCormack, 2004). Looking beyond the medical

condition, the person is seen against a backdrop of social roles, relationships, housing, employment, abilities, preferences, interests, hopes, fears, values, beliefs and spirituality (Boettcher et al., 2004; Bradley et al., 2011; Burke & Doody, 2012; Campinha-Bacote, 2011; Chenworth et al., 2011; Finlay, 2001; McKee & Rivard, 2011; Morgan & Yoder, 2012). Understanding connections between these parts help give meaning to observations and identify how the person can continue to contribute and belong to their social community (Boise & White, 2004; Brune, 2011).

As multiple diagnoses, co-morbidity and differing treatments for the same condition become more common (Musalek & Scheibenbogen, 2008), modern medicine is discovering that the human condition resists categorisation in any one taxonomy (Simmons, 2012). Person-centred diagnostics is less concerned with categorising the patient and more with trying to understand the manifestation of symptoms in a broader context of (possible) causes, irritants and/or mediators (Galland, 2006; Mezzich et al., 2010; Musalek & Scheibenbogen, 2008). A narrative approach to clinical assessment could help practitioners see the person behind the symptomatic patient (Pope, 2012) as inviting patients to (re)tell their story confirms their personhood, helps surface meaning and conveys the message that they have something of importance to tell (Hedelin & Jonsson, 2003). When diagnosing Alzheimer, Mast (2012) advises starting with the person's narrative before moving into quantitative diagnostics as this helps build the trust, openness and authenticity needed for an accurate diagnosis. Parkinson et al (2011) invite patients to identify their strengths and challenges ahead so that partnerships can be built. However, whilst narratives help practitioner understanding and raise the person above the illness/condition, patients may not always be transparent (Fulford, 2011) and their values, beliefs and preferences may change over time (Boise & White, 2004; A. Martin et al., 2012). Knowing a person's past ('was'), present ('is') and future ('becoming') requires time (Finlay, 2001; Mantzorou & Mastrogianis, 2011; A. Martin et al., 2012). Regular contact aids verification of interpretations and differentiation of 'the unusual' from 'the typical' (Dulmen van, 2010; Gaventa, 2008; A. Martin et al., 2012; Specht, 2009).

Whilst the importance of knowing the whole person in context is given considerable attention in care literature, it is not discussed in current leadership or workplace culture literature. Shaw et al (2008) do refer to Rogers' (1983) and Heron's (1999) view that enabling growth and development should be learner-centred, but, make no specific reference to knowing the learner in context.

Descriptor: Being flexible and individualising interventions

As well as understanding the person as a complex, bio-psychosocial being with a past, present and future biography (Lehluante et al., 2012; Leplege et al., 2007), the person-centred practitioner aims to support potential growth and becoming (Elliott & Greenberg, 2007; McCormack, 2003a). For instance, based on the belief that people are unique and

creative, person-centred psychiatry focuses on potentials rather than deficits (Freeth, 2007). This focus on potential growth and becoming reflects Roger's (1980) concept of 'actualising tendency', the natural tendency to utilise one's possibilities, organise self and grow. The literature suggests that practitioners create optimal conditions to enable a person to grow and achieve potential. Where Leplege et al. (2007) refer to creating conditions to enhance service user self-efficacy, practice developers emphasise the importance of creating cultures for learning, growth and development (McCormack, Manley, et al., 2013). Coupling the belief in individuality with enabling growth, I suggest that practitioner/facilitator flexibility is also required so that interventions can be individualised to meet specific needs.

In Finlay's (2001) study, occupational therapists saw 'getting to know the other in context' as the starting point to building person-centred/therapeutic relationships for individualised treatment plans. Respecting the fact that not all individuals have the same resources or goals implies rejecting a 'one size fits all' approach to care (Alharbi et al., 2012; Boettcher et al., 2004a). Seeing, hearing and understanding the other in context aids assessment of how best to interact, intervene, work with limitations, build strengths and evaluate impact (Baumann et al., 2013; Burke & Doody, 2012; Connor & Wilson, 2006; Dulmen van, 2010; Musalek & Scheibenbogen, 2008; Parkinson et al., 2011). Personalised care is not procedure operated nor efficiency/routine focused with a preference for rational problem fixing (Finlay, 2001; Gaventa, 2008). It requires organisational and practitioner commitment to being flexible, adjusting care to meet evolving and fluctuating needs (Fitzpatrick, 2006; Heathcote et al., 2005; Horton et al., 2010; Leplege et al., 2007; McCormack, 2004). However, breaking traditional, non-person-centred routines and rituals has been shown to be very difficult (Bolster & Manias, 2010).

In summary: Individualisation in person-centred practice entails respecting uniqueness and diversity among people, continuously trying to understand the whole person in context and being flexible so as to individualise interventions.

Relational connectedness

Humans need to feel they belong, are important and part of something bigger (Rockwell, 2012; Specht, 2009). Feeling isolated can evolve into feeling indifferent and unconcerned about others, so connecting is important for human wellbeing (MacLeod & McPherson, 2007). For me, connectedness implies a sense of feeling cared about and wanting to be in relation. Being in relation is considered important for person-centred nursing and human wellbeing (McCormack, 2004). To achieve this, Klaver & Baart (2011) argue that (instrumental and beneficent) attentiveness creates space for caring relationships to evolve. Baart & Grypdonck (2008) describe how attuning to the other and being thoughtfully present, creates relational closeness so that when the right moment occurs mutually

meaningful action can take place. Whilst McCormack & McCance (2006) describe the use interpersonal skills to relate intentionally and meaningfully in person-centred nursing, the many accounts of service users valuing 'the human touch' (Connor & Wilson, 2006; MacNeela et al., 2010; Wain et al., 2008) suggests that these skills entail more than just verbal communication.

Being in relation, the person-centred practitioner journeys with the other, remaining open to new insights into their values, beliefs, experiences, idiosyncrasies and ways of reasoning so that they can respond appropriately (Chenworth et al., 2011; Webster & Cowart, 1999; Woodrow, 1998). When both nurse and service users feel acknowledged and able to express their values and beliefs, mutuality emerges (Binnie & Titchen, 1999; McCormack & McCance, 2010). Morse (1991) describes four broad types of mutual (nurse-patient) relationships: the 'clinical relationship' which is short/transient and perfunctory in nature; the 'therapeutic relationship' which is longer but still professional, efficient and involves 'getting to know each other'; the 'connected relationship' in which each person is viewed as an individual then a group member; and the 'over-involved relationship'. To remain connected without becoming over-involved or too clinical, a person-centred nurse moves through different levels of relational engagement (McCormack & McCance, 2010).

Descriptor: Being altruistically caring and compassionate
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Person-centred practitioners criticise the view that cure, technical competence, cognitive reasoning and formal knowledge should be valued above intuitive caring and engagement (Brown et al., 2008; Mantzourou & Mastrogiannis, 2011). Caring, compassion and empathy are considered part of the human condition, actualising the beauty within relationships, raising awareness to common humanity and hope (of recovery), and are essential to human growth, development and flourishing (MacLeod & McPherson, 2007; Mantzourou & Mastrogiannis, 2011; McCormack & McCance, 2010; Titchen et al., 2011). Caring is felt, considered morally right and enacted in response to another's needs (McCormack & McCance, 2010). Compassion as sympathetic imagination is demonstrated in the emotional attentiveness and responsiveness to the misfortune and suffering of others (Björkdal et al., 2010; Kontos & Naglie, 2007; MacLeod & McPherson, 2007). Being empathetic is to try and imagine both cognitively (understanding) and/or affectively (sympathetic feeling) the feelings and meaning another attaches to their situation, without losing self (the 'as-if condition') (Brunero et al., 2010). Being altruistically caring and compassionate fosters other-centeredness and relational connectedness. For instance, Brown et al (2008) found that student nurses who related quickly with patients as persons after starting a new clinical placement, had moved more quickly through preceding stages of focusing on self, the course and the patient as a group. Ryan et al (2006) found that clients felt cared for, important, at ease, relieved and satisfied when consultant nurses showed compassion

and seemed 'bothered' about the person. Binnie and Titchen (1999) also showed that being able to see past routines and strict guidelines has a greater impact on service user experiences than technical competency alone, and creating a climate of concern and support for one another increases team cohesiveness and effectiveness.

Descriptor: Well developed interpersonal skills to build trust and partnerships

Person-centred practitioners focus on mutual understanding and respect (Lehuluante et al., 2012; Leplege et al., 2007) rather than 'contracting care' or 'individual responsibility'. Dialogue enables learning from, with and about each other (A. Martin et al., 2012), moving beyond 'problems' into 'hope' and 'strength' for personal growth. Experience, empathy and unconditional positive regard enable practitioners to move beyond 'structured engagement' and into 'meaningful dialogue' (Kirkley et al., 2011; MacNeela et al., 2010). Some people may be predisposed to being person-centred, although interpersonal skills can be learnt. After conducting a laboratory experiment, Medvene et al (2006) propose that when trained to make multiple differentiated psychological constructs of another person, people may be more likely to think differently about and act differently towards others. However, more research is needed on interpersonal skill competency and usage in person-centred practice (McCormack, Karlsson, et al., 2010).

Relational trust can take time or grow quickly, becoming mutual and therapeutic as conversations move beyond clinical issues and partnership evolves (Burke & Doody, 2012; Cherry et al., 2008; Morse, 1991; Wilson et al., 1998). Trust enhances authenticity and sharing of information that may otherwise have been withheld, such as early symptoms of cognitive impairment or commitment to rehabilitation programmes (Bolster & Manias, 2010; Hawley, 2009; MacLeod & McPherson, 2007; A. Martin et al., 2012). A practitioner's attitude, appearance and behaviour influences relational trust (Hedelin & Jonsson, 2003) and a breach of trust can leave service users feeling powerless and oppressed (Freeth, 2007). Whilst matching service users with practitioners has been claimed to foster partnerships (Fitzpatrick, 2006; Kirkley et al., 2011), familiarity and degree of engagement may reflect the quality of the relationship (A. Martin et al., 2012).

Where the literature and talk around person-centeredness places so much emphasis on respecting individuality and self-determination, there is a danger that practitioners may forget the ontological assumption of interdependency and interpret person-centeredness as a 'right to independence'. Leplege et al (2007) remind us that person-centeredness is not prescribed but tailored in partnership. Partnership implies self-determination within a social context where the values and beliefs of all are acknowledged and mutual trust aids shared decision-making (L. Slater, 2006). McCormack (2001) uses the term 'negotiated autonomy' in this context.

Whilst family, friends and other professionals within the social context of each individual may be altruistic in intent, ethical awareness is still needed when including

them in decision-making and consideration should be given to preventive ethics. For instance, a person's wishes may be negotiated during a period of cognitive wellbeing for the purpose of retaining their self-determination should they become unable to negotiate these at some point (Madeo et al., 2008). Habermasian discourse ethics is also relevant here, where action is based on dialogue between stakeholders who share their interests and intentions transparently so that decisions can be based on mutual understanding. Such discourse within a professional care context involves educating, negotiating boundaries and reaching consensus on how to personalise care (Boise & White, 2004; Burke & Doody, 2012; McCormack, 2003a). Although not 'all' service users are able or willing to actively participate 'all the time' (Connor & Wilson, 2006; Coyle & Williams, 2001; Lawn et al., 2011; Parkinson et al., 2011; Williams et al., 1999) they should still have opportunity to voice disagreement (Stenner et al., 2011), having their desire for and level of participation regularly evaluated (Coyle & Williams, 2001). When caring is sharing, partnerships emerge (Fulford, 2011; Galland, 2006) and people feel more inclined "to reciprocate or work with the nurse prescriber to set and meet targets" (Stenner et al., 2011, p. 43). Various authors also recommend partnerships be built over time and maintained for long term efficiency (Alharbi et al., 2012; McEvoy & Nosowska, 2012; Parkinson et al., 2011).

Partnership reflects connectedness. The relational reciprocity inherent in connectedness develops when patient and nurse recognise the person and not just the social role (Björkdal et al., 2010; Mantzorou & Mastrogianis, 2011; McCormack, McCance, et al., 2013). This implies 'being of equal value' (equity), shared power and responsibility for process and outcome, where no one feels they are only being led (Dulmen van, 2010; Elliott & Greenberg, 2007; Kirkley et al., 2011). These values are also evident in practice development descriptors of effective teamwork, which aims to empower all within a person-centred culture (McCormack & McCance, 2010; McCormack, McCance, et al., 2013). As an enabling factor of effective workplace cultures (Manley et al., 2011), leadership could play a significant role in fostering collegial and care relationships as partnership. Having conducted a discursive analysis of media, policy, literature and nursing press, McSherry et al (2012) argue that genuine partnerships between leaders and front-line staff are essential for excellence in care.

<p>Descriptor: Being present and communing creatively</p>
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Sympathetic presence is the act of communicating a willingness to (metaphorically) accompany the other on their journey (Baart & Grypdonck, 2008; Binnie & Titchen, 1999; McCormack & McCance, 2010). Both young and old value the warm, close intimacy of another 'being there with them' (Bala et al., 2012; Bradley et al., 2011; Jedeloo et al., 2010; MacLeod & McPherson, 2007; Rack et al., 2008; Webster & Cowart, 1999), finding it equally therapeutic as someone 'doing something for them' (Kitson, 2004; Legault & Ferguson-

Paré, 1999). This altruistic act of caring is in contrast to a presence where the carer comes across as being there for the institution (Alabaster, 2007; Cox, 2008). The interpersonal skills involved include: being physically/spiritually approachable and available, letting go of preconceptions, creating safe communicative spaces, attentive listening to the emerging narrative, selecting and grasping hold of salient messages, resonating where possible, demonstrating sensitivity, conveying acceptance, optimism and a positive belief in change (Clarke & Ross, 2006; Coyle & Williams, 2001; Elliott & Greenberg, 2007; Mantzourou & Mastrogiannis, 2011). Presencing fosters the articulation, validation and legitimisation of feelings (Binnie & Titchen, 1999; Rack et al., 2008) and is a key attribute in person-centred psychotherapy (Björkdal et al., 2010; Elliott & Greenberg, 2007; Freeth, 2007). It demands more than being physically present (MacLeod & McPherson, 2007). Rack et al (2008) found that 'expressed concern' was one of the most helpful (measured in terms of extent feeling recognised and acknowledged) strategies that bereaved adults encounter. Baumann et al (2013) found that person-centred art therapists left patients with a comforting feeling that someone was thinking about them between sessions. The act of presencing has also been identified in research-participant relationships where the researcher responds appropriately to participant cues about levels of engagement and participation (Dewing, 2002; McCormack, 2003b).

Interpersonal skills for person-centred nursing include the ability to (non)verbally communicate with service users at a variety of levels (McCormack & McCance, 2010). In an era of managerialistic and consumerist discourses, where health care efficiency and practitioner accessibility prevail (Gaventa, 2008), technological means of communication are increasing being explored and utilised. Person-centeredness is now being claimed to extend into 'telemedicine' and some consider e-mails sent to individual service users as 'person-centred messages' (Robinson et al., 2011). However, this raises questions about whether and how relational connectedness can be achieved in a virtual environment. The findings of Robinson et al (2011) suggest that electronic communication can help give voice to service users as practitioners often communicate differently in a virtual world. For instance, practitioners often find it difficult to verbally communicate their clinical reasoning concisely and comprehensively to patients during a consultation, whilst communicating through multi-media creates space for them to reflect before action (Robinson et al., 2011).

Not all communication is suitable or can take place through multi-media and so being attentive to the way we communicate is essential to person-centred practice. Binnie & Titchen (1999) describe observing with an 'open mind' and Baart & Grypdonk (2008) describe 'devote exposure' as listening to the other's narrative in order to understand their perception and so act appropriately. Richard Taylor, a person with dementia who co-authored a paper on the needs of people living with dementia, makes a plea for carers to continue seeing, hearing and communing with the person with dementia (Specht, 2009).

What we know about a person influences how we communicate with them (McCormack & McCance, 2010) and knowing the whole person is central to communicating effectively (A. Martin et al., 2012). McKee & Rivard (2011) also emphasise the importance of matching the practitioner's verbal communication with the service user's mother-tongue, literacy level, educational background and interests. Communicating creatively may also be needed, especially with people who have cognitive and/or receptive/expressive language difficulties. Creative methods of communication are not unusual in some settings (Boettcher et al., 2004; Hasnain et al., 2003; Iliffe & Manthorpe, 2004) and yet Martin et al (2012) feel this skill is often undervalued. With increasing evidence that only a minimum level of medical/psychiatric stability is needed for patients to negotiate meaningful goals and/or give informed-consent, creative communing should receive greater attention in training and research (Dewing, 2002; Parkinson et al., 2011). Communing creatively, a person-centred practitioner can find answers to the question: "What can I be/do for this person (from their perspective)?"

Descriptor: Enabling empowerment through balanced challenge and support

Encouraging choice and self-determination in all aspects of a person's daily life is seen as important in person-centred practice (Chenworth et al., 2011; Cherry et al., 2008). Williams et al (1999) found that spending more time with clients and not 'interfering' with their mundane daily routines, increased residents' sense of freedom, self-control and self-worth in a community support setting. Self-determination enhances feelings of self-worth and control over one's environment and can be facilitated in the smallest of actions/gestures such as asking someone where they would like to sit or prompting them to initiate self-care (Boettcher et al., 2004; Bradley et al., 2011). Valuing and promoting agency, self-determination and growth is claimed to create the conditions for service user hope (MacLeod & McPherson, 2007) and empowerment (Alharbi et al., 2012) 'to live their lives on their own terms' (Barker & Buchanan-Barker, 2011, p. 341). However, independence is not the ultimate goal for all service users all the time. As Bradley et al (2011) found among palliative care patients, a non-pressured, non-demanding, genuine connection with carers was considered of greater importance. Knowing that service users value negotiated autonomy in non-pressured relationships with practitioners, raises issues around how therapies are offered and negotiated. For instance, discussing motivational interviewing Renisow & McMaster (2012) state that whilst this intervention is intended to increase service user attentiveness to 'self in context' in order to self-direct change, is not necessarily suitable for all clients all the time. Discussing the concept of self-management, Lawn et al (2011) are critical of practitioners who 'prescribe' rather than negotiate programmes as patients often then feel forced to self-manage or blamed for lack of progress.

Empowering care environments that support partnerships, autonomy, innovation and risk-taking enable person-centred practices (McCormack & McCance, 2010). In a meta-

synthesis of four qualitative studies, 'choice' and 'power' were strong themes with staff sometimes enabling patient choice, but, at other times using their professional power to limit choice (McCormack, Karlsson, et al., 2010). In contrast, when a neuro-rehabilitation centre implemented patient-led care, partnerships also failed to emerge (Wain et al., 2008). Empowered service users are more critical, and where management demand more technical, rational, routinized and efficient care, professionals may start to feel undervalued and so return to paternalistic ways of being in order to regain some sense of control. Partnerships need to be seen in context and based on negotiated autonomy (McCormack, 2001).

Negotiating and agreeing (future) goals and care is a basic step to enabling empowerment of young and old at risk of becoming dependent (Burke & Doody, 2012; Ek et al., 2011; Hasnain et al., 2003; Horton et al., 2007; Jedeloo et al., 2010; Mast, 2012; McKee & Rivard, 2011). In modern complex healthcare contexts, practitioners often find themselves balancing being 'receptive' and following service user desires, with being 'prescriptive' and 'directive' (Elliott & Greenberg, 2007). The person-centred practitioner journeys with the other through the complexity of their situation, offering critical companionship (Titchen, 2004) rather than answers and judgements. Popular techniques such as motivational interviewing, where 'comforting the afflicted' (support) runs parallel to 'afflicting the comfortable' (challenge), can be useful if approached with 'other-centeredness' rather than 'professional goal/self-centredness'. Renisow & McMaster (2012) advise avoiding persuasion, instead, helping patients generate a personal rationale for behavioural change by offering information and supporting deep contemplation. In terms of practitioner growth and empowerment, balancing challenge with support is a well-documented strategy in both active (Dewing, 2008) and action learning (McGill & Brockbank, 2004).

In summary: Relational connectedness entails being altruistically caring and compassionate as well as using developed interpersonal skills such as presencing and creative communing to build partnerships. Partnerships with balanced challenge and support enable empowerment.

Blending knowledges

Achieving relational connectedness requires knowing what is important and at play (McCormack, 2003a) and sometimes challenging with an intent to empower involves raising consciousness to false interpretations of the taken for granted aspects of everyday life. Being in relation, the person-centred practitioner will therefore need to use multiple forms of knowledge. Conducting a phenomenological study of women with mental health issues, Hedelin & Jonsson (2003) conclude that nurses should use (pre-cognitive) professional and personal experiential knowledge alongside knowledge embedded in patients' narratives to achieve relational mutuality. However, in an era of 'evidence based

practice; intuitive and tradition-based-practice is being challenged and practitioners increasingly encouraged to base their practice on research findings alone. An alternative movement does exist. The Promoting Action on Research Implementation in Health Services (PARiHS) framework advocates the blending of (professional and service user) experiential knowledge with local and propositional knowledge (Munten et al., 2006; Rycroft-Malone, 2013; Simmons, 2012).

Descriptor: Knowing self and other

Many authors promoting person-centred practice feel that knowing self and ones values is equally as important as knowing the other (Fulford, 2011; MacLeod & McPherson, 2007; Mantzourou & Mastrogiannis, 2011; McCormack & McCance, 2010; McCormack, McCance, et al., 2013). In Peplau's (1952) theory of nursing, self-awareness is claimed to help a nurse understand how her own behaviour helps others (Hedelin & Jonsson, 2003). Whilst we are not 'value free', articulating and critically reflecting on our values and beliefs helps us cope with (emotionally and intellectually) demanding situations and resist socialisation into cultural practices that are non-person-centred (Alabaster, 2007; Freeth, 2007; Fulford, 2011; Manley, Solman, et al., 2013; McCormack, 2003a). Articulating and critically reflecting with others may be risky (McCormack & Dewing, 2010), but the self-knowledge gained can help protect us from the 'enslavement of delusion' (Fay, 1987) as we see aspects of self that we did not know existed.

Knowing the other requires engagement, helps determine action and gage success. Tanner et al (1993) describe two dimensions to knowing a patient: knowing the person (the subjective) and knowing their patterns of response (the objective). Both dimensions are attended to when relating with service users (Mantzourou & Mastrogiannis, 2011) and the resultant knowledge provides standards against which action decisions can be made (McCormack, 2003a). Service users are known to value practitioners who use their personal knowledge as this legitimises their (family's) suffering and experiential knowledge (Kirkley et al., 2011; McEvoy & Nosowska, 2012; McKee & Rivard, 2011). The understanding achieved through engaging in order to surface and work with knowledge of the other, enhances a sense of relational connectedness (Baart & Grypdonck, 2008).

Descriptor: Professional knowledge

Knowledgeable and competent professionals are highly valued by service users (Bala et al., 2012; MacLeod & McPherson, 2007; A. Martin et al., 2012). Practitioners' professional and experiential knowledge includes technical skills, pathophysiology of conditions and how it affect a person's everyday life, as well as how to deal with 'organisational pathologies' that may threaten standards of care (Bala et al., 2012; Boettcher et al., 2004a; Connor & Wilson, 2006; Ek et al., 2011; Gaventa, 2008; Horton et al., 2010; Stenner et al., 2011; Williams et al., 1999). Whilst service users value technical skills more during acute, life

threatening crises, practitioner humanistic and interpersonal skills become increasing important during recovery and stabilisation (MacLeod & McPherson, 2007; McCormack & McCance, 2010).

Descriptor: Blending knowledge from different sources

Cox (2008) warns of an over emphasis and reliance on propositional knowledge. Within the person-centred movement, blending propositional with personal experiential and local context knowledge is recommended in collaboration with service users, as this enables both evidenced-based and individualised-care (Alharbi et al., 2012; Kirkley et al., 2011; McCormack, Dewing, et al., 2010). With regards to collegial relationships, Fulford (2011) recommends reviewing (conflicting) facts and values in a multidisciplinary context. Creating shared understandings and collective knowledge is the message coming through the literature, and McCormack (2003a) sees this as the basis for therapeutic relationships.

In summary: Blending knowledges from different sources is recommended for person-centred practice.

Supportive workplace cultures

Context and environment are major influences of person-centred culture development (Bergland et al., 2012; Lehuluante et al., 2012; McCormack et al., 2011; Morgan & Yoder, 2012), influencing the selection and promotion of practice paradigms (McCormack & McCance, 2010). McCormack et al (2010) found that effective teamwork, workload management, time management and staff relationships are important factors in developing person-centred cultures within the workplace. Differentiated from organisational culture, the workplace culture is the immediate, everyday culture experienced and/or perceived by service users and staff (Manley et al., 2011). The way decisions are made, the way conflict and power is handled, the way learning occurs and the energy generated through interpersonal relationships, shapes the workplace culture (McCormack & McCance, 2010), and influences whether or not people thrive/flourish at work (McCormack, McCance, et al., 2013).

Developing person-centred care through reflection and active learning strategies within the workplace supports 'helpfulness' and constructs of dignity within teams (McCormack, Dewing, et al., 2010; Yalden & McCormack, 2010). Teams with a strong, collective efficacy (Howarth et al., 2012) and who have embodied person-centeredness, tend to create warm, homely, stress free environments where service users feel safe and connected (Björkdal et al., 2010; Ek et al., 2011; Koren, 2010). However, person-centeredness can mean different things to different people in different contexts, so sympathetic management, supervision and support is recommended to help front-line practitioners develop a shared vision (Boomer & McCormack, 2010; Leplege et al., 2007) that values respect, empowerment and choice for patients and staff (Morgan & Yoder, 2012).

Several quantitative instruments for measuring person-centeredness within the workplace have been developed (Edvardsson & Innes, 2010; McCormack & McCance, 2010). These tools are best combined with use of naturalistic techniques, such as participant observation and interviews to surface incongruences between espoused and lived values (Wilson et al., 2005) so that a team can then transform 'moments' into 'patterns' of person-centeredness.

Descriptor: Warm, welcoming (physical) environments with accessible staff

The enactment of individualisation, relational connectedness and blending knowledges creates workplace cultures that maintain personhood and dignity. Although challenging in a healthcare climate driven by clinical efficiency that often depersonalises physical environments, the little things can still mean so much to people (McCormack et al., 2011; Rockwell, 2012). Initiatives such as The Eden Alternative (<http://www.edenalt.org/>), Planetree (<http://planetree.org/>) and Kings Fund healing environment programme (<http://www.kingsfund.org.uk>) are already demonstrating how architecture and design can positively influence care experiences. Alongside homely, aesthetically pleasing environments, cultures where relationships are prioritised above task performance are therapeutic, benefitting both staff and patient wellbeing (Binnie & Titchen, 1999; McCormack & McCance, 2010; Morgan & Yoder, 2012; Tonuma & Winbolt, 2000). In a specialist palliative day centre, clients appreciated the time professionals spent welcoming and accepting them, showing consideration and understanding (Bradley et al., 2011). In dementia care, staff and environmental stimuli create feelings of belonging and self-worth. They also accommodate wandering, offer privacy, nurture community and self-determination, as well as reduce physical restraint usage (Boettcher et al., 2004a; Chenworth et al., 2011; Cherry et al., 2008; McCormack & Dewing, 2010). Unfortunately, as recent cases have demonstrated, the drive for compliance to standards, rules, regulations and targets (claimed to improve service quality) are also creating hierarchical, bureaucratic and impersonal organisations with poor quality of care (Gaventa, 2008; Ham & Hartley, 2013; McCormack, McCance, et al., 2013). As we move further into the new millennium we can only hope that care institutions relinquish the reductionist/managerialistic approach to service provision so that the 'paradox of compliance to regulations' can fade away (Gaventa, 2008).

Regular contact with person-centred professionals positively influences service user commitment to healthcare programmes (Hawley, 2009; Kitson, 2004) and people who are chronically ill feel more secure if they have easy access to professional carers (Bala et al., 2012; Ek et al., 2011). Visibility and accessibility is recommended for leaders too in order to sustain person-centred care (McKenzie & Manley, 2011; McSherry et al., 2012). Binnie & Titchen (1999) found that by consistently coming out of the office to work among and alongside nurses, a senior nurse leader improved her leadership effectiveness in transforming nursing practice.

Descriptor: Person-centred management and leaders

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Person-centeredness within leadership and collegial relationships has limited empirical evidence within the person-centred literature, despite the noted need for team and leader commitment if person-centeredness is not to become another 'buzz word' (McCormack et al., 2011). Hughes et al's (2008) review of 'centeredness', including relationship-, patient- and person-centeredness, concludes that valuing service users and staff as persons was a common theme. Valuing others needs to be enacted and traverse all organisational strata if it is to be effective (Manley et al., 2011) and the practice development principles of collaboration, inclusion and participation can aid person-centred culture development (McCormack et al., 2007). Critically reflecting on, then transforming her style of leadership Binnie (Binnie & Titchen, 1999) successfully created person-centred relationships with her team members so that they could experience what they could create, felt re-energised and rediscovered the essence of nursing as they became skilled person-centred companions to patients, families and colleagues.

Building capacity is an essential strategy for developing person-centred workplaces (Manley, Solman, et al., 2013) as commitment from a few individuals is not enough and multiple interventions are needed before team members become receptive to new ways of working (McCormack, Dewing, et al., 2010). As well as capacity, research findings on the development of person-centeredness are suggesting that not just care relationships need to be the focus of attention. Evaluating the implementation of 'whole person care', a faith-based approach to person-centred care, Joseph et al (2011) found that although nurses were enthusiastic and active in implementing the philosophy, they failed to see its use in other relationships. Kemeny et al (2004) found that despite a whole team following a person-centred care programme, nursing assistants were disappointed that their leaders failed to apply the knowledge in relation to them. McCormack et al (2010) also found that long term care sites in a nationwide Irish study developing person-centred care, those that failed to show improvements were often hindered by a lack of managerial support. Findings such as these have led to recommendations that person-centeredness be incorporated into leadership programmes (J. Martin et al., 2012) and the development of leadership models which nurses find relevant and effective. Current models derived from industry and business are often felt too difficult to transfer to a nursing context (Tonuma & Winbolt, 2000).

Several authors feel that as managers and clinical leaders learn to value person-centred relationships they are more likely to take risks in developing person-centred care and staff empowerment, include staff and service users in organisational decision-making, planning and evaluation, and develop formal learning systems (Gaventa, 2008; Kirkley et al., 2011; Koren, 2010; McEvoy & Nosowska, 2012). Evaluating a programme supporting clinical nurse leaders in developing person-centred cultures, Boomer & McCormack

(2010) found that being reflexive, facilitative and accessible for others, resulted in leaders valuing teamwork. Regular one-to-one meetings and annual appraisals are also recommended for retaining relational connectedness between leaders and staff (McKenzie & Manley, 2011).

Work-based and education programmes can be beneficial, but, workplace learning in a culture of person-centeredness is of greater importance and may be more effective. By actively engaging with staff, role modelling values in practice, facilitating participation in issue identification and resolution, encouraging experimentation and professional accountability as well as learning in and from practice, a leader can enable individual and team flourishing (Binnie & Titchen, 1999). Student satisfaction is also greater in clinical areas where participation, innovation and personalisation are valued (Alabaster, 2007; Brown et al., 2008; Koh, 2012), but such values are needed to sustain growth and development among qualified staff too. Within two years of registration, influenced by professional and organisational constraints, Maben et al (2007) found that nurses could be typified as sustained, compromised or crushed idealists. As newly qualified nurses enter 'the real world of practice' and experience value conflict between self and workplace culture, three coping narratives emerge: acceptance of/desensitisation to workplace values; suffering moral distress and contemplating resignation; or having sufficient self-efficacy to become innovative and challenge/change the workplace culture (Stacey et al., 2011). Leaders are therefore advised to change their focus from managing operations to supporting front-line staff development, actively engaging with both staff and service users (McSherry et al., 2012; Rockwell, 2012). As well as structures and processes for shared governance, creating formal systems for continuous evaluation of performance can provide input for (in)formal learning, as well as create the adaptability, innovation and creativity needed to develop/maintain workplace effectiveness (Manley et al., 2011).

In summary: Not only are warm, welcoming (physical) environments with accessible staff conducive to developing person-centred cultures, management and clinical leaders have an important role to play in fostering person-centeredness within care and collegial relationships.

PERSON-CENTRED CONCEPTUAL FRAMEWORKS AND TOOLS

Some studies in this review failed to refer to a specific conceptual framework or tool, for example, two Swedish studies that report the implementation of a model of person-centred care without naming or describing it (Alharbi et al., 2012; Carlström & Ekman, 2012). Others were more explicit, such as Tellis-Nayak (2007) who used a human relations framework to explore the role of managers in developing person-centred workplaces,

and Kirkley (2011) who used Hughes et al's (2008) 10 themes of centeredness (derived from a literature review on various types of centeredness) to explore the role of organisational culture in developing person-centred dementia care.

Conceptual frameworks for person-centred care have been developed, but, only three were referred to in the retrieved literature. Brown et al's (2008) study on workplace impact on student nurses' perceptions of working with older people used Nolan et al's (2001) Six Sense Framework. The framework states that both older people and staff should experience a sense of security, belonging, continuity, purpose, achievement and significance. Røsvik et al's (2011) study on an implementation model for person-centred dementia care used Brooker's (2004) VIPS framework. This framework states that person-centred care for people living with dementia involves **V**aluing service-users and those caring for them, treating them as **I**ndividuals, understanding their **P**erspective and creating a positive **S**ocial environment. McCormack et al's (2010) meta-synthesis of four studies to explore person-centeredness across various contexts used McCormack & McCance's (2010) Person-Centred Nursing framework in the data analysis. This framework describes nurse attributes, contextual factors, key processes and outcomes of person-centred care.

All three frameworks are embedded in a humanistic paradigm and refer to the wellbeing of both service users and care providers. Whilst the Six Senses framework and VIPS framework were developed specifically for the (long term) care of older people (living with dementia), the Person-Centred Nursing framework integrates doctoral work of two studies in both long term and acute care settings. I find this framework the most 'all round' theoretical framework as it offers a comprehensive view of person-centred practice including practitioner attributes, contextual factors, key processes and outcomes.

The frameworks could be criticised as being too abstract and difficult for nurses and care assistants to translate into everyday practice without skilled facilitation. Røsvik (2011) describes an implementation model for the VIPS framework, emphasising the need for facilitated social and work-based learning. The Person-Centred Nursing framework has been implemented using facilitated active learning processes within the workplace in both residential (McCormack & Dewing, 2010) and acute care (McCormack et al., 2008) settings. Facilitated workplace learning, as opposed to work-based learning, is more congruent with emancipatory practice development principles and a humanistic and critical approach where no precedence is given to service user outcomes above staff outcomes. This further supports use of the Person-Centred Nursing framework to developing person-centred cultures.

The Person-Centred Nursing framework brings together the complexity of person-centred practice into one framework. It states that a workplace context conducive to person-centred practices will have an appropriate skill mix of team members who work together effectively to meet service user needs. Structures and processes such as shared decision-making and power that enable staff and service user participation are

described. It also describes contextual factors to support innovative care as well as an aesthetically pleasing physical environment so that service users and staff experience a warm, welcoming and personal atmosphere. Professionally competent staff, committed to the job, with a clear understanding of their values and beliefs are recommended as they use well-developed interpersonal skills to build therapeutic relationships. The key processes for achieving relational connectedness are explicated and include working with patient values and beliefs, shared decision-making, moving through different levels of engagement, showing sympathetic presence and providing holistic care to meet bio psychosocial needs. The framework also describes the outcomes of person-centred practice: service user involvement in care, staff and service user wellbeing, a therapeutic climate characterised by shared decision-making, collaborative staff relationships, transformational leadership and innovative practice.

The development of tools to measure/identify person-centred contexts is still in its infancy (Edvardsson & Innes, 2010). Duff & Hurtley (2011) describe how items of the 360 Standard Framework were identified to audit the person-centred workplaces. However, these standards were identified by managers of domiciliary agencies and 'relevant studies' rather than service users or front-line staff. The validity of the standards could therefore be questioned, especially as there was no reference made to a person-centred theoretical framework either. White et al (2008) designed and tested the Person-Directed Care measurement tool, containing six dimensions: personhood, knowing the person, autonomy and choice, nurturing relationships, comfort care and supportive environment. Although conceptually robust, the tool only measures staff perceptions of person-centeredness and was tested only in long term older person care. The Swedish Person-centred Climate Questionnaire, in contrast, measures both staff and service user perceptions, has been translated into English and tested in acute care contexts (Edvardsson et al., 2010; Lehuluante et al., 2012). However, whilst the staff questionnaire contains 14 items of person-centred climates across 4 dimensions (safety, everydayness, community, comprehensibility), the service user questionnaire only contains two dimensions (safety and hospitality) with only seven items for comparison with staff perceptions. The three sub-scaled Person-Centred Nursing Index (PCNI) (P. Slater, 2006) has been tested for reliability and validity across a range of clinical settings in conjunction with the Person-Centred Nursing framework. It measures staff satisfaction as well as staff and service user perceptions of care. However, McCormack et al (2013) recommend an evaluation framework that uses data triangulation. This is logical as the original work was developed within an interpretative paradigm and an emancipatory practice development methodology is advised for person-centred practice development. Data triangulation would prevent reliance on quantitative data from the PCNI instrument and counteract fears that it was an 'aggregation' rather than 'correlation' of existing tools into a new one (Edvardsson, 2010).

The importance of supportive management and leadership to developing person-centred care is evident in all three theoretical frameworks too. The Six Senses framework states that sympathetic leadership and management are needed if staff are to sense all six attributes of person-centred dementia care. Later development of the VIPS framework (Brooker, 2011) refers to a management ethos for developing person-centred dementia care, whilst the Person-Centred Nursing framework has emphasised the importance of clinical leadership and managerial support since the beginning (McCormack & McCance, 2006). McCormack & McCance (2006) make reference to Kouzes & Posner's (2007) model of transformational leadership, along with participatory and collaborative leader approaches to developing person-centred care. In terms of leadership items in measurement tools, the 360 Standards Framework has only one theme about 'feeling valued'. This would be posed to staff in focus group interviews and possibly reveal the role of leaders and leadership styles. The Person-Directed Care tool makes no reference to leaders or leadership and the Person-centred Climate Questionnaire has only one item about staff feeling acknowledged as a person, which could be interpreted as referring to the organisation as a whole or the direct leader/manager. The PCNI contains five items inquiring into leadership practice, ranging from feeling respected and treated fair by the leader to feeling supported by management.

A CONTEMPLATIVE PAUSE

The primary aim of this literature study was to identify the core values of person-centeredness embedded within the person-centred literature and not to review the methodological rigour of person-centred research. The search produced a diverse range of article types (research, scholarly and discussion articles), goals (measuring person-centeredness, describing person-centred interventions, related concepts) and fields (nursing, medicine, psychotherapy). Although the scope could be criticised as restricting depth, it has demonstrated the wide use of the term and the complexity of developing person-centred practices. The diverse use of the term person-centeredness and paucity of explicit reference to core values meant that careful and repeated reading of texts was required before a values framework could be deduced. The disparate use of the term also supports Freeth's (2007) concern that person-centeredness could become the latest 'buzz' word that lacks depth and, hence, McCormack et al's (2010) call for (advancing) conceptual clarity. Whilst Kitwood (1997) is often quoted, one should also remember that he defined personhood, not person-centeredness or person-centred care. His work did, however, produce care principles for person-centred dementia care which have been consequently used as a theoretical framework for studies on person-centred dementia care education (Boettcher et al., 2004) and its implementation (Chenworth et al., 2011).

The person-centred literature retrieved for this study predominantly focused on care relationships, despite talk of person-centred practices and person-centred cultures. The few implementation studies that have been undertaken do draw attention to the importance of context and leadership in developing person-centred care, but only a transformational style of leadership is referred to. Leadership is known to play a significant role in organisational/workplace culture and change, and it was clear from the literature that changing the ways things are done (practices) within the workplace is essential to developing person-centred care. As person-centeredness is a relational concept embedded in the interaction between people, a broader scope of relationships attended to would seem appropriate, for instance, leadership and collegial relationships. Having read the literature thoroughly, I personally was left with the thought that if we assume people tend to treat others as they themselves are treated, developing person-centeredness would include attending to all relationships and practices. However, this leaves a question about which style of leadership would be most appropriate for developing person-centred cultures? Using the framework of values and descriptors derived from the above literature study, I embarked on an exploration of leadership models frequently referred to in nursing literature to see which, if any, shared the same values. Six leaderships were reviewed and are presented in the following section of this chapter.

LEADERSHIP MODELS

The importance and role of leadership in developing person-centred care and effective workplace cultures has been implicitly and explicitly acknowledged in the literature studied for the above review. Only one leadership style was explicitly referred to, and no reference was made to leadership theories. Leadership theories can generally be categorised into one of four groups, reflecting theory development across time. The earliest *Great Man/Trait* theories claimed that effective leaders are born with certain traits. However, when research failed to identify a stable set of traits, *behavioural* theories started to emerge which claimed that effective leadership could be learnt. The discovery that contextual factors were influencing leader behaviour gave rise to *Situational/Contingency* theories, which advise leaders to diagnose a situation before responding. More recently, concerns about leader morality have moved focus onto *relationship* theories, focusing on the interaction between leaders, followers and context.

Modern clinical nurse leaders are being repeatedly called on to morally manage challenging healthcare workplaces and workforce issues, and researchers to examine the relationship between specific leadership styles and outcomes. A systematic review by Cummings et al (2010) highlights how relationship focused leadership practices are significantly improving nursing workforce, environment, productivity and effectiveness,

especially when compared to more traditional task-orientated, autocratic and bureaucratic styles. To explore which leadership styles may be relevant for clinical nurse leaders wanting to develop person-centred practices, I selected five leadership models frequently referred to in nursing literature and which explicitly focus on leadership relationships and/or contextual influences. The leadership styles included were: authentic leadership (Avolio et al., 2004), servant leadership (Greenleaf, 2003), transformational leadership (Bass & Riggio, 2006), situational leadership (Hersey et al., 2001) and congruent leadership (Stanley, 2006, 2006a). A sixth model, person-centred leadership (Plas, 1996; Plas & Lewis, 2001), was included but deviates from the others. It was neither developed in healthcare nor referred to in healthcare literature, however, I felt it could prove a useful comparative for the other five models because of its explicit reference to person-centredness.

To explore the extent that each leadership style shares the same values and descriptors as those identified in the literature study, each is described in detail and Box 6 offers an overview of which (coded) style positively refers to which value and descriptor.

Value	Descriptor:	U ¹	V	W	X	Y	Z
Individualisation	Respecting uniqueness and diversity	✓	✓	✓	✓	✓	
	Understanding the person in context	✓	✓	✓	✓		
	Flexible individualised interventions	✓			✓	✓	
Relational Connectedness	Interpersonal skills for trust and partnership	✓	✓	✓	✓	✓	✓
	Altruistically caring and compassionate	✓	✓	✓			✓
	Being present and communing creatively		✓				
	Empowerment through challenge and support	✓	✓	✓	✓		✓
Blending Knowledges	Knowing self and other	✓	✓	✓		✓	
	Professional knowledge			✓	✓	✓	✓
	Blending knowledges					✓	
Supportive cultures	Warm, welcoming environments with accessible staff	✓	✓		✓		✓
	Person-centred management and leaders	✓	✓	✓			

Box 6: Aligning leadership styles with person-centred values and descriptors.

¹ Each letter U-Z corresponds with one of the leadership models presented and models are placed in order of degree of congruency with the person-centred values framework

(U) Person-Centered Leadership

As can be expected and seen from Box 6, person-centered leadership shares the most values and descriptors with the person-centred values framework. It evolved from naturalistic inquiry into profit (Plas, 1996) and non-profit (Plas & Lewis, 2001) organisations. It is defined as:

“a unique form of participatory management that directs as much attention to the individual as to the team, requires senior leadership to be responsible for empowering people at all levels of the organization, and develops quality through continuous attention to organizational culture and system processes” (Plas & Lewis, 2001, p. 35).

As participants referred to the heart, caring, needs and feelings, Plas (1996) saw authenticity and related individualism as core concepts. When person-centered leadership is the chosen leadership style, authenticity within the workplace is encouraged and people no longer feel a need to separate the ‘public’ from the ‘real’ self. They feel connected and committed to the organization and “work is enjoyed for its own sake rather than a means to an end” (Plas, 1996, p. 196). Clearly defined roles, shared responsibility, visioning and decision-making enable effective teamwork as both strengths and weaknesses are accepted. People pull together for personal satisfaction and for the common good.

Plas and Lewis (2001) criticise management trying to replicate the Japanese approach to quality management as Eastern collectivist values clash with the American ‘each for their own’ rugged individualism. Related individualism is proposed as a viable alternative as it acknowledges interdependency and values equity, placing equal importance on the growth, development and wellbeing of the organisation, staff and service-users. Leadership is enacted person-by-person rather than problem-by-problem. Front-line workers are empowered and generate creative ideas rather than have them imposed (Plas & Lewis, 2001).

Although person-centered leadership can be learnt by anyone, knowing self is considered a pre-requisite to building relational trust (Plas, 1996). Like servant leaders (Greenleaf, 2003), person-centred leaders ask the vital question: “What do others need of me?” They operate primarily at the micro/meso-level of an organisation (Plas & Lewis, 2001). Like transformational leaders (Bass & Riggio, 2006), they aim to develop the leadership skills of all whilst acknowledging Argyris’ (1998) warning that not everyone can be empowered all the time. Affording equal importance to the individual as the whole team, internal motivation and commitment is nurtured alongside growth, development and wellbeing. Burnout is claimed to be lower and creativity, quality and organizational success greater. However, I have found no empirical studies except for the original research. Whilst the values of creating supportive cultures and individualisation were clearly reflected in this model, descriptors of presencing, partnership and balancing challenge with support, were not overtly present. The blending of multiple sources of knowledge was only discussed in terms of knowing self and other.

(V) Authentic Leadership

Built on the concepts of authenticity and trust, authentic leadership is the genuine wanting to serve and empower others to make a difference in the workplace (George,

2003) and as such is highly congruent with the person-centred values framework. Authenticity is described as “the unobstructed operation of one’s true, or core self in one’s daily enterprise” (Kernis, 2003, p. 13) and implies knowing self. Authentic leaders facilitate self-actualization, the flourishing of self and others in fulfilling their unique potential. Although limited, some research studies link emotional intelligence with authentic leadership and authentic leaders are seen as highly self-aware, continuously seeking to understand their strengths, purpose, core values, beliefs and desires (Wong & Cummings, 2009). Relational trust is built through demonstrating congruency between espoused and lived values (Avolio et al., 2004). Transparent about their being, thinking and doing, these leaders value individualisation, seek feedback and are open to alternative points of view (Avolio et al., 2004).

Described as a theory and model (see Figure 1 p.41), authentic leadership is a ‘root construct’ of positive leadership. Avolio et al (2004) claims that authentic leaders inspire, serve and transform others into committed team members. Leader honesty, benevolence and commitment to follower development, inspires hope, positive emotions and optimism. Followers feel comfortable and more confident in completing tasks and achieving (shared) goals. No preference is given to directive or participative leadership approaches, only that the leader leads with morality, resists external behaviour regulation and dares to show vulnerability (Avolio et al., 2004; Wong et al., 2010). Aiming ‘to do the right thing(s)’ they engage with followers, altruistically balancing needs and perspectives before making decisions or taking action (Avolio et al., 2004; Wong & Cummings, 2009). Commensurability (shared values and beliefs between team members and leader) enhances relational connectedness as followers feel the leader’s (positive) presence and understanding (Avolio et al., 2004). However, the model does not discuss leader response to a clash of values nor the possibility of reciprocal influencing (Wong & Cummings, 2009). Leader influence is felt to be the consequence of followers identifying with the leader and group values (Avolio et al., 2004). Whilst organisational culture, power, politics and structure are accepted as influencing forces (Avolio et al., 2004), research in this area is lacking.

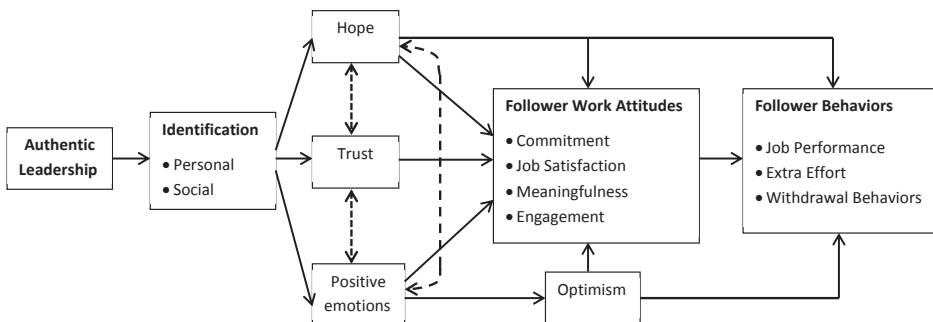


Figure 1: Authentic leadership framework (Avolio et al., 2004)

Wong & Cummings' (2009) systematic review concluded that although authentic leadership may be a viable model for effective nurse leadership, research is lacking. I only found seven studies referring to authentic leadership between 2009 and 2013, all of which were conducted in the USA and Canada. Survey data has shown positive relationships with staff nurse structural (as differentiated from psychological) empowerment, interdisciplinary collaboration and willingness to voice concerns in order to create better conditions (Giallonardo et al., 2010; Laschinger et al., 2013; Wong & Laschinger, 2013; Wong et al., 2010). Except for one narrative inquiry among chief nurse executives (Murphy, 2012), no qualitative studies within nursing were found. Whilst most values and descriptors of person-centeredness can be found in descriptions of authentic leadership, no reference is made to individualising leader interventions, using professional knowledge or blending knowledge from multiple sources.

(W) Servant Leadership

Servant leadership emerged amidst discontent with traditional, autocratic and hierarchical modes of leadership that view people as objects and cogs in a machine. To counteract leadership that quashes passion, creativity and commitment in healthcare organisations, Howatson-Jones (2004) recommends the appointment of servant leaders chosen for their individual competency rather than hierarchical position. Greenleaf (2003) describes servant leadership as a philosophy lived by individuals who consciously decide to serve others and has the potential to create positive changes throughout society. His grand view of leadership describes moral leaders who acknowledge human fallibility and altruistically work towards the greater good. Servant leaders are claimed to enable follower self-actualisation (Greenleaf, 2003) and create collaborative and participative teams/communities that improve the (caring) quality of institutions (Spears, 2003). Only those leaders who prove themselves trustworthy will gain follower loyalty and commitment and can be considered servant leaders (Greenleaf, 2003). Reminiscent of Kitwood's (1997) definition of personhood, servant leadership seems to be a standing or a status bestowed on one human being by others. In light of the descriptors referred to, such as altruistic caring, understanding the other in context and empowerment, this may be due to servant leaders living the values of individualisation and relational connectedness.

As well as being visionary, articulate, attentive listeners, reflexive, non-judgemental, empathic and insightful, servant leaders have foresight, are mindfully aware, persistent and persuasive (not coercive). They want to make self and others whole and are prepared to show humility and vulnerability. Inspiring and supporting making the impossible possible, they encourage leadership development in all. Whilst Spears (2003) describes 10 characteristics of the servant leader, Russell and Stone (2002) based a hypothetical model of nine functional and 11 complementary attributes on a literature review (see Figure 2 p.43). Assuming that the individual leader's personal values and beliefs match the nine

functional variables, the level/intensity of them is moderated by the 11 complementary variables and organisational performance (which itself is influenced by organisational culture and employee attitudes and behaviour). This model captures the mutual influencing between leader and context found in person-centeredness.

Whilst servant leadership is often praised and recommended for nurse leadership, empirical research is lacking. Sturm (2009) did conduct an ethnographic study and found that leaders in consultant roles, such as clinical nurse specialists and pastoral care workers, demonstrated more servant leader attributes in their relationships with nurses than formal, hierarchical nurse leaders. The nurses felt respected and valued when these leaders listened and empathised with them. The leaders regarded undivided attention as more important than immediately doing what a nurse requested (Sturm, 2009). The clinical nurse specialists proved to be better equipped to help nurses see self within a wider context than the managerial leaders. Work stress seemed to influence whether or not formal leaders were attentive towards individual nurses with emotional, personal or professional issues, and whether or not they used coercive rather than persuasive power (Sturm, 2009). Nurse willingness to follow a leader was related to perceived credibility (expertise and competency) as nurses “seldom valued the direction given by a supervisor who lacked these qualifications” (Sturm, 2009, p. 87). Collaborating with leaders to finding ways of enacting a shared vision of high-quality care, despite limited (financial) resources, was valued by nurses (Sturm, 2009).

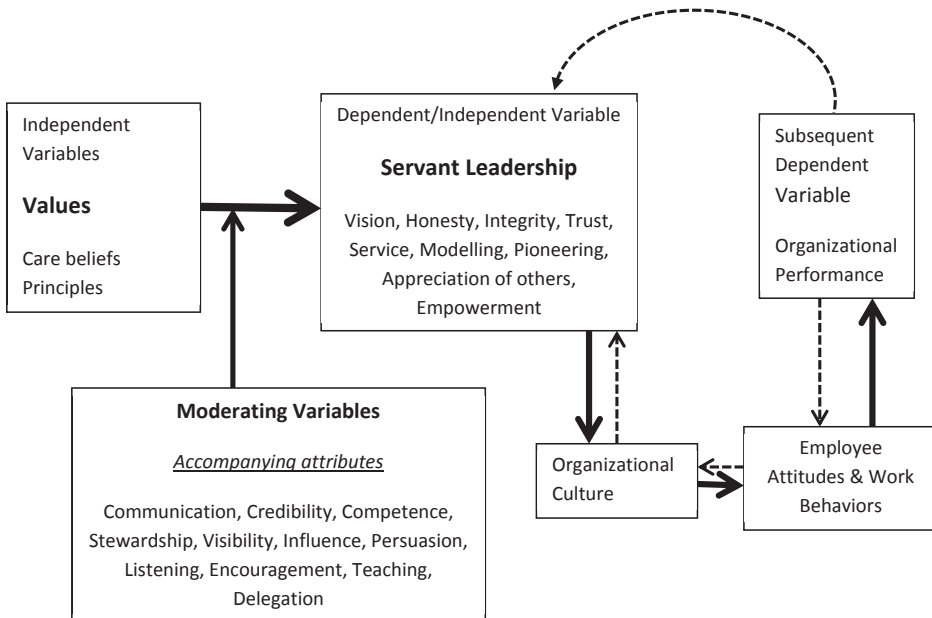


Figure 2: Model of servant leadership (Russell and Stone, 2002)

The effect of context on leader behaviour is an area that many theories fail to address. Using the term 'servant leadership' within a profession that is historically linked to religion, being the 'doctor's handmaiden', selfless dedication and limitless giving, could be met with resistance (Waterman, 2011). However, servant leadership is about stewardship, not subservience. As with transformational leadership, leader charisma is important, but, servant leadership is sooner concerned about the greater good of society than organisational goals. Working from an assumption that context can determine leadership choice, Smith et al (2004) recommend servant leadership for contexts undergoing evolutionary development in stable external environments. Transformational leadership is recommended for organisations facing intense external pressure to undergo change in order to survive (Smith et al., 2004). Whilst most of the person-centred values and descriptors are referred to in descriptions of servant leadership, no specific reference is made to individualising leader intervention, using presencing or communing creatively, nor blending knowledges or creating warm and welcoming environments.

(X) Transformational leadership

Transformational leadership is the most popular theory in contemporary nurse leadership literature and whilst it is the only specific style referred to in the person-centred literature found only seven of the twelve descriptors in the person-centred values framework could be identified (see Box 6 p.39). It has been described as human-capital-enhancing resource management, seeking to align the interests of the individual with those of the organisation and enable performance that exceeds expectations (Hutchinson & Jackson, 2013). James Burns originally conceptualised leadership as being predominantly transactional or transformational in 1978. Later the Full Range Leadership Model was designed (see Figure 3 p.45), followed by the Multifactor Leadership Questionnaire to identify it (Bass & Riggio, 2006). Influenced by the Full Range Leadership Model, Kouzes and Posner's (2006) define transformational leadership as consisting of five practices (see Figure 4 p.47) and the Leadership Practices Inventory was designed to measure it.

The Full Range Leadership Model describes three main styles of leadership. Whilst each leader demonstrates elements of all three styles, the preferred/dominant style is measured using the Multifactor Leadership Questionnaire. Laissez-faire leaders are the least effective and are passive, avoid decision-taking, responsibility or the use of authority. Transactional leaders actively and/or passively monitor processes and use reward and discipline (inter)actions to lead (Bass & Riggio, 2006). Contingent rewarding is a leader behaviour that bridges transactional and transformational leadership. Material rewarding for performance is more characteristic of transactional leaders, and psychological rewarding of transformational leaders (Bass & Riggio, 2006). Transformational leaders are more relationship focused, aiming for empowerment rather than compliance, which reflects a descriptor of relational connectedness in the person-centred values framework (see

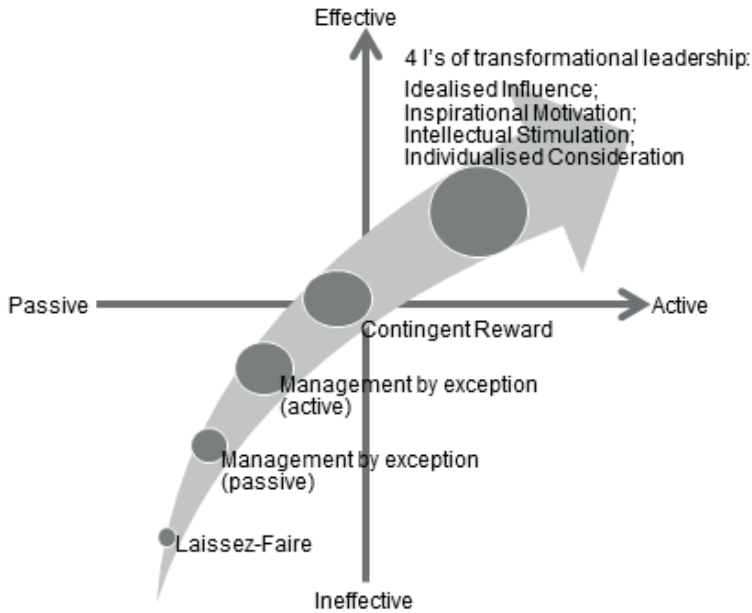


Figure 3: Full Range Leadership Model

Box 6 p.39). Empowerment is said to be achieved through four characteristics. Idealised influence entails ethical and moral risk-taking where leader consistency is admired, respected and trusted. Inspirational motivation is used by charismatic and visionary leaders who inspire and motivate. Intellectual stimulation encourages the use of intelligences to find innovative and creative solutions to problems. Individualised consideration is most reminiscent of person-centeredness. It encompasses seeing and mentoring followers as unique, whole individuals and so reflects the value of individualisation in the person-centred values framework.

In nursing, transformational leadership has been shown to positively influence staff wellbeing and performance, although context is another influencing factor. It has been found to positively influence nurses' intention to stay, organisational commitment, levels of stress, job satisfaction and empowerment (Abualrub & Alghamdi, 2012; Cowden et al., 2011; Gullo & Gerstle, 2004; McGuire & Kennerly, 2006; Stordeur et al., 2001). Kanste et al (2009) showed greater willingness to exert extra effort when followers experience transformational leadership. However, Salanova et al (2011) found that willingness to go the extra mile is mediated by self-efficacy and work engagement and that work engagement was the strongest predictor of extra-role performance. Context is also influential and Al-Hussami (2009) found that job satisfaction and perceived organisational support were more strongly related to organisational commitment than transformational leadership. Considering these findings along with other research showing a positive correlation

between transformational leadership and positive (psychosocial) work environments (Cramm et al., 2013; Malloy & Penprase, 2010; Marchionni & Ritchie, 2008), it becomes clear that leader relationships, individual followers and the context may be of importance for creating effective (person-centred) workplace cultures.

Staff who rate leaders as being transformational tend to be more satisfied with their leaders, perceiving them as more effective and willing to put in more extra-effort than other leader styles (Casida & Parker, 2011; Kanste et al., 2009; Randall Andrews et al., 2012; Spinelli, 2006). In a systematic review, Cowden et al (2011) concluded relationship focused transformational leaders are more likely to retain staff. However, no references are made in the transformational leadership literature about being altruistically caring and compassionate or showing presence, strong descriptors of relational connectedness.

The relational and empowerment focus of transformational leadership, along with the aforementioned findings, make it attractive to a person-centred paradigm. However, of the nine studies reporting follower Multifactor Leadership Questionnaire scores, seven showed that 'individual consideration' and 'intellectual stimulation' were the least frequently experienced characteristics (Abualrub & Alghamdi, 2012; Casida & Parker, 2011; Kleinman, 2004; Malloy & Penprase, 2010; Salanova et al., 2011; Spinelli, 2006; Stordeur et al., 2001), which implies that transformational leaders rely mainly on idealised influence and inspirational motivation to achieve their aims.

Kouzes & Posner's (2007) model also focuses on the leader-follower relationship. Transformational leaders are said to be effective in whatever organisational role they find themselves when they: share their values and practice what they preach (modelling the way); dialogue with and enlist others to share their dreams (inspiring a shared vision); constantly evaluate and challenge the status quo, experimenting and taking risks for innovation and change (challenging the process); build trust, self-efficacy and collaborations to enhance individual strengths (enabling others to act), and care for individuals and celebrate achievements (encouraging the heart). Although caring is named by Kouzes and Posner (2007), one could question whether this is altruistic or a means of encouraging followers to exert extra effort and follow the leader's vision.

Leadership development programmes using Kouzes & Posner's model have shown positive outcomes. Dierckx de Casterlé et al (2008) found that Belgian leaders undertaking the RCN leadership programme were sooner proactive partners than victims of the hospital system. Other programmes have shown significantly higher Leadership Practices Inventory scores post intervention (Duygulu & Kublay, 2011; J. Martin et al., 2012; Wang et al., 2012), but, leaders tend to perceive themselves as more transformational than their followers (Duygulu & Kublay, 2011; Hendel et al., 2005; Kleinman, 2004; McGuire & Kennerly, 2006).

Context should not be disregarded when exploring transformational leadership. Al-Hussami (2009) found that job satisfaction and perceived organisational support were

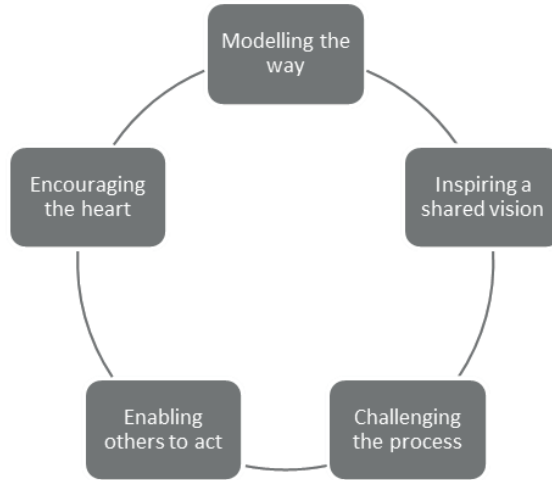


Figure 4: Five Practices of Exemplary Leadership

stronger predictors of organisational commitment than transformational leadership in long-term care facilities. Sturm (2009) suggests that contextual pressures may negatively influence a leader's ability to maintain a transformational style of leadership. Leadership influence has been shown to be mediated by perceived structural empowerment (organisational structures providing access to resources, support and information for effectiveness and growth) (Laschinger et al., 2011) and staff on UK Nursing/Practice Development Units experienced more transformational leadership than conventional wards (Bowles & Bowles, 2000). Gullo & Gerstle (2004) found a (albeit weak) negative correlation between transformational leadership and follower job satisfaction in a hospital undergoing environmental restructuring, which seems strange when transformational leadership is claimed to be more appropriate in unstable environments (Smith et al., 2004). Stordeur et al (2001) also failed to find an effect of transformational leadership as a whole, and contingent rewarding in particular, on nurse emotional exhaustion, whilst stress from the physical and social environment, role ambiguity and active management-by-exception were significant predictors.

Exploring and developing the consultant nurse role in a participatory action research study, Manley (2001) used Kouzes & Posner's model of transformational leadership and was successful in achieving a sustainable effective workplace culture. As a consultant nurse working on an intensive care unit, she worked frequently with/alongside staff. Patrick et al (2011) proposed that the frequency of leader-follower contact may influence follower perception of leadership style, and Laschinger et al (2011) found that senior management had less influence on front-line managers than middle-management. Meyer et al (2011) also found that when highly transformational leaders had 'compressed'

operational hours and a wide span of control, staff satisfaction was lower. These findings suggest that leaders need to be aware of their leadership style and be accessible in order for them to be effective.

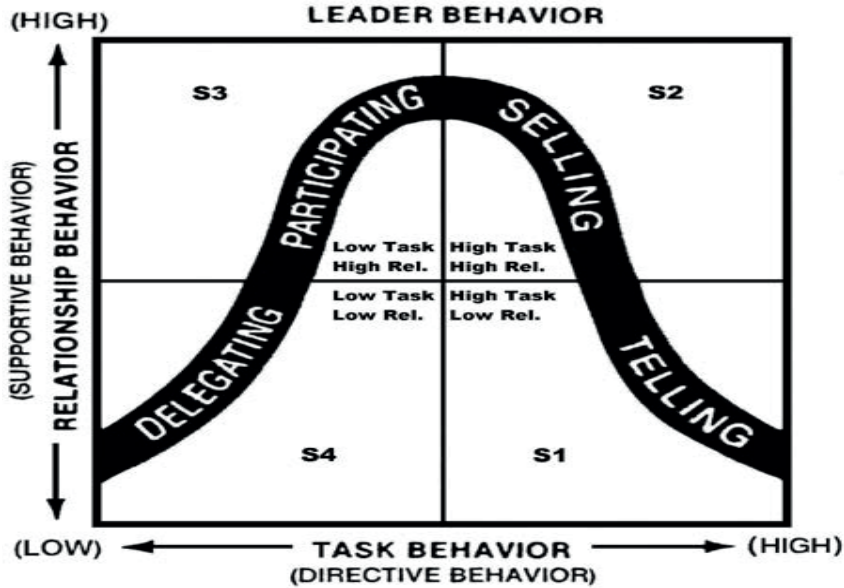
Hutchinson & Jackson (2013) are very critical of transformational leadership in nursing as it was developed in a male business/military context, which may also explain why only two of the four descriptors of relational connectedness in the person-centred values framework were found in the literature studied. Hutchinson & Jackson (2013) claim that there is a lack of consideration for influential concepts such as power, politics, domination and resistance. They also view the dichromatic approach separating transformational from transactional leadership debatable, although, Bass and Riggio (2006) have since repositioned 'contingent rewarding' to bridge the two styles. Hutchinson & Jackson (2013) also argue that the majority of leaders studied are already in posts designed to influence followers, culture and productivity, so relatively little is known about the leadership of informal leaders. As they critique the lack of inquiry into leader integrity, so too is Reinhardt (2004) critical of transformational leaders who 'enlist' followers to share the leader's vision and focus on rational intelligence. She calls for post-modern approaches that enact principles of collaboration, inclusion, participation and value all forms of intelligence.

(Y) Situational Leadership

In 2001, Hersey, Blanchard & Johnson renamed situational leadership theory a model as they felt too much was expected of leadership theories in terms of 100% prediction. It is a normative approach to leadership using applied behavioural science to determine how a leader should respond to follower readiness/development in performing a desired task. The authors see situational leadership style as behavioural patterns observed by others and the leadership process as a function of leader, follower and situational interaction (Hersey et al., 2001). Effectiveness is achieved when the leader successfully diagnoses the task, follower and situation, then adopts an appropriate style to meet (superior, follower, organisational, job etc.) needs and demands. Hersey et al (2001) claim that anyone can learn to be a situational leader, in any context, but the emphasis on task performance and lack of focus on relational connectedness or creating supportive cultures, may reduce its applicability for developing person-centeredness.

Situational leadership has four basic leader modes (behaviour styles) related to the degree of task direction and relational support needed to successfully achieve task completion. Follower 'readiness' to complete the task at hand is a combination of 'willingness' and 'ability'. Each level of readiness (R1-4) corresponds to a leader mode (S1-4) and effectiveness is achieved when the leader matches mode (S) to follower readiness (R) (see Figure 5 p.49).

In 1985, Blanchard et al changed terminologies to "reflect learnings from experience, research on individual learning and group development, extensive feedback from management clients, and from colleagues at Blanchard Training and Development" (Blanchard



R4	R3	R2	R1
Able, willing/confident	Able, unwilling/ insecure	Unable, willing/ confident	Unable , unwilling/ insecure
D4	D3	D2	D1
High competence High commitment	High competence Low/variable commitment	Low competence Low commitment	Low competence High commitment

Figure 5: Situational leadership model with levels of follower readiness/development

et al., 1993, p. 24). The four S's became 'directing' (S1), 'coaching' (S2), 'participating' (S3) and 'delegating' (S4). 'Readiness' was replaced by 'development', determined by 'commitment' and 'competency'. Graeff (1997) felt there was no justification for this terminology change as 'competence' is just a fashionable synonym for 'ability' and few studies had tested the model or tools. His critique of situational leadership extended to include inconsistencies, incongruences, ambiguities and the succumbing to 'quick-fix' and 'management fad' hypes (Graeff, 1997).

Lynch et al (2011) have combined situational leadership with the Person-Centred Nursing framework (McCormack & McCance, 2010) to create a leadership model for the development of person-centred nursing in residential care. Development of follower attributes needed for person-centred nursing (professional competency, interpersonal skills, self-knowledge, clarity of own values and beliefs and commitment) are used to determine leader mode (S1-S4). This model is currently being tested in a doctoral action research study.

Published research on situational leadership in nursing is limited to a few Portuguese studies (García García & Santa-Bárbara, 2009; Lourenço et al., 2005) which have conceptual and methodological weaknesses. Norris & Vecchio (1992) failed to find support for situational leadership in nursing as measurement was problematic and there was a lack of evidence for predicted outcomes when leader behaviour matched follower readiness, especially around 'delegating'. Hersey et al (2001) state that leaders in supervisory roles (such as ward charge nurses) tend to prefer a S1/2 mode, wanting to be in control, which would prevent the staff empowerment needed for delegation. In a Dutch study examining the relationship between leadership style and absence due to sickness, Schreuder et al (2011) found that whilst four out of six nurse managers showed effective leadership and lower levels of short-term sickness, the most frequently identified modes were S1 and S3. Hersey et al (2001) state that leaders showing a preference for S1/3 modes show preferential treatment, supporting those they consider 'with them' and closely supervising those they consider 'against them'. They tend to have a negative view of followers, use coercive power and use reward and punishment to achieve effectiveness.

Although respecting uniqueness and diversity and being flexible in leading others is described in situational leadership, leaders who show a preference for any mode would not be living the value of individualisation and so could not be considered person-centred. The focus on task performance and competency implies that situational leaders do not have to see the whole person in context, which compromises the valuing of individualisation. There is also minimal reference to descriptors indicative of trying to achieve relational connectedness and no reference to creating warm, welcoming environments.

(Z) Congruent Leadership

Stanley's (2006) grounded theory is the only model of leadership that was developed within nursing. Initially, a survey questionnaire asked UK nurses to label 42 leader characteristics (derived from a literature study on transformational and transactional leadership) as most or least characteristic of clinical leadership. The response rate was low (22.6%), but, the 'top five' attributes included: being approachable, clinically competent, motivating, supportive and inspiring confidence. Subsequent in depth, semi-structured interviews with a random selection of respondents provided more information on desired clinical leader attributes, and included: clinical competence and knowledge; effective communication and decision-making; role modelling; empowering and motivating; being visible, open and approachable. Asking respondents to name ideal clinical leaders, Stanley approached nominees for an 'insider' perspective. Although surprised by their nomination, these leaders were passionate about delivering high quality care and prepared to role model their values and beliefs. With only three of the eight interviewed having undertaken formal leadership education, clinical leadership was viewed as a personal quality linked to how one related to others rather than a formal position. Balancing clinical and managerial

responsibilities was an issue for these leaders, as was maintaining morale within a team. Theorising his findings, Stanley (2006a) defined congruent leadership as:

“where the activities, actions and deeds of the leader are matched by and driven by their values and beliefs about (in this case) care and nursing. Congruent leaders may have a vision and idea about where they want to go, but this is not why they are followed. Congruent leadership is based on the leader’s values, beliefs and principles, and is about where the leader stands, not where they are going.” (Stanley, 2006a, p. 138)

Whilst recognising similarities with authentic leadership, Stanley (2006a) differentiates congruent leadership from transformational leadership in terms of the approach to vision and motivation. Unlike transformational leadership where leaders try to ‘enlist’ followers, congruent leadership is more focused on inspiring and empowering others to join the leader in providing high-quality patient-centred nursing (Stanley, 2006a). Interestingly, Stanley (2006a) repeatedly refers to Manley’s (2000) work, although, she refers to Kouzes & Posner’s (2006) model of transformational leadership when discussing her leadership.

People are said to be more inclined to follow the leader when they experience congruency between what the leader says and does, and leaders are less likely to compromise their values and beliefs in order to achieve organisationally imposed goals (Stanley, 2006a). This implies a strong focus on building good relationships with staff and descriptors of valuing relational connectedness were found in Stanley’s publications. However, no descriptors were found indicating that the congruent leader values individualisation and little discussion found on which types of knowledge were needed/valued. Congruent leadership supports the notion of ‘grass roots’ leaders, promoting clinical leadership development and the creation of warm and welcoming physical environments. With no subsequent research found since Stanley’s original doctoral work, congruent leadership may still need further development before it could be considered relevant for developing person-centred cultures.

A CONTEMPLATIVE PAUSE

Several points have stayed with me whilst reading literature on the six chosen leadership models. Person-centered leadership and congruent leadership had no visual representation of their model and I can imagine practitioners may find it difficult to rely on the written word to guide their practice in practice. Of the twelve descriptors of person-centeredness, a maximum of nine were found in literature on person-centered leadership and authentic leadership. Congruent leadership scored the lowest with only five descriptors found in the literature, but, this may be related to the lack of published work using congruent

leadership theory. Some descriptors were only occasionally or indirectly referred to, i.e. presencing, balancing challenge with support, blending different sources of knowledge to inform action, and creating warm and welcoming environments. Collectively, the models covered all core values and descriptors except for communing creatively.

I was struck by the prolific use of the term 'follower' by the majority of authors. Dictionaries usually define 'follower' as someone who supports and admires a particular person, a fan, an enthusiast, a servant or subordinate. Such images are incongruent with the picture painted by person-centred literature, where collaboration and partnership are valued as people (regardless of role) are viewed as being of equal value. Plas & Lewis (2001) use the term associate instead of follower as "individuals are motivated to think of themselves as associates who labor within a learning environment" (Plas & Lewis, 2001, p. 160). This term seems more appropriate for a person-centred paradigm. Dictionary definitions of associate refer to 'existing in connection' and partnership, terms not uncommon in everyday discourses.

Each leadership model had its strengths and weaknesses in terms of person-centred values. Situational leadership has as its strength the proposition that by diagnosing (although I prefer the term 'assessing') associate readiness/competency for task completion, the leader is able to respond appropriately. This is also its weakness as the focus is organisation and tasks rather than the person, and the whole person is not seen in context. Servant leadership has as its strength the premise that by positioning self as an enabler of others, the leader can exercise a moral stance of contributing to the greater good of all. This resonates with the person-centred aim of empowering others through relational connectedness. Unfortunately, the term 'servant' does not conjure images of equity and may be unattractive to front-line nurse leaders due to the historical influences as mentioned earlier. Moreover, they may also see the ultimate aim of contributing to the greater good of society as being too far from their practice world. Transformational leadership also aims to enable (transform) associates and context, and the 4 I's offer processes to guide leader behaviour. Whilst the 'what' of leadership is described, little is said over 'who' transformational leaders are in terms of characteristics, values and beliefs. Bass & Riggio (2006) also warn of 'pseudotransformational leaders' who may demonstrate the 4 I's, but, not be acting with moral intent. In contrast, authentic and congruent leadership place emphasis on the leader as a person who knows self, is open and transparent in their being, and promotes cultural authenticity.

Person-centered leadership is explicit in referring to the strength of building partnerships with associates. The concept of partnership within leadership relationships suggests a belief in intersubjectivity. Reading the literature I often observed that authors viewed leadership outcomes as the product of only leader and not follower values, beliefs and behaviour, i.e. leader-centric and unidirectional. Seldom is the influence of the associate's role on outcomes discussed. If leadership is seen as a relational concept, intersubjectivity

and mutual influencing are unavoidable assumptions. Followship research has developed knowledge on the role of associates, but, more relational dynamic research is needed as “much work is still left to be done in moving toward the study of leadership and followership as complementary, and equally important, organizational processes” (Bligh & Kohles, 2012, p. 208). Küpers & Weibler (2008) have also called for more integrated approaches to leadership, looking at intrapersonal, interpersonal and contextual influences on leadership. They criticise the predominance of quantitative surveys, a phenomenon I also observed. This implies that there is a need for more qualitative and participatory approaches to leadership research.

CONCLUSION

‘Person-centeredness’ is a multi-dimensional concept that could be described as the essence of nursing, with concept analyses and theoretical frameworks to support it. Although predominantly found in older person nursing literature, expansion into other fields is evident. Person-centeredness is replacing previous terms such as ‘patient-centeredness’ and being expanded to cover all relationships within healthcare. Created through people being in relation, person-centeredness does not manifest spontaneously and an aim of this chapter was to identify underlying values influencing person-centred practices. Four core values and 12 descriptors were identified, forming a value system framework. The value of ‘individualisation’ leads to respecting uniqueness and diversity as one tries to understand the whole person embedded in many contexts, and being flexible in individualising interventions. ‘Relational connectedness’ requires the use of interpersonal skills to build trust and partnerships to empower others through challenge and support, and stay connected by being present and communing creatively. Person-centred practitioners ‘blend knowledges’ from different sources, combining knowledge of self, other and professional experience with propositional knowledge. ‘Supportive workplace cultures’ are warm and welcoming, staff are easily accessible and led by person-centred managers and leaders.

The person-centred value system framework was used to view the appropriateness to this study of six leadership models, most of which are frequently referred to in nursing literature. Clinical leaders wanting to develop person-centred care within the workplace would do well to consider using a leadership model that shares the same values system. Whilst transformational leadership is the most popular style researched and recommended within nursing literature, person-centred leadership and authentic leadership share the most descriptors with the person-centred values framework. Congruent leadership is the only model developed within a nursing context and yet shares the least descriptors. Each model has its own strengths and weaknesses, and collectively they embrace the whole

person-centred value system, except for communing creatively. This raises research questions about what person-centred clinical leadership would look like in a nursing context, and how it could be developed. As none of the leadership models reviewed and used within a nursing context shared all values and descriptors in the person-centred values framework, or had limitations and weaknesses that may hinder their implementation in practice, I feel it may be more appropriate to approach the exploration and development of person-centeredness within clinical nurse leadership without a leadership model and instead use the Person-Centred Nursing framework as a theoretical framework. The methodology and design of the participatory research undertaken is presented in the following chapter.

Methodology

Chapter 3



INTRODUCTION

Having presented myself, the inspiration for this study, the research context and the need to study person-centeredness within clinical nurse leadership in previous chapters, this chapter focuses on the philosophical underpinnings guiding the research methodology choice and description of the research design. The philosophical framework is comprised of assumptions associated with critical social science (Fay, 1987), critical realism (Bhaskar, 1998, 2008) and critical creativity (McCormack & Titchen, 2006). The theoretical framework guiding the work was McCormack & McCance's (2010) conceptual framework for person-centred nursing and critical participatory action research (Kemmis, 2008) was the chosen methodology. The study evolved as an orientation phase followed by four action spirals. Ethical considerations are discussed later in the chapter before closing with a description of the thematic data analysis framework used in post fieldwork analysis.

PHILOSOPHICAL FRAMEWORK

Although the research questions for this study do not immediately imply any one scientific paradigm, personal values and beliefs about leadership, its development and how it could be studied are based on certain ontological and epistemological assumptions. Critical of the often hierarchical and autocratic leadership styles I was encountering in practice, I believed that there was a 'better', more person-centred way for clinical nurse leaders to lead. In the past I had met leaders I would now consider person-centred, but, the concept is not referred to in the nursing leadership community or literature. Thinking about leadership I considered what made leaders lead the way they do and concluded that I believed that this was a combination of personal values and beliefs, as well as relational and contextual influences. The two research questions created an opportunity to generate practical and practice knowledge on what person-centred leadership is in a nursing context and how it could be developed. Based on past experiences of working in practice development, I believed that creating safe, critical and creative communicative spaces where participants could share their experiences, ideas, values and beliefs, would enable them to explore the concept of person-centred leadership inductively. There was after all no theoretical framework for person-centred leadership in nursing to be tested or guide us. Combining inquiry with individual and collaborative action planning would help the critique and transformation of personal being and contextual structures, conventions and practices that may be hindering a person-centred approach to leadership.

My personal belief that a more person-centred approach to leadership was better for all, was strengthened by the review of six leadership models, all of which shared values and goals closely aligned to person-centeredness (see Chapter 2). Thinking about

facilitating research participant leaders in overcoming barriers to a more person-centred approach brought me into contact with the critical social science emancipatory aim of enabling participants to empower themselves and create a better world for all. Reading the works of critical theorists helped me understand how we (pre)consciously contribute to the creation of the social reality we inhabit. Enlightenment to the way personal values and beliefs, social structures, conventions and practices may be restraining us from being what we feel we ought be in order to create a better world, can be empowering and instigate transformative action. A 'spiral of influence' emerged in my mind as I read Bhaskar's (1998, 2008) account of critical realism and how people socialised by the social context produce and reproduce those contextual structures, conventions and practices that may be oppressing them. Habermas' (1984) theory of communicative action helped me understand how critical dialogue could enable enlightenment and empowerment to break the reproductive cycle. Fay's (1987) description of the human condition explained how as active beings we have the capacity to transform our social reality. Working with (and later supervised by) Brendan McCormack and Angie Titchen, helped me see how creativity helps overcome the limitations of rational thinking and verbal communication. Talking alone is not always productive or efficient and creative expression can help us express (pre-)cognitive and embodied knowledge freely. Space is created for people to communicate on a different plane/level. Their critical creativity theory (McCormack & Titchen, 2006) offered the final pieces for supporting the creation of critical and creative communicative spaces where people can engage in dialogue, raise awareness to influencing processes and plan actions to transform their social reality (see Figure 6 p.58).

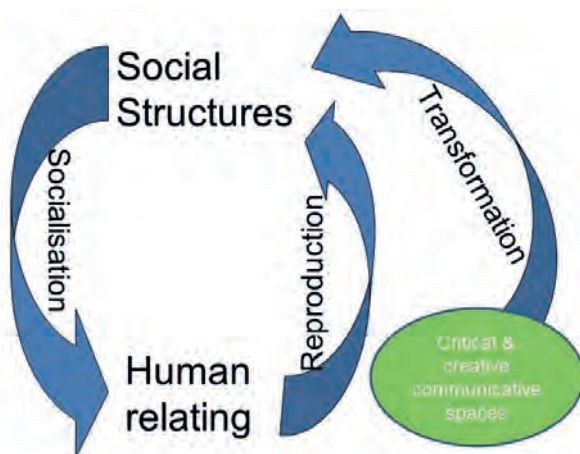


Figure 6: Visualisation of the philosophical framework

As a researcher, I envisioned that I could generate knowledge about person-centred leadership by enabling participants to reflect on their current practice within critical and creative communicative spaces. Identifying ideologies, social structures, conventions and practices that may be enhancing or inhibiting a more person-centred way of leading others would then enable its development within the local context. Moreover, gathering data of the transformational process would generate knowledge on person-centred leadership and its development within a nursing context. There was still one issue troubling me: How could I minimize the possibility that by facilitating this process I wasn't replacing one restraining reality with another? In this context my rationale was that by including data on my own leadership of the action research study, participating in the communicative spaces, including participants in decisions being made about the study and seeking feedback and critique from participants and others external to the study, I could not only contribute to data on person-centred leadership but also monitor how my being was influencing the process.

To guide the methodological design of the study and support me during fieldwork, I formulated three 'statements' to supplement the visualisation of my philosophical framework (see Figure 6 p.58). These were:

- What we perceive, think and talk about is not necessarily all that there is.
- Human relating produces a social context that influences human being
- Together we can produce transformative knowledge

"What we perceive, think and talk about is not necessarily all that there is."

My thinking about ontology began with a discussion with myself about the existence of a tree. Looking out of a window my eye caught a tree. I know things about trees, such as how they grow and what they look like, but, would the tree cease to exist if I had no sensory perception of it? My answer was 'no'. The rationale for my thinking was that there are things that exist in this world that we are, as yet, unaware of. New species of flora and fauna are constantly being discovered. Medical science also reminds us constantly that what we thought to be true is no longer the case. I remembered nursing a patient suffering from AIDS in the early 1980's and how then strict isolation was said to be necessary as AIDS was thought to be highly contagious.

Just because we do not/cannot perceive something is no reason to presume it does not exist. Our knowledge of that which we perceive is constantly evolving as we inquire into its being. Bhaskar's (2008) theory of critical realism refers to two dimensions of reality. The intransitive dimension is where objects exist independent of the human mind and are governed by stable mechanisms/processes which may or may not be known to us. As science tries to discover these mechanisms, we move into the transitive dimension of reality as knowledge production is a social activity conducted within the limits and influences of current knowledge, resources and social culture. As such, it is vulnerable to

human error and has only a “relative immunity to revision” (Bhaskar, 1998, p. 5). While the objects of our knowledge may remain constant, human understanding (knowledge) of them can be transient and transformed. What we perceive is not necessarily a whole or absolute truth. My belief was that whilst there was no scientific knowledge of person-centred leadership within a nursing context, this did not mean that it does not exist. Experimental and theoretical inquiry could reveal its existence as well as offer plausible explanations for its manifestation.

Describing the manifestation of objects in reality Bhaskar (2008) refers to a stratification of reality. What we can perceive with our senses, not only our minds, forms the ‘empirical’ layer of reality. These objects do not just appear. They are the product of ‘generative mechanisms’ (powers, liabilities or tendencies) in the ‘real’ layer of reality which, when ‘actualised’, produce events in the ‘actual’ layer. Perceived objects emerge from an ‘ontological depth’, although, if conditions are not conducive for their actualisation they may lay dormant or be counteracted by other actualised mechanisms. Although person-centred leadership may not have manifested itself in nursing literature, this may be the result of generative mechanisms not being actualised or counteracted by other mechanisms. For example, nurse leaders may find themselves in contexts that are not conducive to person-centred leadership or in contexts in which it is present and practiced, but it is not named or conceptualised.

Person-centeredness is perceived within the empirical layer of care relationships and knowledge of it is being produced, but, there has been no research on person-centeredness within nurse leadership relationships. To discover the ontology of person-centred leadership will require looking deeper than the ‘obvious’ to find and understand the ‘real’ layer. Theorising and looking with ‘new eyes’ at actual events will be needed, as well as daring to experiment and possibly actualise generative mechanisms that may be dormant or counteracted. Fay (1987) describes false-consciousness as misconceptions/perceptions of human experience, and claims the aim of critical social science is to enlighten people to their false-consciousness and enable the search for more superior ways of being. In the context of this study, critically exploring leadership experiences could raise awareness to misconceptions about current leadership: what it is, how it functions, what it produces and whether it could be classed as/become (more) ‘person-centred’.

Whilst McCormack & Titchen (2006) acknowledge the value of Fay’s (1987) critical theories, they highlight a limitation in that the theories ignore the important place that creativity plays in enabling practitioners to create new knowledge from their practice and use abstract theory in practice. They also add human flourishing to the moral intentions of social justice, democracy and equity in the critical paradigm. They state that synergising creative expression, critical dialogue and contestation enables people to perceive and understand the world they inhabit better/differently and so produce knowledge (McCormack & Titchen, 2006). Creative expression is an alternative to verbal communication and

in using creative arts in research “the focus is on expression of one’s vision, understanding, interpretation” (Titchen & Horsfall, 2007, p. 216). It has been shown to help people share more than when they are restricted to using words and raise critical awareness by making the familiar strange (Mannay, 2010; Simons & McCormack, 2007). Assuming we experience the world both in image and language, working with imagery offers more freedom of expression because language is a product of human activity and limits what and how we express meaning to those terms and concepts already known to us (Nairn, 2012). Fay (1987) draws attention to our embodiedness and how learnt values, beliefs and skills can move from a conscious/cognitive mind to take up residence in the precognition and physical body. Creative expression can be a vehicle for surfacing embodied knowledge and bypass cognitive shaping through rationalisation (constructing logical justifications) and reasoning (looking for reasons for beliefs, conclusions, actions and feeling). As an alternative to verbal communication, it can help prevent the withholding of information for fear of ridicule/reprimand, or divergence away from the core subject as discussions on semantics take over (Lieshout van & Cardiff, 2011). This is important to remember as language “is not the main object of knowledge for critical realists, but rather a route into trying to make sense of a world that is more than mere language. No matter how clumsy or accurate our use of language maybe we can still identify the difference between a useful [practically adequate] concept and one that is not” (Nairn, 2012, p. 11). Verbal communication is not discarded, only complemented by creative expression. Personal narratives can be considered a form of creative expression, whether expressed verbally or artistically, and reveal much about how events and the world are perceived, as well as the identity of the narrator (Holloway & Freshwater, 2007; Riessman, 2008). The sharing of personal narratives within critical and creative spaces could reveal much about the generative mechanisms producing them, supplementing second/third person observations and critical examination of what was observed. However, narratives may be compiled to reveal only what the narrator feels others want to know, what they feel others need to know and/or be used to mislead (Riessman, 2008). It is here that the artistic and cognitive critique McCormack & Titchen (2006) discuss in critical creativity raises inquiry from everyday conversations to scientific study.

“Human relating produces a social context that influences human being”

In his discussion on autonomy, Fay (1987) describes how we can never be completely autonomous as we are embedded in a ‘system of relations,’ a social context producing conditions which individuals rarely create themselves, or have control over, yet these conditions can still limit and influence their behaviours, perceptions and feelings. Bhaskar (1998) speaks of social conditions that pre-exist and influence (often unconsciously) human activities that reproduce or transform the social structures, conventions and practices producing these conditions. This takes us back to the spiralling process of social

structure reproduction/transformation as depicted in Figure 6 (p.58) and to Archer's (1998) use of time and the terms morphostasis (reproduction) and morphogenesis (transformation). Archer (1998) contends that previous human relating produced the social and cultural structures in the here and now, which are influencing current human behaviour (socialisation). Current human relating, under the influence of current social structures, conventions and practices, reproduces or transforms the social context that will influence future being. Following these assumptions, I will need to observe not only how existent social structures influence leader behaviour and relationships, but also which reproduced and/or transformed social structures, or structures introduced as part of the study, create conditions conducive to a style of leadership considered person-centred.

Whilst natural generative mechanisms can ontologically exist independent of human activity in the intransitive dimension of reality, social structures (as generative mechanisms) have an existential rather than causal independence from human activity (Archer, 1998; Benton, 1998). Fay (1987) and Bhaskar (1998) refer to the critical social science emancipatory intent of revealing those structures and conditions that negatively influence human being and the role human activity plays in (re)producing them. Enlightening people in the here and now to processes creating oppression and/or preventing social justice, democracy, equity (Fay, 1987) and human flourishing (McCormack & Titchen, 2006), is the first step towards transformation of the social structures that will influence the people of tomorrow. This implies that the research design should include processes to foster participant leader awareness to what influences/can influence their practice.

However, 'knowing that' and 'knowing how' is no guarantee to realising transformation (Fay, 1987). The network of events produced by social mechanisms exist extraneous to individuals and can still prevent them from achieving their desires (Fay, 1987). A leader may 'know that' being person-centred will result in happier, more committed staff, and 'know how' to be person-centred, yet lack the self-efficacy to juxtapose self to dominant leadership styles within their context. Conscious reflection on such situations and the internal moral conflict it can produce, may heighten participant awareness to how they as individuals contribute to the social environment they inhabit and so motivate them/actualisation their potential to undertake transformative action. And so the spiral of inter-relatedness can continue.

"Together we can produce transformative knowledge"

For Fay (1987), emancipation from oppressive conditions follows enlightenment to them and empowerment to transform them. Particularly in relation with others, humans have the potential to rupture, mutate or transform those social structures causing oppressive conditions because "the reproduction and/or transformation of society, though for the most part unconsciously achieved, is nevertheless still an achievement, a skilled accomplishment of active subjects, not a mechanical consequent of antecedent conditions"

(Bhaskar, 1998, p. 40). Critical social science is a means of enabling emancipation as it produces transformative knowledge in what Bhaskar (1998) describes as a continuous three phased dialectic cycle: identifying a range of phenomena, constructing explanations for them and then testing these empirically in order to identify generative mechanisms. The mechanisms identified can themselves then become the phenomena of study in a new cycle of inquiry. Consequently, knowledge is continuously challenged, refined and/or developed. This does not construct reality, only our conceptualisations (knowledge) of it, but as active beings we can self-induce and self-effect change by internalizing new concepts of self and society into our being and so instigate social transformation (Fay, 1987). In trying to develop person-centred leadership within a nursing context where it has, as yet, not been identified or developed, participants will need to be supported in identifying which ways of being could be considered person-centred, formulating explanations for this and then testing new ways of being in future practice.

As active beings we possess four fundamental dispositions (Fay, 1987) that support knowledge production and social transformation. We are curious beings who seek information about the world we live in and have the ability to reflect on our own desires and beliefs on what the 'right' thing to do/be is. As intelligent beings we have the capacity to give up old, or take on new beliefs and behaviour, based on new knowledge we have sought and our reflections. Lastly, we have the ability to be and act on our reflections and so transform self as well as our environment. Fay (1987) states that developing the capacity to question and reveal false-consciousness is to become 'wise' and Freire (1970) calls reflecting and acting in order to change the world we live in, 'praxis'. Linking these beliefs with Bhaskar's (1998) statement that science should problematize and analyse (critique) conceptualisations of reality then test them in practice, this study should aim to foster wise leaders with regards to person-centred relationships through praxis. Even if expected outcomes do not manifest, theories with practical-adequacy can be developed for others wishing to engage in exploring and/or developing person-centred leadership.

The production of knowledge and transformation of society is not conducted by individuals in isolation. Discussing human existence, Macmurray (1949) states that people need to interact as this constitutes the community/society they need in order to feel like a person. Building on the idea of interdependency, Bhaskar (1998) rejects individualism, claiming that society is not produced by the sum of individual actions but by the inter-relating between them. Fay's (1987) adds a further depth to the idea of interdependency by stating that exercising curiosity, reflectiveness, intelligence and wilfulness requires interaction with others. These assumptions suggest that collective and collaborative processes will be needed to explore and develop person-centred leaders and knowledge. In relation we learn about self, others, the group, the world we share and alternative ways of being. Learning about potentialities and inadequacies can also stimulate the will to

change self and existing social structures, although knowledge alone is insufficient. People need to feel/be free to inquire and transform.

Critical social scientists and critical realists have a specific view on freedom. Freedom entails knowing one's interests, having the ability, resources and opportunity to act on achieving them, and being disposed to do so (Bhaksar, 1998). These are areas needing consideration in designing a study in which participants are studied as they explore leading others in a more person-centred way. The research methodology needs to accommodate/focus on creating structures producing conditions for participants and I to exercise our curiosity, reflectiveness, intelligence and wilfulness to reproduce/transform social structures conducive to person-centred leadership and research. Habermas' (1987) concept of communicative spaces as 'ideal speech situations' for 'truth-telling' is relevant here. He discusses interrelatedness between humans who are 'in' their lived world and which is 'in' them (Finlayson, 2005). He refers to the 'lifeworld' of linguistically created shared understandings kept alive through constant reaffirmation, and 'systems' responsible for material reproduction. For Habermas (1987) transformation of the lived world (social reality) can be achieved through communicative action, which is collective and collaborative human activity based upon a rationale arising from public critique, contestation and debate. The process of "intersubjective agreements, mutual understanding and unforced consensus about what to do" (Kemmis, 2008, p. 122) takes place within communicative spaces where individuals are recognized and heard (Gurevitch, 2000). Although Habermas makes no specific reference to psychological safety, Gayá Wicks & Reason (2009) name creating a sense of safety for differences to be expressed without fear as an important element of opening communicative spaces. Brown & McCormack (2011) also found psychological safety to be an essential theme when facilitating practitioners in transforming their practice. From a critical realist stance, the safe and critical process becomes a generative mechanism that can potentially produce events to transform social structures and ultimately influence future being.

Psychological safety is important as becoming 'enlightened' to the 'as-yet-undiscovered' can be catalytic or detrimental to the quest for intersubjectivity. Consciously choosing between rejecting, maintaining and/or transforming tradition and personal identity can be highly challenging for people. For instance, having been challenged to juxtapose self to a dominant non-person-centred leadership culture, leaders may experience difficulty in accepting how they themselves may have contributed to such a culture. Such confrontations with self can be extremely painful and so, as a facilitator and researcher, I needed to be sensitive towards this moral dimension of social science without shying away from questions such as: "Is this the right thing to do? For whom? What are the possible consequences?" nor from supportive processes such as sympathetic presence (McCormack & McCance, 2006) or graceful care (Titchen, 2000).

Whilst I believe that knowledge of social reality is co-created, with individuals contributing personal perceptions and theories into a (transitive) pool of knowledge, people do not always perceive reality under the same conditions and so difference in meaning is to be expected. For instance, personal history may have resulted in embodied ways of being which a person is no longer conscious of until engaging in critical and artistic critique. Our perceptions are value-laden and seldom expressed as 'neutral' descriptions. Participatory research can create safe, critical and creative communicative spaces for shared understandings (knowledge) that is practically-adequate (Danermark et al., 2002), i.e. viewed adequate by those involved in its generation (Tromp, 2008) and by stakeholders.

The idea of probability, so prominent in critical realist thinking, is compatible with Habermasian ideas of communicative action. There is no guarantee that complete understanding and an agreement (consensus) among group members is attainable (Kemmis, 2008) or that they will undertake transformative action. Breaks in the process should be expected and accepted as time runs out and/or dialogues run aground (Kemmis, 2008). Habermas (1987) acknowledges that time may be an issue as creating the conditions needed for an ideal speech situation (communicative competency and speaking free from coercion) is extremely difficult. However, during temporal breaks between gatherings, actualised generative mechanisms may continue to work and/or be counteracted, which may respectively enhance or hinder the transformative process. This has relevance in terms of research design in terms of temporal spacing between collective gatherings and possible ways of fostering/maintaining dynamics between gatherings.

Knowledge is space-time dependent. It is produced with the resources available to us and within the social climate of the time (Bhaskar, 1998). Our conceptualisations of reality are naturally shared through the narratives we hold, although, in science we need to check conceptualisations embedded within narratives using (cognitive) resources such as theories and evidence available at that time (Winter & Munn-Giddings, 2001). Encouraging participant leaders to share their lived experiences/narratives for collective inquiry will aid conceptualisation of person-centred leadership. As narratives and inquiries accumulate, so will understanding of what person-centred leadership is and how it can be developed. Inquiry within a research setting cannot, for practical reasons, be a never-ending process. After the agreed period of fieldwork, the overarching narratives of person-centred leadership (see Chapter 4) and its development (see Chapter 5) will be used to create a conceptual framework for person-centred leadership and discussed in light of existing leadership research and theory (see Chapter 6).

THEORETICAL FRAMEWORK

“Facilitators all have a variety of theories and theoretical models through which they make meaning of their art and of the community or group phenomena which they are studying and attempting to facilitate” (Mackewn, 2008, p. 621).

To help participants and me to explore the concept of person-centeredness within leadership relationships I chose the Person-Centred Nursing framework (McCormack & McCance, 2010 – see Figure 7 p.67) for the following reasons. Firstly, I agree with Fotiou (2000) who sees the development of a person-centred society, where the enrichment and development of humans is the primary goal rather than the production of a greater number of goods, as the biggest challenge for the 21st century. Secondly, the rise in interest in person-centred nursing is timely and descriptions of person-centred care/nursing (Barker, 2001; McCormack, 2004; Nolan et al., 2004) uphold the values of equity, respect and reciprocity associated with a person-centred society (Fotiou, 2000). Thirdly, person-centred care is starting to appear in UK and Dutch governmental healthcare policy e.g. the UK National Service Framework for Older People (DOH, 2001); Essence of Care (NHS, 2010); The Dutch Quality Law for Care Institutions (Kwaliteitswet zorginstellingen) (VWS, 1996). Fourthly, none of the six leadership models reviewed in chapter 2 showed a complete fit with all the values and descriptors of the person-centred values framework derived from the literature study. Lastly, human flourishing as striving for potential is also associated with person-centeredness, and considered the means and outcome of critical and creative research and practice development (McCormack & Titchen, 2006).

Initially referenced in older person care (McCormack, 2004) and mental health (Barker, 2001), person-centred practice is reaching other fields such as people living with chronic illnesses (Zoffmann et al., 2008) and palliative care (Hall et al., 2007). As a social/relational phenomenon, it brings a whole set of philosophical questions to light such as: What is a person, a patient, a (professional) carer? Which social structures, values and beliefs create the conditions enabling professionals to provide person-centred care? What resources are available to enable professional enlightenment and practice of person-centeredness? Whilst concept analyses of person-centeredness (Slater, 2006) and person-centred care (Morgan & Yoder, 2012) have been published, as Dewing (2004) highlighted in her critique of conceptual frameworks available at that time, few offer practitioners practical interventions on how to relate in a person-centred way. McCormack & McCance's (2006, 2010) Person-Centred Nursing framework, although a conceptual framework, does offer practitioners key processes to guide how they relate with others.

All the values and descriptors of the person-centred values framework presented in chapter 2 can be found in McCormack & McCance's (2010) detailed description of person-centred nursing. The valuing of *individualisation* and *relational connectedness* is evident in



Figure 7: Person-Centred Nursing framework (McCormack & McCance, 2010)

their conceptualisation of caring and developing therapeutic relationships. The need to *understand the person in context* is reflected in their conceptualisation of persons being in place (a context through which personhood is articulated) and the nurse attribute of knowing the person. *Flexible individualised interventions* are employed when nurses work with a person's values and beliefs and "a particular course of action [is chosen] from a variety of potential options" (McCormack & McCance, 2010:90). Shared decision-making and the concept of negotiated autonomy enable the development of *partnerships*, and *developed interpersonal skills* are attributes of person-centred nursing that can foster *trust* and *creative communing* for a therapeutic relationship. To achieve person-centred nursing outcomes of involvement and satisfaction with care, as well as feelings of well-being, nurses are advised to use particular attributes and processes to *challenge and support* patients, as well as each other. Workplace cultures that enable nurse *empowerment* are considered imperative to creating therapeutic cultures and in their description of the care environment, McCormack & McCance (2010) clearly emphasise the importance of a physically and socially warm and *welcoming environment*. Such a care environment is created by *management, leadership* and staff who create a culture which supports shared decision-making and shared power. Although not explicitly discussed in the framework,

examples used to describe elements of the framework and its use in practice settings, demonstrate the value of *blending different knowledges*.

The framework for person-centred nursing offers a pragmatic and comprehensive tool for planning the development of person-centeredness within practice. It describes four constructs: nurse prerequisites; care environment; person-centred processes and expected outcomes. The outcomes situated in the centre of the figure are claimed to be achievable by systematically moving from the outer pre-requisite nurse attributes inwards.

Although focused on the patient-nurse relationship, I felt that the concepts contained within the framework may be of relevance for person-centred leadership in a nursing context and saw congruency with my philosophical framework. I could imagine nurses wanting to relate with patients and other stakeholders in a person-centred way and to create a context conducive to the exercising of person-centred processes. As well as the 'actualisation' of contextual generative mechanisms, individual nurse attributes would also be important, although, I would not position attributes hierarchically before context as this suggests a linear causal rather than existential dependency. Person-centred relationships would not exist if the social structures, conventions and practices in which they occur did not produce the conditions conducive to person-centeredness, and it is interrelating individuals who can produce and reproduce these social structures.

The framework shows that to be/become a person-centred nurse requires professional competency and specific knowledge, practical/technical skills as well as interpersonal skills and a moral attitude of respecting personhood if the nurse is to relate with different individuals at different levels. Being in relation with patients in a person-centred way requires knowledge of self and one's personal values and beliefs as these will influence relating. Being committed to the job enhances the inclination to provide the best possible care. However, as also shown theoretically earlier, a nurse's being is influenced by the conditions created by workplace, organisational and societal structures, conventions and practices. When individual nurse values are aligned to person-centred values of equity, respect and reciprocity, and a context with systems fostering shared power, decision-making, professional autonomy, innovation and risk-taking are present, the probability of person-centred care being produced is heightened (McCormack & McCance, 2010).

Within the framework, person-centred processes include knowing the other and working with their values and beliefs, knowing how patients view their lives and making sense of the situation they find themselves in. Shared decision-making implies partnership with nurse and patient acknowledging and respecting the information, knowledge and perceptions each holds. Showing sympathetic presence supports patient coping by recognising their uniqueness, personal goals and agenda. Aiming to create a therapeutic relationship, the nurse needs to engage at an appropriate level, varying from full engagement as partners through partial engagement to complete disengagement where

distance is created for reassessment of the situation and action planning. The provision of holistic care is often the first “way in” (McCormack & McCance, 2010, p. 104) to building a person-centred relationship, with the other processes following.

Patient satisfaction with care is claimed to be the most tangible expected outcome of person-centred nursing (McCance & McCormack, 2010), although more recently, McCance et al (2013) have more explicitly articulated that the focus of person-centred practice should be improving patient and staff experiences in health and social care. When patients feel valued and respected they experience a greater sense of mental and/or physical wellbeing. Naming therapeutic culture as an outcome, McCormack & McCance (2010) ensure that the role context places in creating conditions for person-centred care is not forgotten in evaluations and the influence of context on developing person-centred practices was reinforced in a later study by McCance et al (2012). Although not explicitly named an expected outcome in the conceptual framework, reading McCormack & McCance’s (2010) work, human flourishing of all seems a feasible, ultimate outcome and has been included in Manley et al’s (2011) concept analysis of an effective workplace culture where the enactment of person-centeredness is classed as an essential attribute.

The Person-Centred Nursing framework is a logical choice for this study because it offers a rigorous and well theorised conceptualisation of person-centeredness within a nursing context and congruency with the person-centred values framework derived from the literature study of chapter 2. Whilst descriptors are derived from studies on nurse-patients relationships, the framework offers a structure to formulate critical questions about leader-associate relationships such as: “Which leader attributes are conducive to person-centred leader-associate relationships? How does context influence relating? What are the outcomes of person-centred leadership?” Studies such as those by Binnie & Titchen (1999), Manley (2001) and Dewar (2011) have already shown the importance of a leader, for instance, intentionally role modelling and living values of compassionate and person-centred care. Introducing critical questions derived from the Person-Centred Nursing framework in safe, critical and creative communicative spaces could facilitate leader inquiry into their own practice and adequacy for developing person-centred cultures. Neither is it unrealistic to imagine some concepts of the framework being generic to leadership and care relationships, for instance, interpersonal intelligence or sympathetic presencing.

METHODOLOGICAL CHOICE

Critical realist research has emphasized the value of intensive methodologies in producing practically-adequate knowledge, i.e. useful for human activity, whether that be in the natural or social world (Danermark et al., 2002). Whilst no one research methodology is

propagated, researchers are advised to choose their methodology in light of the research object and goal (Danermark et al., 2002). Person-centred leadership is a relational concept and my aim was to explore its ontology in terms of leader attributes, contextual influences, processes and outcomes. As my conceptualisation of it could not be substantiated by existent propositional knowledge, I felt a need to conduct active research, i.e. attempt to 'actualise' possible generative mechanisms producing person-centred events, and/or transform counteractive mechanisms inhibiting its manifestation in participant leader practice. Inferring conclusions would involve abduction and retroduction. Abduction is the interpretation and decontextualization of a phenomenon within a conceptual framework and requires researcher creativity and imagination (Danermark et al., 2002). The frameworks chosen to guide exploration and action were McCormack & McCance's (2010) Person-Centred Nursing framework and the person-centred values framework (see Box 6 p.39). I used Danermark et al's (2002) formula to construct an inquiry question: "What meaning is given to leadership, interpreted using two frameworks?" Retroduction is the process of describing and analysing a concrete phenomenon in order to reconstruct the conditions necessary for its manifestation and requires researcher ability to think abstractly. The central question here was: "What (leader/contextual) qualities must exist for person-centred leadership to be possible?" Abduction and retroduction became key processes for knowledge production.

I also had a critical intent of raising participant awareness to current leadership practice and facilitate exploration of a possible alternative leader style that was considered 'better'. According to Fontana (2004) a critical approach to inquiry in nursing is characterised by seven processes: an external critique of ideology and social structures alongside an internal critique of consciousness; studying the phenomenon in context; political activism in exposing unequal power relationships; an emancipatory intent of enabling participants to become aware of oppressive forces and act reflexively in order to transform them; collaborative, non-hierarchical relationships between researcher and participants (enactment of the democracy value); dialectically analysing contradictions between the 'desired' and the 'actual', the 'ought' and the 'is'; and reflexivity where the researcher examines influences within the research process itself which may be limiting the emancipatory goal. These processes also suggest a participatory approach to planning a study and creating safe critical and creative communicative spaces in which ideology and practice can be dialogued and actions planned.

While I initially saw my role as a 'facilitator' of leader transformation, discussions with my supervisors helped me see that I was, in essence, leading others too, albeit in a research project. My own lived experience could therefore contribute to data collection as well as help me achieve a personal goal of conducting research 'with' rather than 'on' participants. Plas & Lewis' (2001) explicitly state that participation is key to person-centred leadership, and so I considered research methodologies that would accommodate in-

tensive, active and participatory relationships with participants whereby knowledge of practical adequacy could be produced through the inference processes of abduction and retroduction. Stephen Kemmis' (2008) description of critical participatory action research met these criteria.

Critical Participatory Action Research

Action research (AR) is an orientation to inquiry often associated with Kurt Lewin's (1946) belief that if you want to understand a system you should try to change it. Descriptions of AR range from broad definitions such as: "... a family of practices of living inquiry that aims, in a variety of ways, to link practice and ideas in the service of human flourishing" (Reason & Bradbury, 2008, p. 1) to more detailed ones such as: "a period of inquiry that describes, interprets, and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem focused, context specific and future oriented. AR is a group activity with an explicit critical value basis and is founded on a partnership between action researchers and participants, all of whom are involved in the change process. The participatory process is educative and empowering, involving a dynamic approach in which problem identification, planning, action and evaluation are interlinked" (Waterman et al., 2001, pp. iii-iv). Common to most definitions is that researching change should take place in natural settings, with varying degrees of participant participation and a basic structure of an orientation phase followed by spirals of planning, action, observation and reflection/evaluation (see Figure 8 p.71).

Winter and Munn-Giddings (2001) link AR with the critical realist view, discussed earlier, that science is a continuous three phased spiral process of identifying a phenomenon,

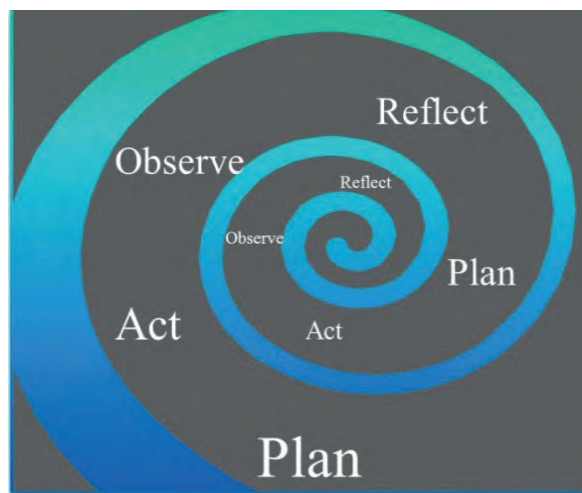


Figure 8: The basic action research spiral

conceptualizing it and empirically testing explanations. Whilst the aim of this study would be to identify 'objective' social structures generating conditions influencing leader activity, I would need to work with 'subjective' human experience. The researcher-participant partnership has implications for the action researcher in a dual role of researcher and facilitator of change. Building partnerships with participant leaders and critically reflecting on stakeholder perceptions of leadership are proposed to help reduce bias, enhance practical-adequacy and the likelihood of social structure transformation through consciousness raising to current mechanisms enabling/hindering a more person-centred approach to leadership. Reflection on power structures influencing leader and associate being and exploration of how empowering practices helped emancipate leaders and associates from oppressive forces would also be included. In doing so, AR's primary aim of bringing about change for the good of all is congruent with the critical realism and social science aim of producing emancipatory knowledge. Transformation would be supported through the enactment of the values of justice, rationality and truth as attempts are made to suspend relational hierarchy in safe, critical and creative communicative spaces free of coercion or fear of reprimand. Consensus on how to act should then be genuine.

Kemmis' (2008) lengthy definition of critical participatory action research (CPAR) can be summarised as: collective participant inquiry into their historically and contextually influenced practice, regularly critically and self-critically reflecting in communicative spaces and intervening along the way with a practical aim of acting rightly and eliminating as far as possible the irrational, unjust, unproductive and unjustifiable. There are three key elements of CPAR which I will use to introduce the design for this study. Firstly, collective inquiry fosters historical enlightenment to participant practice as praxis, where praxis is defined as "morally informed, committed action, oriented by tradition, that responds wisely to the needs, circumstances and particulars of a practical situation" (Kemmis, 2008: 135). Primary participants were the unit nurse manager (UM), two charge nurses (CNs) and (later) two primary nurses (PNs) who conducted first person inquiry by critically reflecting on how person-centred their leadership practice was. Second-person inquiry was enabled through feedback to one another, and the scope of inclusion expanded by collecting feedback from associates and my participant observations. Whilst discussions amongst themselves on 'how to lead' was not new for participants, guided critical reflection and collecting feedback from others was and would therefore need to be approached with sensitivity. The collective inquiry would also include first and second person data on my own leadership as a leader of the inquiry process.

Participation is the second element of CPAR and participant leader participation increased during the fieldwork. As the research questions, aims and orientation phase had been formulated before meeting the CNs, I refer to a participatory instead of emancipatory action research. In an emancipatory approach these key people would have participated from the very beginning, but, this preparatory work was needed to meet university ethics

requirements before entering the field. In saying that, the research proposal did serve as an introductory paper for potential research settings and participants and helped them make a decision whether they wanted to commit to such an intensive study. Feedback and suggestions on the proposal were also obtained from the CNs after entering the field. Active participation in terms of data collection and analysis gradually increased throughout the study, influenced by their willingness, ability and capacity. Their influence on the design of the study was most prominent after the orientation phase as we planned the action spirals in communicative spaces. Participant participation is closely linked to communicative spaces “for collective reflection and self-reflection through communicative action aimed at intersubjective agreement, mutual understanding and unforced consensus about what to do” (Kemmis, 2008, p. 136). By creating a safe critical space participants we were able to transcend individual self-interest and pose questions derived from Habermas’ (1984, 1987) four validity claims to help us: “Do we understand one another? Is this true/accurate? Is it sincere? Is it morally right?”

Various critical and creative communicative spaces were formed during the study and the principles of being critical, with or without creativity, underpinned meetings in which experiences were shared, issues explored and plans made. These principles were also evident in all the workshops employed. Being (self)critical is the third element of Kemmis’ (2008) definition of CPAR. Criticality entails exploring existing conditions influencing being in order to discover irrational, unjust, alienating or inhumane structures, conventions and practices, and is congruent with critical realism and critical social science philosophy. Kemmis (2008) describes criticality as acting negatively towards oppressive social structures rather than acting positively towards a predetermined view of what counts as rational, just or good. This view has been criticised from an appreciative action inquiry approach (Dewar, 2011), and I agree that it can be limiting. There is no guarantee that acting on negatives will result in the emergence of person-centred leadership, and I felt that such negative energy could demotivate rather than motivate and inspire. I was interested in exploring leadership practices that were considered ‘good’ and person-centred, as well as resolving/removing barriers to its development. Guba & Lincoln’s (1989) suggestion of exploring claims, concerns and issues helped keep a balance between the positives and negatives.

CPAR is interested in changing individuals in relation with self and with others (the social, cultural and economic ‘fields’ they are embedded in) (Kemmis, 2008). My role as facilitator would be to enable group cohesion, psychological safety and skill development for genuine rather than tokenistic participation (Snoeren & Frost, 2011) and for participants to feel like they had chosen a ‘system’ rather than it being imposed upon their ‘lifeworld’. As the action researcher, my first-person inquiry on this issue began during the orientation phase and continued as a self-reflective inquiry action spiral.

Orientation phase

During the orientation phase, I, as an 'outsider', was interested in gaining understanding of social structures and culture within the research setting in general and care/leadership relationships in particular. I also wanted to get to know the leader participants as individual people rather than research participants/co-researchers/ward leaders. This phase of 'getting going' has been given relatively little attention in action research literature (Bello, 2006; McArdle, 2002) and some may consider an orientation phase lasting one year to be excessive. However, colleague researchers were finding that taking the time needed to build clarity on issues to be addressed in action cycles and collaborative relationships is extremely important (Lieshout van, 2013; Snoeren & Frost, 2011). The following sections describe how I attempted to be flexible in gaining an understanding of the context, raise participant awareness to factors influencing leadership and care relationships, and increase participation.

Exploring context

One of the very first activities was an introduction evening in which I presented the project's central theme and orientation plan (as agreed with management, participant leaders and myself) to the whole team. After I had facilitated a hopes, fears and expectations² exercise in which staff could share their reactions to the proposal, two university colleagues and I facilitated subgroups in a creative workplace culture workshop³. Three main data collection activities hereafter undertaken were: narratives of care and leadership relationships, participant observation and an interview with a consultant physician.

Care experiences of eight patients were captured during narrative interviews just before their discharge from the ward. Patients were physically and cognitively able to verbally share their narratives in Dutch, had been admitted to the ward for at least 72 hours and interviews lasted an average of 22minutes (range 8-46mins). Although narrative interviewing has no defined structure (Holloway & Freshwater, 2007), Riessman's (2008) suggestions for interviews 'as narrative occasions' were incorporated into an interview guideline (See Box 7 p.75). In line with the Knowledge Centre's strategic aim of using research activities and findings to contribute to the education of students, four student nurses, trained and supervised by myself, collected patient stories as part of their bachelor dissertation (Cardiff et al., 2011).

Sixteen associate stories of care experience were collected by me during the routine 'daily evaluation meeting' held each weekday between 13.45 ± 14.00hrs. Normally, these

2 An ice breaker exercise where individuals documented their hopes, fears and expectations with regards to the AR project on post-its and presented them on a corresponding flip chart. Also called the 'silent wall' technique as sharing does not entail discussion or debate.

3 A workshop in which participants creatively express then critically debate 'the way things are done around here'.

Interview Phase	Principles
Opening	<i>Open with general 'chit-chat' for self and participant to acclimatise to the setting and each other. Check informed consent.</i>
Initiation	<i>Once the atmosphere feels relaxed, pose the opening question: "Could you tell me about your stay here on the unit?" Listen attentively and encourage continued telling by use of open body posture and supportive sounds, such as: "Aha," "OK," "Oh?" Refrain from questioning until the 'coda' - that moment of silence when it is obvious the narrator has come to the end, for the time being Continuation can be encouraged by simply asking: "Is there anything else you'd like to share with me?"</i>
Depth	<i>Questioning during this phase is aimed at surfacing details. Questions should be chosen and posed carefully, offering space to tell as much as the narrator wishes, respecting those avenues they wish to keep private. 'Follow' the narrator as he/she re-visits the initial story, encourage elaboration Simple and open questions help maintain a relaxed, safe atmosphere: "Could you tell me some more about?" "What happened then?"</i>
Closure	<i>Round the interview off once it has come to an obvious end. Brief evaluation, thanking the narrator for their time and story Graceful returning to 'chit-chat'/everyday normal interaction.</i>

Box 7: Narrative interview guide

meetings were used for staff on the day shift to share experiences of workload and determine (supportive) actions for the rest of the day. In agreement with the CNs and staff, one meeting per week was dedicated to 'storytelling'. Facilitating the sessions I invited associates to share stories of interest about nurse-patient relationships and helped them achieve consensus on which story would be shared. My role was informed by McGill & Brockbank's (2004) description of the person-centred facilitator of action learning sets. I was conscious of my presence and (non)verbal communication, role-modelled critical and supportive questioning, called process reviews when focus and/or safety was threatened, enabled participation by all, and raised attentiveness to ethical issues such as confidentiality. Facilitating these sessions offered me insight into associate experience of care relationships, skills in critical/reflective questioning and ability to balance challenge with support. It was my first confirmation of Trondsen & Sanduanet's (2009) finding that researcher active involvement can produce deeper insights into context and dynamics than threats to validity.

I gathered eleven associate stories of the relationships with leaders (averaging 17mins; range 5-30mins) using narrative interviewing with individuals. All individual and group narratives were audio-taped, a verbatim transcribed and 're-presented' as a narrative which was member checked. The re-presented narratives were then used in two hourly critical and creative hermeneutic analysis workshops, facilitated by me. Building on Boomer &

McCormack's (2007) work, the critical and creative hermeneutic analysis framework is a seven phased process based on the principles of criticality, hermeneutics and creativity (Lieshout van & Cardiff, 2011). In the first phase, interview data was 're-presented' as a structured narrative with a beginning, middle and end and participants were invited to attend the workshop. In the case of (potentially) 'sensitive' narratives, such as associate narratives on leadership relationships, only the narrators were invited. Inviting patients who had already left the ward to participate in the workshops was deemed impractical and as associate narratives of care relationships had already been shared in a public sphere, the issue of anonymity for them was less relevant.

In phase two, participants were invited to familiarise themselves with, but not study, the narratives before the workshop. They were asked to note questions, images and/or feelings arising whilst reading. Phases three to seven took place within the workshop. After agreeing ways of working together, an ice-breaker exercise helped people make the transition from busy ward life to an environment conducive for analytical thinking and creativity. Participants were then invited to contemplate the narratives they had read and enter dialogue with self (Dewing, 2008) about the imagery, thoughts and feelings these narratives awakened. Some sat in quiet contemplation whilst others took a contemplative walk.

Phase four consisted of using creative materials to express individual interpretations of the collection of narratives as a whole (for an example see Figure 9 p.76). Expressions were then visited and interpretations offered respectfully using sentence constructs such as: "I see ...; I feel ...; This reminds me of ...". Returning to their own creative expressions, participants had opportunity to review their interpretation of the meaning embedded in the narratives. Contestation and critique in dialogue with other formed phase five as interpretations were shared, questioned and verified. This progressed into phase six where collective/shared understanding was sought in the form of themes. Facilitation helped formulate themes at a relevant level of abstraction providing answers to the analysis



Figure 9: Example of a creative expression & feedback

question: "How is leadership/are care relationships experienced within this ward?" In phase seven, participants returned to the narratives with the thematic framework to extract supportive raw data whilst remaining open to new themes that may have emerged with re-immersion.

The critical and creative hermeneutic analysis and culture workshop offered some insight into workplace culture, care and leadership relationships, however, I felt a need to gain a 'feel' of the context for myself, from an 'outsider' perspective. Initially I worked alongside nurses in care activities, which was pleasant in terms of 'going back to my roots' and staff welcomed 'the extra pair of hands', but, I found it more distracting than beneficial. Engrossed in caring for patients, I was less aware of what was happening around me. Participant observation is an established method in ethnographic research and Kite (1999) describes overt 'participant' observation, or 'shadowing' as we named it, as a useful way of gaining detailed observation data with minimal involvement in practice.

I was an 'outsider' in terms of possessing local knowledge about the ward nursing speciality and culture, but an 'insider' in terms of familiarity with general and regional nursing practice and hospital life. Initial observations by the insider/outsider researcher are important as their status and perspective may change across time as relationships evolve (Allen, 2004). Engaging in participant observation had been agreed with the whole team during the introductory evening, my observing was overt and verbal consent was consistently obtained from each individual before observation started. As all researchers entering the field, I had pre-conceived concepts and ideas about what I felt I should be observing (Gerson & Horowitz, 2002). Therefore, so as not to be constricted by this tendency, I also took moments to be mindful and to let anything that my gaze fell upon be viewed and then released. I was also aware of my opinions whilst trying to describe what I saw in neutral language.

Observation periods lasted on average two hours, after which I retreated from the ward to review and add to my notes. Reliance on my own observations could be criticised as limiting (Sayer, 1998), but, they helped raise my awareness to what I considered to be good and/or more person-centred practices and were not the only source of data. Participant leaders did not show curiosity about what I was documenting or my opinions until nearly the end of the orientation phase when they seemed much more comfortable with me shadowing them. I was initially hesitant in sharing as I felt "the people we are talking to are more important than the person asking the questions" (Allen, 2004, p. 22). Participant observation was new to me and I did not want to be perceived as the expert offering approval and/or direction. I had taken note of Winter & Munn-Giddings (2001) warning that authoritative expertise can merely replace hierarchical power relationships in AR. It would have been very easy for me to fall into a traditional, authoritative facilitator/leader role, and I was grateful to my supervisors who consistently raised my awareness to prejudices I had and the danger of observing from a position of attributed authority. I gave

careful thought to how I expressed my thoughts, explicit in differentiating propositional from experiential knowledge so that any attributed authority would not be perceived as authoritative, and participant leaders and I could build relationships based on mutual respect for each other's personal knowledge. Gradually, our relationship evolved and my status changed from an outsider looking in, to a position more consistent with Titchen's (2000) description of a critical companion who accompanies others on their personal, experiential learning journey within a workplace setting, using self and a range of interpersonal and educational strategies to support reflective practice.

Initial data analysis of my observations of leadership and interpersonal relationships within the ward was not conducted collaboratively with participants. I followed phases 1-4 of the critical and creative hermeneutic analysis framework, but refrained from identifying specific themes. Instead, I chose to present my creative expression of all the observation data in two posters for collective analysis during the gallery evening.

Collective critical dialogue

Participation and criticality are core principles in CPAR and in order to live these values I designed and facilitated a three hour, open-invitation, gallery evening was organised for the whole (multidisciplinary) team to view and debate the products of the critical and creative hermeneutic analysis, creative expression of my participant observations and the consultant physician interview. The aim of the evening was to include team members in further analysis of data, enable team enlightenment to the current situation and start collaborative identification of action spirals. The room was decorated with A4 size posters of the various data sets (photos of creative expressions, themes, data extracts). The patient and associate re-presented narratives were also available two weeks previous for people to read at their leisure.

Participants were invited to view the posters as if visiting an art gallery exposition (see Figure 10 p.79), viewing and asking themselves: What does this all say about the care and leadership relationships within our ward? I encouraged people to view posters close up and from a distance in order to see each in context of the other posters. Gradually, people spontaneously moved into subgroups, sharing impressions and interpretations. Some of the interviewees and critical and creative hermeneutic analysis workshop participants were also present and willing to share their explanations of their creative expressions, the interviews and workshop. Subgroups were invited to identify claims and concerns about care and leadership relationships, which were then pooled and collated during critical dialogue.

Flexible facilitation and external support systems

I believe that social contexts are constantly being consciously or unconsciously reproduced and at times transformed, so social research should be conducted in natural set-



Figure 10: Orientation data presented as poster gallery exposition

tings and plausible explanations rather than 'causal laws' generated. I see action researchers as both facilitators of individual and contextual transformation, as well as generating knowledge on the phenomenon and change process. Winter & Munn-Giddings (2001) refer to the action researcher as a facilitator who 'coordinates' a group of participants in living the action research principle of collaboration. Some may feel uncomfortable referring to action researchers as leaders, but for me, the action researcher role extends beyond pure coordination of activities to reflect the definition described in Chapter 2: guiding and supporting a team in working towards predetermined and co-created goals.

Facilitator is the term more commonly accepted in action research and practice development. In practice development literature, facilitator actions are presented as continuously moving along a continuum between technical and emancipatory approaches (Manley & McCormack, 2004), but with an intent of enabling transformation and emancipation (Shaw et al., 2008). During each encounter, the facilitator assesses the person, group and context in order to act appropriately and support movement towards the agreed goals. Sometimes this may be a more technical approach of doing for others, and at other times more emancipatory and enabling others to do for self. As well as time, resources and a willingness to participate, the action researcher as facilitator also needs to be sensitive to participant being and needs, so as to foster commitment and participation (Grant et al., 2008). Van Lieshout (2013) also advises AR facilitators to focus first on trying to gain a thorough understanding of the complex and dynamic swampy lowlands of the context during the orientation phase, and to take stock at regular intervals thereafter. AR is essentially the continuous facilitation of learning, requiring interaction at different levels and in different styles in order to meet different and changing learner and contextual needs.

Being flexible can include temporarily diverging from a planned course of action, which may create opportunities for reaching goals from a new direction. Although workload was not an area I considered fundamental to exploring and developing person-centred leadership, facilitating participant leaders in finding new ways of approaching the workload issue, I gained insight into their current being and they learnt about applying the practice development principles of collaboration, participation, inclusivity and creativity.

An action researcher needs to be mindful of the wider field (Mackewn, 2008) and critical subjectivity (Trondsen & Sanduanet, 2009), deciding whether, when and how to raise awareness to what is happening in front of them or looming in the background/at the edge of their fields of vision. Being mindful alone may be insufficient and intervention needed if potentially destructive forces are to be prevented from hindering transformation and emancipation. Being active within the context of change, the action researcher needs to be able to identify how their facilitation contributed to individual/contextual change from other factors, as well as how the research process is influencing the researcher's being, and guided reflection can help (Allen, 2004). Having the support of supervisors and an action learning set helped me maintain the reflexivity required not to impose my own desires and convictions of how things should be done, and instead find ways to work with the participants' values and beliefs. I also found that a network of different support systems, each with their own expertise and relationship with me, was more effective in questioning and examining my own position than relying on one support system.

ACTION SPIRALS

The participant leaders and I used the issues and suggestions identified during the gallery evening to plot a 'river of action' (see Figure 11 p.81). Although the river ended with their ultimate goal of person-centred nursing, displayed on the laptop screen, some actions contributed specifically to exploring and developing person-centred leadership and are described below. Existing activities and plans which could potentially contribute to the development of person-centred leadership and nursing, such as the hospital management competency training, were also considered and placed on the banks of the river to show their relationship with the research project. This allowed us to visualise a specific plan within the greater context/picture of the whole ward and organisation.

Planning action research involves finding a balance between being systematic and flexible (Winter & Munn-Giddings, 2001). Placing 'action boulders' and 'stepping stones' along the river helped us visualise a systematic journey without rigid timelines or a specified path. In total, four action spirals were planned (see Figure 12 p.81), with an option for future spirals so as to remain responsive (Winter & Munn-Giddings, 2001). The first action

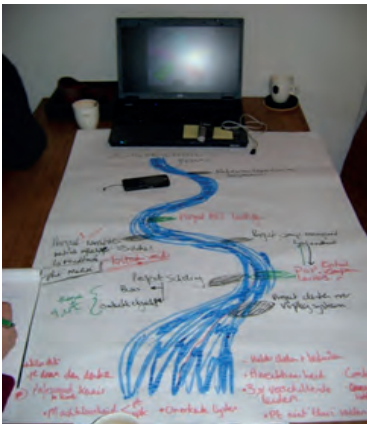


Figure 11: Plotting a river of action

cycle consisted of fortnightly critical and creative reflective inquiry sessions offering a safe, critical and creative communicative space for collective, guided reflection on leadership experiences. This was the core action spiral fed by and feeding into other action

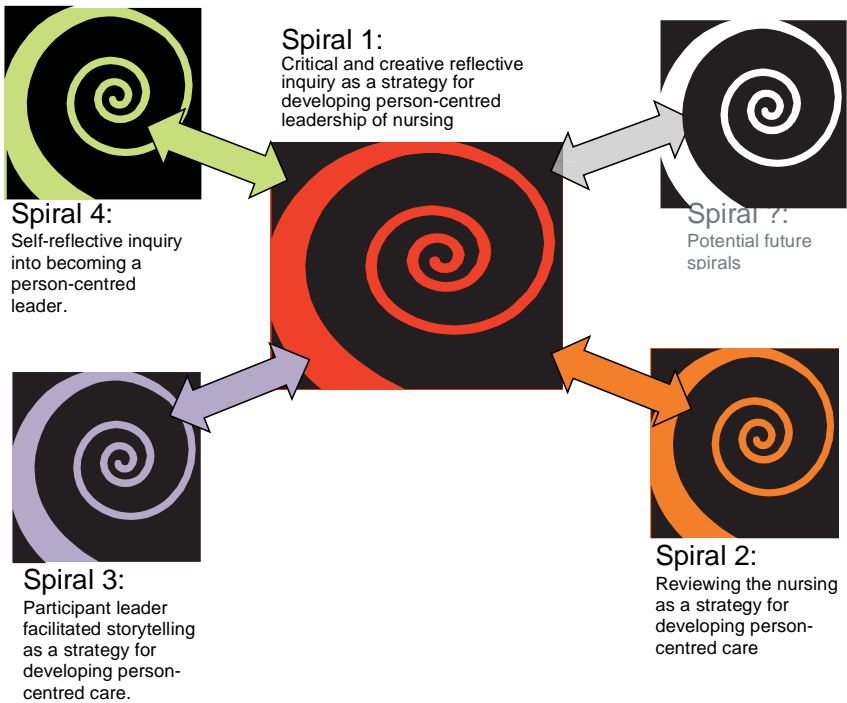


Figure 12: Action spirals

spirals. The second action spiral entailed reviewing the nursing system. The third action spiral consisted of short (15 minute) storytelling sessions facilitated by the CN's. The fourth action spiral of self-reflective inquiry created a space for deeper first-person inquiry by each of us.

Action spiral 1: Critical and creative reflective inquiry

Critical and creative reflective inquiry (CCRI) is a method designed to create narrative spaces for participants to share personal experiences and explore a phenomenon embedded within those narratives (Cardiff, 2012). The three phased structure is based on Kim's (1998) description of critical reflective inquiry and Mezirow's (1981) levels of reflection. Participants co-create practical and emancipatory knowledge which can potentially transform their being and doing, and so lead to changes in the social structures, conventions and practices that influence their being.

As storytelling is a simple act (Jovchelovitch & Bauer, 2000) and part of everyday human life, it feels like a natural way of gathering data. Working with participant narratives has been described as fundamental to action research (Walker, 2007) and been used to understand and change organisations (Abma, 1999; Boyce, 1996). Narratives reveal the sequence of events as well as the meaning a narrator attaches to them (Riessman, 2008). Therefore, I proposed that through collective CCRI, participants could identify possible empirics and processes of person-centred leadership whilst trying to develop it. The participant leaders and I met fortnightly for two hourly sessions structured in three phases (see Appendix 1), which I facilitated using McGill & Brockbank's (2004) principles of action learning facilitation.

The first 'descriptive' phase of a CCRI focused on surfacing a detailed, meaningful and thick description of a lived experience – a narrative. Having made a shared decision on whose narrative to work with, participants supported the narrator using narrative interviewing principles and skills. All leadership narratives have potential, even those initially classed by the narrator as 'not really much of a story'. The narrative interviewing principles and skills are needed because a story, as first told, is often not whole or complete, influenced by memory, what the narrator is prepared to share and/or what they feel the listener wants/needs to hear. Co-participants' support helped surface detail from the pre-conscious to the conscious and/or bring information from Johari's hidden/avoided window into the open and public arena. Listening attentively and encouraging narrative flow helped the narrator think consciously about what happened to whom, when and where, an act of reflectivity (Mezirow, 1981). As the narrator became aware of how they felt, thought and acted, they moved onto an affective level of reflectivity (Mezirow, 1981). This can be challenging and/or confrontational, so being more attentive to the other than self (other-centeredness), and psychological safety, were important principles for us to observe.

To aid psychological safety within the communicative space, the narrative was separated from the narrator before starting the second reflective phase. Unlike the guided reflection of action learning (McGill & Brockbank, 2004) where critical questions are directed at the narrator, in CCRI questions were directed at the (written) narrative and all participants could offer answers. Narratives shared during the initial sessions were transcribed and re-presented in written form and member-checked before being handed to all participants in a new session that started with phase 2 of the CCRI. However, as participants became more skilled, all three phases of the CCRI were worked through within each 2 hour session.

During the reflective phase, critical questioning of leader intent and efficacy, contextual factors and espoused theories, moved participants onto a discriminant and judgemental level of reflectivity (Mezirow, 1981). Although verbal communication was an option, initially expressing personal interpretations creatively was my preference, followed by dialogue with self before entering dialogue with other. Any form of creative expression was considered feasible, but participants had a preference for sculpturing a 'tableau vivant' (for an example see Figure 13 p.83) using each other and artefacts within the vicinity to express what they were seeing through sympathetic imagination (Kontos, 2007). A digital photo of each tableau vivant was taken so that collective dialogue about all images could take place. Interpretation involved reading body positions and posture, as well as sharing how it felt to be in those positions. The collection of sculptures helped bring different perspectives to the foreground.



Figure 13: Example of three tableau vivant of the same narrative

Thinking about the narrative, formulating critical reflective questions as well as putting together and voicing one's own answers to questions posed within a short space of time, was complex and challenging. To support participant focus on the process and content of the inquiry rather than the structure and formulating questions, I designed a short guideline (see Appendix 1, the Reflective Phase). This included guidance questions based

on Mezirow's (1981) levels of reflectivity and Johns (1995) Model of Structured Reflection (9th edition).

The third, critical/emancipatory phase, was aimed at identifying key elements of person-centred leadership based on their presence/absence within the narrative. The critical dialogue with other started in the reflective phase flowed naturally into the critical/emancipatory phase and a conceptual level of reflectivity (Mezirow, 1981). Leader attributes and key processes were identified and compared with existing knowledge. At a psychic level of reflectivity key values and influences of our perception of situations were identified. Offering plausible explanations of events embedded within the narratives and how the leader could have responded, brought dialogue onto a theoretical level of reflectivity (Mezirow, 1981).

Each CCRI was evaluated using Guba & Lincoln's (1989) claims, concerns and issues structure, which fostered a spiral of improvement of the CCRI method. The secondary aim of CCRI was to formulate action plans, but these were sometimes not achieved as participants gave preference to finishing a robust critical reflection rather than break mid flow to formulate action plans. This concerned me initially. I feared that without concrete and detailed action plans, intentions would get lost or be overshadowed once participants returned to the messiness of everyday ward life. However, as Mezirow (1981) states, perspective transformation is of greater importance and always precedes transformative action.

Action spiral 2: Implementing a new nursing system

Findings from the orientation phase raised concerns about whether the current nursing system was meeting individual, team, service user and organizational needs. In consultation with the physician manager, the UM formulated an assignment for a multidisciplinary think group to review the nursing system. As one of the CNs was changing post to become the unit clinical nurse specialist (CNS), this created an opportunity to reconsider leadership too. The question posed was: "Is our current way of working still suitable for now, or, are there alternatives worthy of consideration?" The think group consisted of the UM, remaining CN, a senior staff nurse (who was also the project leader), a junior staff nurse, a nurse practitioner, a consultant physician, head of the continuing education department and myself. I was a group member, not the facilitator, and I was invited as people wanted me to contribute my knowledge and experiences of primary nursing. The group met four times across seven months, other settings of the same speciality working with alternative nursing systems were visited, and Dutch nursing literature on nursing systems was studied. The think group advised the adoption of primary nursing tailored to fit and meet the needs of the local context. The physical layout of the ward meant that four equally portioned sections could be created. Two sections each containing two single bedded rooms and two twin rooms were designated for the more high dependency patients and

would be led by two PNs. The remaining two sections contained a four bedded room and a twin room, were designated for the less dependent patients and would be led by the CNs who now had a dual role of charge nurse/primary nurse. Each PN would work a four-day week, be accompanied by a qualified/student associate nurse each shift, and all PN's should be present on Monday's for the 'large ward round' and 'multidisciplinary team meeting'. The primary nurse/associate dyad would collaboratively care for six patients, negotiating how they worked together each shift. Whilst effort would be made to ensure continuity of allocation, this would be dependent on skill-mix and patient dependency and so determined each day. The new system started in January 2010.

Primary nursing has not received the same degree of positive attention in The Netherlands as in other countries such as the UK and USA. This may be associated with the diversity in how it has been interpreted, i.e. as an organisational system and/or a philosophy of care (Binnie & Titchen, 1999). There has also been very little research on primary nursing within The Netherlands. Early studies such as Bekkers et al (1990) and Molleman (1990) showed promising results. However, a lagged experimental study implementing primary nursing on five units of an 850 bedded hospital failed to show expected improvement in quality of care, job characteristics (experienced autonomy, feedback/clarity, complexity/difficulty, job demands and responsibility), influence on patient care, communication (Boumans & Landeweerd, 1996) or nurse wellbeing (Boumans & Landeweerd, 1996, 1999; Nissen et al., 1997). Nissen et al (1997) defined primary nursing as: "the assignment of each patient to a nurse who assumes the responsibility for assessment, planning, coordination and evaluation of care throughout the patient's hospitalization, 24 hours a day, and 7 days a week" (Nissen et al., 1997, p. 94). I have personally observed a lot of resistance when nurses have been presented with this image of primary nursing, and the most common reaction was that primary nursing could not possibly work as no nurse would be willing to take responsibility for care when not on duty themselves. The influence of contextual factors on the implementation process are not discussed in the research reports either. Other methodological flaws in the quasi-experimental design, such as controlling for variables in a natural setting and poor detail on the implementation strategies, make it difficult to consider the value of the findings. Implementation strategies used included "in-service training, on-the-job-training and staff development activities in order to improve the nurses' skills in planning, coordination, evaluation and provision of care of the patients" (Nissen et al., 1997, p. 96). This reads as a very traditional, technical approach to implementation and as Marie Manthey herself states: "Successful implementation of primary nursing required not only a major redesigning of unit organizations, administrative structures, and managerial philosophy, but also a far more challenging transformation of roles and relationships at the point of patient care [C]hanging to this new care delivery model involved far more complex processes than could be described in traditional operational change language" (Manthey, 2009, p. 36). Believing in the principles



Figure 14: Creative expressions of the primary nurse role

of emancipatory practice development, aware of Binnie and Titchen's (1999) success, I shared with participant leaders how we could take a different, less technical or top-down approach to implementation.

Practice development literature and personal experience has taught me the importance of starting change implementation by creating a shared, local vision. Before starting the new nursing system in the research setting, two visioning workshops were undertaken with participant leaders and the newly appointed PNs. The first workshop I facilitated used dialogue with self, creative expression (for examples see Figure 14 p.86) and critical dialogue with other to formulate a vision for the new nursing system (presented in Chapter 4 p.110). The second workshop I facilitated examined the role of the PN and participants conducted semi-structured interviews with various stakeholders to explore expectations on PN tasks, responsibilities and competences. Blending personal and stakeholder expectations, statements about the PN role and responsibilities were formulated (presented in Chapter 4 p.110).

As the PNs worked in closer proximity to associates, this was an ideal opportunity to observe clinical leadership practice. It was agreed that 'shadowing' would recommence, but this time my observing would be followed up with post-observation interviews with the leader and where possible/relevant with those they engaged with. A critique of participant observation is that participants will act 'unnaturally' in the presence of an observer, but, Berendsen (2008) found this to be short lived. Taylor-Powell & Steele (1996) describe four key processes to participant observation: capturing detail, discerning what is important, awareness of personal interpretation and validating observations. Aware of these things, shadowing offered me opportunity to observe and reflect on everyday

leadership practices (Larsen, 2007), but, as people rarely verbalise their thinking whilst acting (Berendsen, 2008) I needed to conduct post-observation interviews in order to gain insight into the thinking behind the doing and how associates experienced the leader relating.

More focused on leader-associate interaction than during the orientation phase, my observations were more detailed. I continued to note multiple sensory observations, as relational interaction and contextual influences are not restricted to verbal communication (Savage, 2000) and I occasionally focused on topics that had arisen in previous observations and/or post-observation interviews.

Reflecting observations back to participants and associates, during post-observation interviews, prompted sharing and helped raise consciousness to the taken-for-granted sociocultural conditions. I tried to conduct these as soon as possible after the observation session to reduce the risk of memory loss, and reading and reflecting on my notes in preparation for the interview helped me become aware of my own interpretations and formulate exploratory and critical questions. The interviews felt more like 'dialogical investigations' (Larsen, 2007), where the aim was not just to collect data from participants, but also to engage in a critical conversation about events observed and reflect together on their meaning. My style reflected Larsen's (2007) description of person-centred ethnography where an outsider tries to gain insight into insider perspectives through engaging in dialogue with participants where their perspective has equal footing with that of the researcher. Exploring the intersubjective space was important as I could never really stand in another's shoes, only show sympathetic understanding. Reciprocity of perspective (Savage, 2000) was possible when I was able to pull from personal experiential knowledge and engaging in this way I was able to validate my interpretations, make the strange familiar or the familiar strange, as well as destabilise habitual ways of thinking and/or stimulate new ways of thinking about future being (Allen, 2004; Gerson & Horowitz, 2002; Larsen, 2007). Like Pols (2006), I also found that participant observation with post-observation interviews helped raise awareness to embodied/preconscious ideologies of which too much and too little had been said to date. By starting with what people were doing and then questioning the thinking behind it, I helped participant leaders gradually move from concrete situations to more abstract concepts.

We had agreed that the leaders would inform patients and associates of my role before observations started and that their anonymity would be safeguarded. Twenty three observation sessions were undertaken between September 2009 and June 2010, averaging 2 hours per session. A total of ten hours of interview material was collected and some observed events were also taken into the CCRI sessions of action spiral 1 for collective reflection and learning.

Methods used to evaluate the new nursing system and leadership of its implementation were varied and undertaken at various stages. During the initial month of imple-

mentation (December 2009), staff shared their experiences during the daily evaluation meetings, facilitated by the participant leaders using Guba & Lincoln's (1989) claims, concerns and issues structure. A journal was placed in the staff room for people to document their thoughts and questions as and when they wanted to. In January and February 2010, the PNs met fortnightly to evaluate progress based on their own experiences and feedback received from others. My facilitation in structuring and starting up these meetings was only needed for the initial 3 sessions. In March 2010, an evening of three parallel workshops created space for associates to participate in an evaluation of cultural change, analysis of results from a structured questionnaire designed by the leaders, and to share their experience of current leadership. The culture workshop, designed and facilitated by a CN and the UM, centred around participants taking digital photos on the ward of images they felt reflected the current culture. These photos were collectively dialogued and compared to findings from the workshop conducted during the orientation phase. Running parallel to this workshop, a group of associates used animal cards to creatively express how they experienced current leadership, facilitated by a colleague of mine with no connections to the ward. The third workshop was a collaborative analysis of the quantitative questionnaire data (N=38, response 39%), facilitated the second CN and I.

Action spiral 3: Storytelling

The participant leaders' ultimate goal was to develop person-centred nursing within the ward. To foster awareness to current nursing practice and critically dialogue how this goal could be achieved, the leaders agreed to facilitate short storytelling sessions similar to those used in the orientation phase. We felt that although narratives reflect and reinforce cultural values and beliefs, creating a framework for meaning-making (Abma, 1999), when critically dialogued they can work responsively and lead to practice and organisational change (Boyce, 1996; Breuer, 2006). The storytelling sessions took place weekly, during the 'daily evaluation' sessions, and offered me a new opportunity to observe the leaders in a different role. In response to their hesitancy in starting the sessions, I created a short guideline (see Appendix 2) to support them and role modelled the initial meetings before then taking on the role of participant observer. As time progressed, the leaders also started to observe each other. Towards the end of the study I was no-longer physically present and would engage in critical dialogue with the facilitator after listening to the taped session.

Action spiral 4: Self-reflective inquiry

Winter and Munn-Giddings (2001) state that critical reflection is a central principle of action research. Reflexivity is the (self) questioning of interpretations of events, and dialectics the focusing on contradictions, tensions and dilemma's within the situations being explored. Action spirals 1-3 focused on collective critical reflection, and whilst this was

generating knowledge about leadership practice and the social context, and contributing to bringing about practice changes, data on personal transformation was limited. We were able to address this limitation in action spiral 4.

As reflective and wilful beings (Fay, 1987) we have the ability to connect our thinking with our doing and so influence our future being. Knowledge of self and our values influences professional being (Horton et al, 2007; McCormack, 2003). Leaders and action researchers interacting with others, with intent of enabling change, empowerment and knowledge generation, also need to be self-aware. Action spiral four was devoted to enabling the leaders and me to explore personal identity, values informing our practice and to transform individual being. Engaging others in our self-reflective inquiries enhanced critical subjectivity (c.f. Reason, 1994). As in the critical and creative reflective inquiries of action spiral 1, we did not suppress primary subjective experiences but accepted them, and by articulating them and engaging in contestation and debate with others, we inquired into their trustworthiness. Two main activities were undertaken. Three annual reflective inquiries workshops were conducted in which we individually reflected on and evaluated personal transitions during the previous year, as well as identified areas for growth and development in the coming year. Alongside these workshops, I also engaged in several forms of guided reflection as an action researcher.

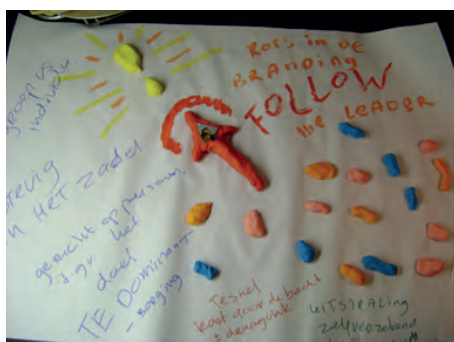
The annual reflective inquiries started towards the end of the orientation phase in response to participant leaders expressing that they felt they were already starting to change. I designed a safe, critical and creative communicative space for individual reflection on self, with input from others. The primary inquiry questions were: "How has each leader changed during the last year? What do they attribute these changes to? What needs to be done to continue desired change?" The workshop had four distinct phases lasting a total of approximately four hours. The first phase was a creative expression of "who I am now", followed by a phase two of dialogue with self, using Mezirow's (1981) reflective, affective, discriminant, judgemental and conceptual levels of reflectivity. The third phase was dialogue with other, enabling confirmation and/or challenge to self-perceptions. The last phase involved identifying plausible explanations for change, this

- What was/am I like as a leader, what is characteristic of me? (Reflective)
- How did/does it feel to be a leader? (Affective)
- How effective was/am I as a leader? What were/are my successes/failures due to? (Discriminant)
- What were/are my strengths and weaknesses? (Judgemental)
- What did/do I see as important concepts and values for leadership? (Conceptual)
- How have I changed? Where, if anywhere, was I going wrong? What, if any, were my misconceptions/beliefs? (Psychic)
- What has brought about this change? What still needs to be done? How can I become even more person-centred in my leadership role? (Theoretical)

Box 8: Facilitative questions for self-reflective inquiry

time using Mezirow's (1981) psychic and theoretical levels of reflectivity (see Box 8 p. 89 for facilitative questions).

For the first annual workshop, participant leaders used a photo of self from the previous year to start their creative expression of 'who I was then'. In subsequent years, new expressions of 'who I am now' were compared to photos of the expressions from the previous year (for an example see Figure 15 p.90). As had become the norm when offering feedback on creative expressions, we used the phrases: "I see I feel This reminds me of"



'Who I was as a leader'



'Who I am as a leader':

Figure 15: Examples of creative expression of self as a leader

Engaging in first-person inquiry enables action researchers to respond to research situations with a "sense of being morally grounded and confident in [their] actions" (Brydon-Miller, 2008, p. 205). Tools to support reflection on value systems, identity, access to and use of power and privileges, as well as influence on research participants and the research process are extremely varied. For self-inquiry into my own being as an action researcher, I consistently evaluated activities I facilitated, held a researcher journal and used meetings with my PhD supervisors and action learning set (ALS).

Whilst I reflected in-action as an action researcher, the most productive reflections took place on-action (Schön, 1987). Reflective dialogue with self as "a form of discourse with one's self, [and] exploration of possible reasons" (Hatton & Smith, 1995, p. 41) mostly took place in the 1-1½hr drive to and from the research setting. In solitude, I could contemplate what had occurred, how I felt, what influences outside my own being needed consideration, my plans and possible consequences of intended actions. Although unguided and unstructured, I would often find landmarks that triggered my thoughts and/or were inspiring.

As well as recording short notes of these reflections in my hand journal, I would also record preparations before/after activities. Familiarity with several structured models of

reflection helped me move through various levels in a short space of time. Occasionally, I spent longer periods reflecting on an issue/incident using a model and documenting my thoughts in more detail. However, reflecting in isolation has its limitations as the personal perspective may be distorted, certain areas (pre)consciously avoided and/or personal knowledge limit the viewpoint that can be taken in trying to understand situations (Johns, 2002). Supportive, guided critical reflection offered by others enabled me as a learner action researcher to transcend habituated ways of doing and thinking and reach a more critical level of reflection in which more and broader historical, cultural, social and political perspectives were taken into consideration (Hatton & Smith, 1995; Lieshout van, 2013).

Six weekly PhD supervision sessions and my own ALS group formed the setting for guided critical reflection. They helped raise awareness to issues that I may never have seen if left to my own devices. For instance, questioning my views on the role of action researcher and the concept of leadership, my PhD supervisors enabled me to think critically about whether and how I could include my own experiences of leading an action research study as data for the conceptualisation of person-centred leadership. They supported the development of 'an attitude of inquiry' (Marshall & Reason, 2008), curiosity and commitment to finding out more, willingness to share what I felt should be done whilst remaining open to alternatives, re-framing of my perspective when need be, and exploration of power issues both within my relationship with participants as within the context. Similarly, my own ALS members helped me reflect on how to respond appropriately to experiences and ethical dilemmas such as when the UM was threatened with displacement from her post. I learnt how my own presence was (in)directly influencing the whole system, and how to look forward and build on what was working well rather than remain fixated and frustrated by slow progress and resistance. I also learnt to accept what I did know whilst acknowledging its possibly limited validity, and to be intrigued by that I did not know.

ETHICAL CONSIDERATIONS

In the Netherlands (local) ethical committee approval is only required for scientific medical research when "treatment or behavioural codes are imposed on participants" (Borst-Eilers & Sorgdrager, 1998). Ethical approval was required from the University of Ulster Filter Committee and obtained in September 2009 after proposal review by an experienced Dutch action researcher with no professional ties to myself or the study, as well as an experienced practice developer from Northern Ireland.

Formalities such as ethics committee review and obtaining signed informed consent from the participant leaders was just the starting point and for me not the most important aspect of the ethical journey. Winter & Munn-Giddings (2001) principles for ethical action

research (duty of care; respect for the individual person, cultural diversity and individual dignity; protection from harm) were the starting point for my ethics framework. In light of the central concept of this study, person-centred leadership, I sought depth from Bergum & Dossertor's (2005) account of relational ethics, and McCormack's (2003b) framework for person-centred research.

Ethical reasoning, the 'how to behave' questions I posed myself and participant leaders, became part of daily research life (c.f. Pålshaugen, 2008) as we felt responsibility for the wellbeing of others (c.f. Winter & Munn-Giddings, 2001). As an action researcher facilitating change I was aware of the need to be active and supportive without taking control (c.f. Winter & Munn-Giddings, 2001). There was the risk that my ideology of what constituted person-centred leadership and good action research practice could possibly have been in contrast or conflict with participants' perceptions, and so measures were needed to prevent them being left with an established change they did not feel comfortable with. I felt that actions and changes should be undertaken consciously, with consideration of potential consequences and reflect the principles of collaboration, participation and inclusivity to help maintain ethical focus (c.f. Winter & Munn-Giddings, 2001). Acknowledging the importance of input from others in decision-making moved me into the field of relational ethics, situated within the relational space between myself and participants as we made a conscious effort to engage with mutual respect (c.f. Bergum & Dossertor, 2005). The other-centeredness inferred in mutual respect does not exclude respect for self, or being respected by others (Bergum & Dossertor, 2005). Creating safe communicative spaces, we were able to share our values, beliefs and desires before making shared-decisions and engage at both a professional and personal level, as recommended in AR by van Lieshout (2013).

Whilst a relational approach to ethics helped me from taking a parental stance towards participants, McCormack's (2003b) framework for person-centred research helped the study design and execution. He recommends consideration of seven areas when conducting research that demonstrates person-centeredness: time investment; environment preparation; researcher socialisation; boundary (re)negotiation; informed consent, authentic representation of participant voice and disengagement from the setting. The following describes how these were evident in this study.

With regards to time investment, the study ran the agreed three years as participants and I wanted to complete the full duration, despite pressure from a physician manager to end the study early. The timing of research activities were negotiated and primarily took place within participant working hours. The environment was prepared by introducing the study to the whole team before commencing in fieldwork and associate hopes, fears and expectations immediately collected, acknowledged and responded to appropriately. Issues that arose were clarified, resolved and/or agreements made as soon as possible. Presentations of the study's progress were also offered throughout the study. Research ac-

tivities during the orientation phase helped me become socialised within the setting, and small gestures such as receiving the same gifts as other members of staff demonstrated acceptance of my presence within the team. From the beginning, people knew who I was and my researcher role was kept clear by not engaging in providing patient care and not wearing the same uniform as other members of the nursing team. New comers (including patients) were informed of my role and the study aims, and their participation negotiated with them. Sharing my experiences with participants and collectively reflecting with them contributed to transparency. Seeking consent before engaging in observation and overtly recording notes made data collection explicit, as did overtly audio-recording interactions that could potentially be used for data analysis, which also helped ensure authentic representation of their voice. Such explicitness demonstrated my intent of acknowledging their being and importance and fostered the building of person-centred relationships. Boundaries were continuously (re)negotiated, proxy consent never used and quotations used to illustrate findings member checked with participants. Personal characteristics such as gender, role and the ward speciality were consciously disguised to lower the risk of identification. This was particularly relevant as we worked with participant narratives and sometimes those named in the narrative were not always aware of this and yet their role within the narrative was of too great importance to eliminate them. The primary leader participants also followed and member checked post fieldwork data analysis, as well as the concept draft of this thesis before submission.

DATA ANALYSIS FRAMEWORK

Data analysis, as the systematic interpretation of collected data in order to discover patterns and relationships, was broadly speaking hermeneutic and emancipatory praxis in this study. Hermeneutic praxis is thoughtful action based on interpretative 'reading' of written/verbal narratives/texts, with a moral intent of transforming understandings of individuals, teams, organisations and communities (McCormack & Titchen, 2006). Whilst reflecting on the data gathered with participants during the action spirals contributed to the transformation of local understanding of person-centred leadership, post fieldwork analysis enabled me to expand the scope of influence to include a wider public through presentations and publications. Emancipatory praxis is thoughtful action with a moral intent of enabling people to free themselves from internal and external barriers to their sought goals. During the study, critical and creative communicative spaces helped participants identify and remove/transform personal and contextual barriers to developing person-centred leadership. Analysis of the developmental journey, combined with our accumulated understanding of what person-centred leadership was, resulted in a conceptual framework (presented in Chapter 6). The conceptual framework of person-

Phase	Primary data gathering events	Key subjects
Orientation	Patient Stories	8 patients
	Staff stories on care	16 staff nurses
	Staff stories on leadership	11 staff nurses
	5 open observations of unit culture	Staff/patients/visitors
Action spiral 1	19 Critical and creative reflective inquiry sessions resulting in 15 narratives	2CNs 1UM 1CNS 2PNs
Action Spiral 2	Workshop – visioning primary nursing	2CNs 2PNs
	Workshop – primary nurse role	2CNs 2PNs
	23 observations of leadership practice + post-observation interviews	2CNs (16 sessions) 2PNs (4 sessions) 1UM (3 sessions) 2 staff nurses 2 students 1 Physician
	4 meetings to evaluate PN implementation process	2PNs 2CNs
	Culture workshop facilitated by UM+CN	5 staff nurses
	Unit leadership evaluation workshop facilitated by external researcher	5 staff nurses
	Data analysis of evaluation questionnaire (response n=15) facilitated by action researcher + CN	4 staff nurses
Action spiral 3	13 facilitated storytelling sessions + post-observation interviews	2CNs
Action Spiral 4	Annual reflection 1	2CNs 1UM
	Annual reflection 2	2CNs 1UM action researcher
	Annual reflection 3	2CNs 1UM action researcher
	19 supervision sessions	4 supervisors 1 action researcher
	3 Action Learning Sets in which researcher was presenter	±7 members

Table 1: Overview of primary data sources

centred leadership offered answers to both research questions and is a potential tool for other individuals, teams and/or organisations interested in developing and/or researching person-centred leadership.

More traditional methodologies refrain from data analysis until after data collection has been completed, but, in action research the continuous action spirals necessitate tentative interpretations ‘along the way’ so that momentum can be maintained (Winter & Munn-Giddings, 2001). Data analysis during the orientation phase was structured, systematic and participatory, offering a solid foundation from which to determine action spirals. Data analysis during the action spirals was less elaborate, time-consuming or rigorous,

but sufficient to maintain a steady flow of exploration and action. Practical knowledge of person-centred leadership was continuously being developed. As we were careful to (audio)record any and all potentially relevant data, a more rigorous post fieldwork analysis contributed to the generation of emancipatory knowledge.

Leaving the field, I was able to take a step back, no longer distracted by the intense sensory input of everyday life in the research setting. I was able to quieten my mind and focus on the bigger picture emerging from the last two years of data collected during the action spirals. Winter & Munn-Giddings (2001) state that data analysis of action research projects results in a description of the development journey, rather than a summing up of findings and conclusions. Whilst a thick description of the developmental journey was feasible for the research question "How can person-centred leadership be developed", a thematic framework was needed to describe person-centred leadership as a concept. I therefore designed a data analysis framework based on thematic analysis.

Thematic data analysis is one of the least publicised yet widely used forms of data analysis (Braun & Clarke, 2006; Buetow, 2010). Braun & Clarke (2006) view the distilling of themes with meaning from data to be a fundamental skill for qualitative research, and thematic analysis as the most flexible of all methods as it is appropriate for a wide range of theoretical and epistemological approaches. It includes identifying, analysing and reporting patterns across a data corpus (whole of the data) and/or data sets (collection of data collected at separate intervals). Themes are presented as structured, rich descriptions which do not reduce or disguise complexity (Braun & Clarke, 2006). Van Manen (1990) talks of recovering themes embodied and dramatized in the evolving meanings and imagery of the data that offer answers to the research questions. Themes and their thick descriptions offer those unfamiliar with the phenomenon or context an accurate picture without having to read and interpret the raw data. They are created by identifying and integrating (repeated) phrases, incidents, attitudes, behaviour and/or expressed understandings (Buetow, 2010; Ely et al., 1991).

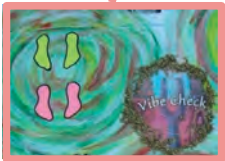
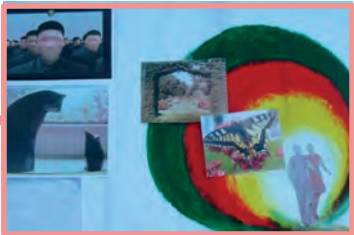
The data corpus consisted of more than 215 hours of audio-recordings, plus texts written during the fieldwork such as participant observations and summary/analysis documents of various workshops. The accumulated mass of data needed to be reduced if analysis was to be feasible. It felt like a farmer after the harvest, separating the corn (relevant data for the research questions) from the chaff (irrelevant/everyday chit-chat). I started by identifying those data sets I felt held the most fruitful data. For the research question 'What is person-centred leadership?' the primary data set included: critical and creative reflections on 15 leader narratives shared during action spiral 1 (32 hours of transcript) and 23 participant observations and post-observation interviews from action spiral 2 (10 hours of transcript). For the second research question 'How can person-centred leadership be developed?' the primary data set included: eight post-observation interviews of leaders facilitating storytelling sessions in action spiral 3 (four and a half hours

of transcript), three annual reflection sessions of action-spiral 4 (eight hours of transcript), a halfway participant leader evaluation of the whole project (two and a half hours of transcript), participant leader evaluations of my leadership from action spiral 4 (one and a half hours of transcript) and a staff evaluation of participant leaders from action spiral two (one and a half hours of transcript). Remaining documentation and audio-recordings formed secondary data sets and were scanned for complementary extracts/new themes after the initial analysis.

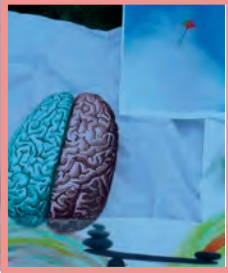
To 'lift' the essence of person-centered leadership and its development from the data, I designed the inductive six phased framework presented below, by combining processes from Braun & Clarke's (2006) framework for thematic analysis and van Lieshout & Cardiff's (2011) critical and creative hermeneutic analysis. Although the phasing seems linear, there was fluidity of movement between phases. For instance, having indexed themes using the primary data sets, I sometimes returned to phase 1 and secondary data. Moving on to phase 4 I used data extracts to blend with existent (sub)themes and/or introduce new themes.

1. *Familiarization and submergence*: Familiarisation requires reading the whole data set, refreshing and enhancing the knowledge already gained through participation in fieldwork. I was now able to step back and view the whole, recognising the familiar and discovering new areas for contemplation. Having read the whole once, I submerged myself in the texts again, noting relevant events and citations on post-its which I then clustered and reduced to tentative sub-themes.
2. *Creative expression*: Thought processes (inferences, associations and memories), feelings and images activated in phase one felt overwhelming and chaotic. Fear began to rise that I would not find structure and coherence among the mosaic of words. Setting the texts aside to focus only on the images in my mind and body sensations, I used creative arts materials to express cognitive and embodied inferences on a very large blank sheet. Whilst words did fly through my thoughts, I resisted the temptation to add them to the imagery until after I was satisfied the whole was complete and coherent. I made a conscious effort to regularly step away from the emerging imagery to view the whole as it emerged, zooming in again to attend to detail. Colours changed and cut-out images moved around until I was happy the final image portrayed the narrative I was reading in the data (see Figure 16 p.97). The image narrative reflected both the developmental journey and person-centred leadership being.
3. *Blending & Melding*: Returning to cognitive and linguistic expression, I added the sub-themes already noted in phase 1 to the imagery, along with new themes and sub-themes emerging during the creative process. Seeking patterns and connections, I moved words around. Some blended into each other whilst others retained their distinctiveness and/or were melded together. After retreating for a while, I returned with new eyes and key processes of person-centred leadership started to emerge. When

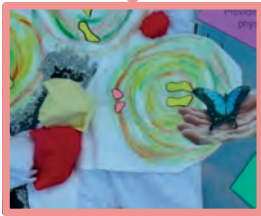
1: People with no faces, cat overshadowing the mouse, the butterfly set against the hedged garden & two people meeting against a backdrop of primary colours



2: Circles of colour, footsteps & vibe check



3: Balanced stones, bicoloured brain & kite in the sky



4: Coloured rocks, black holes & butterfly being released

Figure 16: Creative expression created during data analysis

I repeated the process with the second data set, the image did not need to change and subthemes were easily categorised into leader attributes, facilitation processes, contextual influences and outcomes.

4. *Indexing*: Having identified themes, extracts were lifted from the raw data to produce thick descriptions. Any new sub-themes emerging from rereading data were considered in relation to the imagery and emerging thematic framework. The process was documented with the help of theme matrices.
5. *Reviewing and refining*: Writing thick descriptions of the themes continued the reviewing and refining process, often returning to raw primary and secondary data to check the context in which things were said and/or to seek other examples.
6. *Critiquing*: The thematic frameworks for each research question were presented to the participant leaders for member-checking, accompanied by the question: "To what extent do these frameworks resonate with your personal recollections and conclusions of what person-centred leadership is and how it can be developed?" Simultaneously, PhD supervisors read the thematic frameworks, questioned and/or contested assumptions, and occasionally reminded me of events that I had discussed previously but which seemed to be missing. The final frameworks and descriptions were presented to the management team of my university faculty for public scrutiny. Recognition of the leadership process and contextual influences enhanced trustworthiness.

Two thematic frameworks emerged from the data analysis and are presented in Chapters 4 and 5. Bending the thematic frameworks and reflecting on their content in light of existent theory and research, produced a conceptual framework for person-centred leadership (see Chapter 6).

CONCLUSION

Embarking on a research study entails examining ontological and epistemological beliefs before choosing a research methodology to guide design decisions. The philosophical framework for this study pulls assumptions from critical social science, critical realism and critical creativity. Social structures, conventions and practices are seen as the product of human relating, which themselves are influenced by the conditions produced by the social structures, conventions and practices. These conditions may be oppressive, limiting or preventing human flourishing, but, as active beings, humans have the potential to transform the social structures and so enable empowerment and emancipation.

Studying reality demands working with the empirical layer that people are able to perceive, but this is the product of (interacting) generative mechanisms that create events. Dialoguing such perceptions in safe, critical and creative communicative spaces enables a freer exploration and development of plausible (theoretical) explanations as well as

ways of transforming social structures. Knowledge is the product of human relating and an inclusive approach to data collection and analysis increases the robustness of findings and adequacy of transformative actions.

As person-centred leadership was not a phenomenon documented or dialogued with in nursing, the conceptual framework of person-centred nursing and values framework of Chapter 2 were used to support reflections on leader behaviour and social structures potentially characteristic of person-centred leadership. Critical participatory action research offered a methodology to accommodate the philosophical framework and design activities for the exploration of person-centred leadership in a nursing context. An orientation phase exploring care and leadership narratives, alongside participant observations of the contextual structures, conventions and practices, preceded four action spirals. All four action spirals were intended to support the critical exploration of current leadership practice, identifying mechanisms and structures generating leader thinking and doing, so that theories could be formulated and decisions made on how to generate leadership practice that could be classed as more person-centred. The first action spiral entailed the implementation of primary nursing tailored to meet contextual resources and needs. The second action spiral created space for collective, critical and creative reflective inquiry into participant leadership. The third action spiral involved participant leaders facilitating short storytelling session within the working day to foster person-centred practices. The fourth action spiral was a self-reflective inquiry into participant and researcher growth and development.

Whilst analysis was an on-going process within the action spirals, post fieldwork critical and creative thematic data analysis produced two thematic frameworks for each research question. These were later blended to create a conceptual framework for person-centred leadership.

**Person-centred
leadership processes**

Chapter 4



INTRODUCTION

The thick description of person-centred leadership in this chapter is the result of a thematic analysis of narratives shared and collectively reflected upon with participant leaders, alongside participant observations and reflections of the leaders in action. Fifteen leader narratives underwent a critical and creative reflective inquiry during biweekly sessions. Other narratives were shared during post-observation interviews (n=23) with leaders/associates. The thematic analysis began with a creative expression of my interpretation of 'the whole' after immersing myself in the raw data set (see Figure 16 p.97). This creative expression helped me identify eight core themes/processes describing the essence of person-centred leadership. Before describing each theme in detail, definitions of (person-centred) leadership and primary nursing are offered to 'set the scene'.

DEFINING PERSON-CENTRED LEADERSHIP

After the first critical and creative reflective inquiry of March 2009 it became apparent that participant leaders had no shared vision or definition of leadership. In previous workshops they had identified key values: openness, communicativeness, honesty, enthusiasm, flexibility, responsibility/accountability, freedom, humour, efficiency and trust. During the study these values did not change so much as gain depth of meaning and expanded in number. Leadership had, as is common, been linked to hierarchical positioning within the organisation: directors led sector managers, sector managers led UMs, UMs led CNs and CNs led nurses and students. In May 2009, participant leaders defined leadership as 'supporting individuals and groups in achieving common goals'. As they explored the meaning of person-centred leadership, the importance of seeing the individual in context started to emerge:

"UM Betty: By being person-centred you continuously look anew: "Who is this opposite me? What are the circumstances? What is the goal I want to achieve? And, how can I achieve that?" I feel that person-centeredness doesn't tell you what you should do."

Action spiral 2 resulted in the implementation of a nursing system closely aligned to primary nursing: the 'regie systeem'⁴. Pool et al (2001) had previously proposed 5 core roles for bachelor educated nurses, one of which was the role of 'regisseur'⁵. Early vi-

4 For the readers convenience, the term 'primary nursing' will be used to denote the Dutch term 'regie systeem'

5 For the readers convenience, the term 'primary nurse' will be used to denote the Dutch term 'regie verpleegkundige/regisseur'

sion workshops had resulted in a shared vision for primary nursing and the PN role. The ultimate goal of changing the nursing system was to create a workplace culture in which people (patients and staff) could come into their own⁶. Primary nursing was defined as “creating a safe climate for collaboration, characterised by acceptance, respect, offering direction and coaching”. The main tasks of the PN included: delivering person-centred care; improving coordination and continuity of care for six patients; facilitating the learning of others; responsibility for ward logistics; and creating an effective workplace culture. Competences required included: positive attitude; specialist nursing knowledge; empathy; abstract thinking; systematic thinking and doing; interpersonal skills; stress resistance; decisiveness; and being a team player.

As the UM (Betty), CNs (Loes and Fleur) and PNs (Tess and Chloé) implemented primary nursing they started to envision leadership as more than a hierarchical position within the hospital organogram. Loes and Fleur held a hierarchical leadership position, but, also a non-hierarchical position as a PN. Tess and Chloé, two experienced staff nurses who had successfully applied for the post for an experimental period of 2 years held a non-hierarchical position. Each PN worked closely alongside associate students and staff nurses, as well as collaborating with physicians and allied healthcare professionals. In essence, they aimed to be person-centred clinical nurse leaders. A year after initial contemplations, person-centred leadership was collectively defined as:

“... a style of leadership in which the leader tries to enable people to come into their own whilst working towards a shared vision/common goal.”

THE CORE PROCESSES OF PERSON-CENTRED LEADERSHIP

The following is a short explanation of the creative expression made during the data analysis. Whilst core processes are alluded to here, and then named explicitly in the subsequent text with a graphic representation of the thematic framework, more detailed descriptions supported by raw data follow thereafter.

During the analysis, when looking at the imagery in Figure 16, I was struck by the sense of continuous movement and flow, as opposed to a series of singular actions. On the far left of the main image are two cards of people with no faces, no identity and a cat overshadowing a mouse (see thumbnail 1 in Figure 16 p.97). This represented the past now left behind. The photos of a butterfly and hedged view of a garden were reminiscent of the continuous movement between the parts and the whole, the individual and the group, a single situation and the greater context. Pictured against a backdrop of primary

6 people can develop, transform, grow, feel safe and be acknowledged as an individual.

coloured spheres are two people, engaged with one another. This symbolised leader and associate meeting against a backdrop of different spheres of being/habitus particular to and influencing each person's being.

The footsteps (see thumbnail 2 in Figure 16 p97) were indicative of leader position self in relation to the associate, and the variations of colour dominance in the swirls under the feet signified how some spheres of being were more influential at times than others. The vibe check card represents a leader's sensing and checking of an associate's state of being. Spread across the scene are various coloured rocks and black holes (see thumbnail 4 in Figure 16 p97) characterising the barriers to achieving person-centred relationships and coloured to show their origins in the different spheres of being. The balanced stones (see thumbnail 3 in Figure 16 p97) were symbolic for the balancing of needs, sometimes a heavy task. In contrast, the bicoloured brain denoted the use of rational and creative thinking and doing which, when connected, influenced future being. The kite in the sky reminded me of shared visioning and how vision offered direction to leaders and associates. On the right hand side is a butterfly being released (see thumbnail 4 in Figure 16 p97) which epitomised moments of coming into own. The windmill image on the far right of the creative expression is a representation of McCormack & McCance's (2010) framework, made in response to associate feedback that the original diagram was too flat and did not speak to them.

To answer the research question 'What is person-centred leadership?' the eight core processes open with a close-up shot from the creative expression in Figure 16. This style



Figure 17: The thematic framework of core person-centred leadership processes

of presentation is intended to help the reader gain a sense of the parts (core processes) in relation to the whole (person-centred leadership). The opening sentence of each theme forms a definition and italic citations are quotations and the plain text within them are my own additions to aid readability. The core processes are: sensing, contextualising, balancing, stancing, presencing, creating safe critical spaces, communing and coming into own. They are shown in relation to each other in a graphic representation (see Figure 17 p.105), which has been purposely configured as a circle to represent the dynamic movement of the leader-associate relationship.

Sensing



Sensing is the continuous process of actively and passively seeing, hearing and feeling, gathering and analysing information and cues from the person, their performance and context. Verifying interpretations helps the leader choose an appropriate response/stance conducive to the ultimate goal of enabling others to come into their own.

Leaders would engage all their senses to gather information about self, the other and context. Sometimes they would choose a different path to where they were heading in order to hold a short conversation or observe events. At other times they would engage in more lengthy, private conversations.

"... I also thought, "I need to check that out," and that's why I asked the people I ran into [how are things where you are] ... I can think that it's all fine ... [but] that's why I also walked along the corridor, so that I could get a feeling again with West, like, "Does it feel good?" Yes, for some reason I can get a feel of things really quickly ... It's the atmosphere that you sense ... or you see family walking around [looking for a nurse] ... I just want to have a quick look ... and when I walked along [West] it felt fine to me."

(Post-observation interview with CN Fleur)

The most frequently cited senses were 'seeing', 'hearing' and an inner 'feeling'. A whole range of verbal and non-verbal cues were 'read', including: tone of speech; eye contact; people talking in the third party when sharing a narrative that seemed personal; fidgeting; poor performance and unexpected emotional reactions. Positioning self, in order to sense optimally, sometimes included choosing to work alongside associates, as Fleur explained when asked why she had decided to work alongside staff nurse Jane who was on a graduated return after a period of sickness:

"... I had a talk with her last week and things are not going well for her. She can't organise her work well. She's very muddled and quite chaotic in her work and I know why that is. So that is why I was extra attentive with her today and I went to help her in her rooms because I saw that she wasn't coping well. I saw it on her face and in her eyes ... I wanted to have a clearer picture of her throughout the day. I asked, "How are you coping?... You come across as being a bit muddled." I shared that with her, like, "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 with CN Fleur)

Being human, a leader is fallible and susceptible to false consciousness. Verifying the accuracy of their interpretations helped them choose an appropriate, if any, stance or response. It also demonstrated other-centeredness and caring. I once observed Fleur reading Loes' non-verbal language and asking: "You've got a lot on your shoulders, haven't you?" Whilst this invited Loes to verify Fleur's interpretation, Fleur's choice of words also displayed a sense of sympathy. Loes verified these interpretations, but did not want to discuss the subject in the corridor. Fleur now knew that she could follow-up on her observation and Loes had been recognised and supported in that brief moment.

One's own state of being influences sensing accuracy and, even when leader intuition is right, immediate and/or intuitive responses may not always be appropriate or effective. Whilst leaders instigated feeding back observations, the situation in which this was offered and the time spent giving feedback, was tailored to the individual. It was also non-judgemental and sometimes supported with the leader's rationale. It could open new communicative spaces for the associate to share their narrative and enable communing. The context in which interpretations are offered is also important. Anne, the clinical nurse specialist (CNS) was stressed by the difficulty she was experiencing coordinating physician contributions to an internal education programme. When faced with a panic-stricken consultant who was unaware that he had been planned in for one session, she reacted assertively, shortly and sharply. During the CCRI she asked herself whether she was missing something or just needed to accept that this was typical behaviour for him. Her reflected action was to re-engage with the consultant physician in private, inviting him to tell his side of the story/interpretation of the event, so that she could verify her interpretations before undertaking further action. Knowing the person, Anne choose to engage with him in a quiet room alone, rather than approach him, as would have been feasible with any of the other consultants, as he rushed between tasks.

Briefly checking-in with associates was the most common strategy employed by the CNs to gather information and/or verify observations. Initially, unrequested feedback was frequently given immediately. As this strategy was reflected upon, their practice changed to inviting the associate to share their narrative of an event before offering feedback.

Leader perceptions and interpretations of associate being in the here and now were sometimes supplemented by information and cues from other sources and/or knowledge of an associate's history and personal traits. I observed leaders using feedback from others who had engaged with an associate, memories of past leader-associate encounters and more objective facts such as sickness records. The blending of information and cues gathered from multiple sources helped them understand the associate within context and make decisions on how to respond/act, made either alone or in collaboration with the associate. At times, new emerging questions instigated new cycles of information gathering and analysis and whilst the blending of new information sometimes increased complexity, it also helped identify core issues. Jo, an experienced but insufficiently technically competent staff nurse, was angry at being expected to attend the internal education programme: "Why do I need to be re-educated when I perform well and am caring towards patients?" Anne was surprised that anyone would not welcome the long awaited schooling and felt frustrated at Jo's resistance. But, hearing the panic in Jo's voice and recognising this as characteristic of Jo in new circumstances, Anne listened attentively to Jo's anxiety about having to concentrate at her age and in the middle of her menopause. Loes and Betty offered extra information that Jo had also lost several loved ones that year and was struggling with her own health. Anne concluded:

"Yes, the person-centeredness is very much in the fact that you know her in that moment, have experienced her in different situations and know how she can react and, of course, know that if you give her a nudge, all will be fine. So, in those terms, there is a bit of pre-knowledge, history."

(CNS Anne's CCRI - Story 3)

Factors influencing leader sensing and positioning of self in relation to the associate (stancing) include: associate openness towards the leader and receptiveness for leader feedback, an associate's situation/narrative resonating with the leader and emotional intelligence. The leader's personal values and beliefs also influenced what they were aware of and sensed. Whilst observing the leaders in practice I tried to remain open to what I felt, saw and heard. I started to notice that I would pick up on aspects of patient care which I felt were important but seemed to fall outside the CN's field of awareness. Questioning and/or feeding back my observations of patient care verified that the leaders were often more focused on associate wellbeing, workload and (task)efficiency than patient care.

"Fleur: It was busy and cramped there in the room ... what did I think about it? ... There was a lady who made a lot of noise in the wheelchair... I can't remember much about it ... I stood on the side line, because Loes was in the room too. If I start to give opinions about what was happening, then we'll soon all be giving opinions about the situation. So, I consciously shut myself off

a bit, because Loes was in the room ... In hindsight I could maybe have gone and stood outside, then it wouldn't have been so busy in the room, and they would have had more room to ...

Shaun: What did you think about the way they treated the lady?

Fleur: ...I wasn't really concentrating about that at that moment ... I think that I shut myself off a bit at that moment, because Loes was there too, and it wasn't appropriate at that moment ...

I could get in (the room)."

(Post-observation interview with CN Fleur)

Summary

Sensing is the process of 'seeing', 'hearing' and 'feeling' where the other is in the context of present, past and future circumstances. Aware of their fallibility as a human being, the person-centred leader may gather supplementary information from other sources to verify the accuracy of their interpretations before choosing a stance or response. They demonstrate other-centeredness and caring, tailoring their response and offering non-judgemental feedback accompanied by rationale. Factors influencing leader sensing and stance include: personal values and beliefs, associate openness towards the leader, an associate's situation/narrative resonating with the leader and leader emotional intelligence.

Contextualising



Contextualising is the process of seeing the associate in context, against a backdrop of different influences. The underlying assumption is that a person (positively/negatively) influences and is influenced by the social structures, processes and people within the various 'spheres of being' they inhabit. For instance, I am a foreign national living in a Belgian village, a partner at home, a lecturer at a university etc. I influence and am

influenced by these contexts and the people in them.

A person-centred leader tries to understand how various spheres of being are influencing an associate's current state of being. In Jo's story above, increased expectations of nurse competency within the professional and workplace spheres of being were exposing her weaknesses. In another example, staff nurse Jane's situation was complex as she was new to the ward and had no specialist nursing knowledge and was struggling to cope with pubescent children as well as marital problems.

"... A bit out of anger too because her husband just happened to have changed jobs, just like that! So she thought, "I can do that too," and so she did, and her safe working environment disappeared."

(CN Loes' CCRI – Story 9)

After a long period of sickness and a 6 month graduated return to work, Jane's performance failed to improve. Fleur began to question whether she could ever come into her own within the ward. Such narratives create moral dilemmas requiring leader reflexivity if the aim of enabling the associate to come into their own is to be achieved.

"It is very difficult for me to detach the two. Is it all due to her being ill, that she hasn't been able to function adequately here? Or is it simply that she's aimed too high this time and needs a longer induction period than others?... We're at a stage of graduated return now and are we going to give her every chance to come back later and begin from the beginning, with an induction. Which everyone has a right to. But, will she then be where she was, or, will it turn out that it was not such a good step for her to make at all [changing posts]?" (CN Fleur's CCRI - Story 9)

Using historical and actual knowledge of an associate in context, alongside sympathetic imagination, the leader tries to gain a deeper understanding of the interplay of the various spheres of being on associate wellbeing and performance. Using knowledge of Jane, her history and current situation, Fleur tried to imagine a situation in which Jane could feel safe and supported enough to recover during her graduated return. One option was for Jane to temporarily return to her previous workplace, but, Fleur questioned for whom this would be beneficial? If Jane could not cope there either, would this accentuate the home situation? On the other hand, if she did cope, it may create space for her to resolve issues at home without losing contact with the hospital. There was also the possibility that she may come to a realisation that working on the specialist unit wasn't enabling her to come into her own at work and so decide to remain on her previous unit. Seeing Jane in context, exploring possible consequences of actions, Fleur attempted to do the right thing and find a situation in which Jane could experience a state of relative wellbeing at work without being experienced as a burden to others.

Contextualising extends further than inquiring into an associate's values and beliefs. It involves looking deeper than initial, (potentially) superficial impressions. Pam was a young newly qualified staff nurse who, having had no clinical placement experience in an acute hospital during her training, had consciously chosen a relatively small and quiet ward within the Trust satellite hospital for her first post. Unfortunately, due to reorganisations the ward was closed before she started. As the Trust was contractually bound to find Pam work, she was offered a position on the acute specialist ward. Despite strategies to help her develop, after several months it became apparent that Pam was finding life hard and her development was becoming slow and burdensome for others too. Even though she was liked as a person, the CNs concluded that the ward did not have the resources to continue supporting her. Loes struggled with this dilemma. She did not want to hurt Pam, but felt that Pam needed to become aware of the reality of the situation.

"I have to do something. It's not good. It's not good for anyone. We're not happy with the situation. She isn't really going to get any better under these circumstances. She won't become a good nurse if we leave her here like this. It's not good. Something needs to happen. And we need to look critically at where we can help her. I was full of doubt. As I said to you [Fleur] this week, "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, go and do something else." ... She's still a nurse. She has done her training and she does try her hardest. She's a pleasant girl and fits in well with the team. People like to work with her."

(CN Loes' CCRI - Story 14)

Alongside relational history and events in their personal spheres of being, demands, standards and criteria from other spheres sometimes negatively affect both leader and associate wellbeing and performance. This in turn may affect the leader-associate relationship. Emotional intelligence and openness about such influences can aid mutual understanding, shared decision-making and retain a sense of connectedness between leader and associate. Loes' conflict with staff nurse Nadine showed the consequences of a lack of reciprocal contextualising and sympathetic presence.

Nadine was an experienced staff nurse who, after a traumatic childbirth, could no longer perform physically demanding tasks and was working on a therapeutic basis. There was history of conflict between Loes and Nadine and whilst Nadine tended to wear her heart on her sleeve, Loes tended not to express her emotions and believed in keeping work and home life separated. In light of Nadine's physical limitations it had been agreed that she would start later and only work several hours a day. The CN who started at 07.15hrs would cover for Nadine until she arrived. One particular morning Loes accidentally arrived too late. Realising her mistake, immediately sensing a workload issue and Nadine's anger and yet wanting to protect her 'office day', Loes proceeded to organise everyone and the workload situation. As she left the work floor for her office she said, "I've organised extra help. If you need me, come and get me." Later that day Loes was called into the daily evaluation session. Nadine was in tears, blaming Loes for having overexerting herself and now suffering pain which would last all weekend. Whilst other members of staff explicitly expressed sympathy for Nadine's situation, there was no recognition of Loes' situation. Loes felt under acknowledged and relational distancing between herself and Nadine increased.

"...what I have problems with is ... I'm trapped ... on the one hand I have my work, my head is full, Nadine is therapeutic, we're really [busy] ... I feel that I am very caring around her, and ... do everything to integrate her into the ward ... We're trying to find all sorts of constructions to make it good for her. Now she has run up against her own limitations and it's my fault? That bothers me, and I think to myself, "OK Nadine, I let you run up against your own limitations so that you can experience that you have limitations, and have to acknowledge that. You feel your

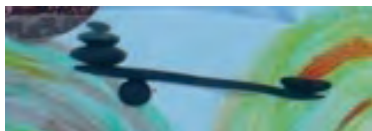
own body, not me.” ... We’ve not spoken to each other for nearly a week. We say ‘good morning’ and ‘good afternoon’ and that’s as far as it goes.” ... You know, my husband isn’t well ... he stood here two weeks ago and said, “I’ve been to the doctor ... I need to see the neurologist...” So I’m shocked by this and it keeps playing on my mind ... but not to the extent that I need to talk about it here. That doesn’t even enter my mind.” (CN Loes’ CCRI - Story 10)

If contextualised connectedness is to be achieved, understanding and being with the associate in their unique situation is necessary for the leader to enable them to move on and come into their own. Knowing self and one’s context, as well as a willingness to share one’s vulnerability (be it leader or associate) is vital to mutual connectedness within the leader-associate relationship.

Summary

Contextualising is the process of seeing the associate in context. Context includes all the past, present and future spheres of being a person inhabits in their private and working life. The leader tries to understand how these influence an associate’s current state of being. It involves looking deeper than initial impressions or values and beliefs. Emotional intelligence and openness about these influences can aid mutual understanding, shared decision-making and retain a sense of connectedness. Contextualised connectedness demands understanding and being with the associate in their unique situation in order to enable them to come into their own.

Balancing



Balancing is the process of (morally) weighing the needs of the associate against those (competing) needs of other individuals, groups and self.

“I feel that you should always start from a position where you ask what the other needs, but also make known what the restrictions and possibilities are.” (PN Chloé 07/12/’09)

Finding the right solution(s) involves sensing and posing critical questions. Seeing the individual within the group should not distract the leader from seeing the whole group too. Decisions made at one level (individual/group) may (in)directly have consequences for other(s) and uncomfortable (shared) decisions may need to be made when competing needs are an issue. Leaders are also led, and a hierarchical workplace culture can influence leader choice, however morally aware they may be, as Anne and the CNs discovered during a conflict of vision with the new consultant physician Fiona. Fiona had promised a gentleman that he would be discharged to long-term care where his wife had recently been admitted, without consulting the CNs or clinical nurse specialist and despite the

gentleman not meeting admission criteria for long-term care. When challenged about the decision she had made, Fiona was not prepared to negotiate, stating that she would rather the Centre for Care Indication rejected the application than inform the gentleman and family herself and begin exploring alternatives. Anne, who coordinated complex discharges, was consequently left with a difficult situation and troubled by the process. During the CCRI a dialogue ensued about the balancing of one individual's needs with those of others.

"Betty: ... There's the individual case, but, you also have a responsibility that rises above the individual. The CNS was focused on reaching consensus among the people involved – patient, family, geriatrician etcetera ... Because there were opposing opinions, she wanted to try and meet all their wishes ... A place [in the nursing home] is now blocked for someone who does have a right [and meets criteria] ... What's troubling me is, "To what extent can you place the interests of an individual above the group's interest? ... Is person-centeredness concerned with the individual person, or, also with the next person to come along?" ... How do the interests of the individual weigh up against those of the group? Or the interests of a person who, as yet, has no face. Being person-centred for one person always has a relation with how you can be person-centred to others... you have the tendency with person-centeredness to look really closely at the person in front of you, organising it as good as possible for that person, whatever that may be. Whilst person-centeredness is of course a broader concept than just the person opposite you."

(CNS Anne's CCRI - Story 1)

The process of balancing is of greater importance than actual outcome(s). A poorly executed process may result in no needs being met, or only partially met. People may also feel as if their situation and needs have not been acknowledged, as Loes experienced during her conflict with Nadine.

"I try so hard to carry out my administrative tasks as efficiently as possible, so that I can then spend the week on the ward floor [bedside] and it is so disappointing when people then react like this towards me."

(CN Loes' CCRI - Story 10)

A leader needs to be both reflexive and other-centred, asking critical questions and considering possible consequences of decisions and actions for the individual and the whole group. For instance, I observed Fleur asking one nurse to take over temporarily the care for patients from another staff nurse and student. This way the staff nurse could attend a delirium team audit and the student observe an admission assessment of a patient, even though the patient would not be admitted to the student's allocated case load. This arrangement was intended to help her catch up because she was falling behind

in achieving her learning objectives and was showing little creativity in finding ways of achieving them.

Balancing involves using knowledge of self, one's strengths and weaknesses, as well as asking critical questions such as: "Should I be protective or supportive? Or should I challenge the other? Will the challenge exceed their capacity and ability to deal with it?" There's a constant weighing of whether, how and when to intervene, as Betty described when she considered what and how much information she shared with CNs.

"...I always look at things in the breadth, and you should teach them [CNs] to look broadly, but I also think, "You'll only have discomfort from it because they'll have difficulty focusing and following it through." So then I think, "Let's not teach them that." But at other times I think, "Yes, it is important that they know something about this or that, or that they consider certain things when making decisions." ... it is my role to enable them to come into their own, individually. To enable them to grow in their role, to support and facilitate them in that ..."

(Post-observation interview with UM Betty)

The number and range of self, other, group and/or contextual needs that a leader has to consider can be extensive. Add to this possible interaction between the various stakeholders and the whole becomes very complex. The urgency of situations often requires the leader to reflect-in-action, but even small decisions/actions can create large positive or negative consequences for others. Dealing with such complexity is a daily phenomenon and taking time to reflect-on-action can help leaders see and again appreciate this complexity. I too learnt the importance of inquiring into the rationale for decisions. For instance, observing Loes deciding to revert back to the old nursing system one morning when three people phoned in sick, I assumed that this was a spontaneous reversion to a habituated/comfortable way of being rather than a carefully reflected decision. Inquiring about the rationale for her decision denied my assumptions, as well as raised Loes' awareness to the complexity of the everyday decisions she makes.

Using an open and participatory approach when considering options available to the leader and associate recognises the associate's needs and gives them voice, but balancing needs also demands consideration of time and resource investment.

"She's worked here before, not that often, she usually works on the paediatric unit ... she's not that at home with administering medication here and that's why she chose not to do them. She doesn't work here that often that we would say, "Shall we start to really invest in her?" She doesn't want to either."

(Post-observation interview with CN Fleur)

In the case of Pam, the needs of the group overrode her need for supervision and education. Pam and Ellen were two young, newly qualified staff nurses. Both lacked adequate

knowledge and clinical experience when they started on the ward. This placed pressure on the team in terms of investing time and energy investment in supervising their competency growth. Unlike Ellen, who showed significant improvement, Pam required more supervision and showed slower progress, and no-one could estimate how long it would take for Pam to reach an acceptable level of competency. Loes felt that her decision not to renew Pam's annual contract was in the best interest of both the team and Pam herself.

"Loes: I really looked at her, what was best for her. I really don't think that she would have been happy here if we had kept her on."
(CN Loes' CCRI - Story 14)

When balancing needs, the level of engagement with associates may vary. Sometimes the leader may choose to distance self from the person(s) and situation, aware of how their own history, needs and contextual influences may positively or negatively affect their interaction with the associate. At other times a communicative space needs to be created to share and discuss competing needs, as well as potential consequences of actions. The participant CNs became aware of this when exploring their use of annual appraisals.

*"Loes: How can you reach the other at a personal level?
Fleur: And, how do you come together as a unit, leader and other person. What do you agree on?
Really and truly, it's not all about what I think and what she thinks. No, it's about how we agree something together?
Loes: And what are our expectations.
Fleur: How can you see each other and how do you come to a point in the middle."*
(CN Loes' CCRI - Story 13)

Modern day CNs are increasingly faced with balancing the demands of the outer world with the needs of their own staff. For instance, competency profiles are demanding more technical skills and yet educational resources are limited. Some associates were only happy to work their eight hour shift without further developmental activities. A significant number of part-timers were mothers or between the age of 45-50 years, and some had their own business at home too. Although they were valued staff, often they were only willing to participate in non-beside activities and/or continuing education if it fell within their working hours and/or minimally encroached on their private lives. Loes and Fleur found themselves trying to balance these competing needs and were sympathetic as they could still remember periods in their own careers when they too were only interested in working their shift hours. However, they were also becoming increasingly aware of the limited competency of some members of staff, such as Jo. Jo was a 58 year old staff nurse who had worked on the unit for 10 years and was usually viewed by colleagues

and patients as a very sympathetic and caring nurse. A complaint about her technical competency was becoming a moral dilemma.

"Loes: I find her case difficult. ... I mentioned it later in the annual appraisal, like, "God, how would you approach it now if it happened again? What did you learn from that?" And now she says, "I wouldn't go in that room anymore. For instance, I'd let someone else do it." I said, "What do you then learn?" Yeah, I find this sort of thing difficult. I really find it a dilemma ... But, whether she's suitable for acute care ...

Shaun: Mistakes are being made.

Loes: ... Not to that extent anymore ... it's not so that we need to enter a trajectory that would lead to her dismissal. I don't think that's necessary. But, we won't be employing any nurses like her again. I know that."

... ..

Fleur: It's a big thing, to say to someone that they don't belong here. That's what you're implicitly saying."

(CN Loes' CCRI - Story 13)

Recruiting highly skilled qualified nurses had become difficult, professional and work ethos were no longer the same, and motivating young, newly qualified staff to develop themselves professionally had become an issue.

"Loes: But if I look at Mary, a young girl, 21 years ... She was a bachelor student. The only thing she does is work and hasn't any other interests. I don't think that's good ... she does her shifts and nothing else ... if we offer her something, she just waves it away. I don't feel that's acceptable."

(CN Loes' CCRI - Story 13)

As Fleur and Loes reflected on annual appraisals they came to the realisation that various associates have varying needs and ambitions. This led them to consider creating a shared vision with the team on what a nurse should (minimally) be able to do. Acknowledging that balancing needs could be based on equity rather than equality, they saw a need for salary differentiation, skill mix and valuing qualities and expertise rather than 'cloning' a team of identical individuals. Skill mix would affect interviewing/recruitment and daily planning of associates on the ward, focusing on strengths rather than weaknesses. Jo, for instance, could not take responsibility for coordinating a team, but, could be an asset as the third person on an evening shift. Balancing requires a leader to differentiate between the needs and qualities of the individual against those of the greater whole. Whilst a minimal level of competency is necessary, not all associates have to be equally competent. Equal value was more important than equal competency.

Summary

Balancing is the process of morally weighing the needs of the associate against those competing needs of other individuals, groups and self. The individual's needs cannot be considered without attentiveness to the needs of others, context, time and resources. The process is more important than actual outcomes as poorly executed balancing may result in people feeling unacknowledged. Knowledge of self, one's strengths and weaknesses are also required. Sometimes the leader may choose to distance self from the person(s) and situation. At other times the balancing process may be helped when conducted in a critical communicative space.

Stancing



Key: Leading from the:

- A:** Front
- B:** Side line
- C:** Alongside
- D:** Behind

Stancing is the process where a leader uses the knowledge gained through sensing, contextualising and balancing to position self in relation to the associate, aimed at helping the associate 'move on' in a particular moment/situation. An 'invitational' rather than 'imposing' attitude is characteristic of stancing, as Loes and Fleur described when questioned about Betty's leadership style.

"Fleur: ... helping me plan my steps in a different way ... about what I still need to learn. She approaches me differently than you [Loes]. ... She asks me, really clearly, "How are you going to approach this in particular?" ... At that moment I really have to think, "Do I know what to do? And if I do, am I going to do it?"

Loes: ... I tell what I have done and you [Betty] accept that ... I feel it is person-centred towards me ... she [Betty] challenges me ... it is about looking at what I feel I need ... and what do I feel that I don't need ... Betty looks at me.

Betty: And that is a real difference to a couple of years ago ... I would have been more like, "This is what you need to do." ...

Fleur: But she doesn't tell me how I should do things ... you let me think about how I want to do it first. ...

(Post-observation interview of CN and UM meeting 30/11/09)

Four basic stances were identified in leader narratives and observations. Although the leader may have a habitual/preferred stance, there is constant movement between stances in response to new understandings of unfolding events/narratives. The power of stancing lies in the leader's ability to continuously match stance with person(s) in context. For instance, during Jane's sickness and graduated return, the leaders had initially taken a step back, creating space for Jane to seek help in her own time and way. However, Jane never came with solutions for her situation or undertook action to help herself, so a new stance was deemed necessary to help her move on from a state of inertia. Engaging more closely with Jane, professional help within the hospital was offered alongside encouraging Jane to undertake action herself.

Leading from the front and side-line

Leading from the front and/or side line, a person-centred leader invites an associate to follow direction. Directing here has a moral intent of doing the right thing rather than only making sure things are done right. Offering to step in and take over the hygiene care for Brigit's patient and directing her to attend to non-bedside duties, Loes was acting with moral intent.

"She's [Brigit] doing the diploma course, so, she's on the shortened course and this is her first ward ... she has to work hard to be able to understand how things work here ... she can handle the care [ADL activities], but, if there's too much at the same time then she can't get it coordinated ... I wanted to give her some peace so that she could gain more insight into the patient and attend the ward round, and document the orders and activities ... It gave her more peace in her head ... That's what I hoped to achieve. Create a bit of rest ... for her learning process."

(Post-observation interview with CN Loes)

Choosing to 'do for'/'role model' for an associate (leading from the front) or direct/instruct what to do/how to do it (leading from the side line) does not include losing sight of the other in context. 'Doing for' is based on mutual consent and 'directing' becomes a reminder. Turning what the leader feels needs to happen into a question invites the associate to think before acting and encourages collaboration without distraction from the issue at hand. Having observed Fleur organising and coordinating others, I asked her to define her actions in terms of managing or leading others. She started to reflect on how she could have altered her stance.

"Fleur: ... I think that when you are leading, then it is a more supportive form and you ask people, "How do you want to tackle it after the break, and lunch?" and, of course, whether I need to be involved. I could have said, "Is everything OK? Are you going to organise the breaks and how to tackle things yourselves?" (Post-observation interview with CN Fleur)

Leading from the front/side line could easily be confused with more traditional, autocratic styles of leadership. However, as the charges nurses discovered, a more authoritative and imposing attitude can induce associate passivity, dependency on the leader and relational distancing as the associate is suppressed rather than enabled to come into their own. Sensing is also a useful process for picking up on subtle clues that directing is being perceived as imposed, rather than invited. During the early days of primary nursing, the CNs found themselves having to negotiate how they were going to divide their extended workload with the associate working alongside them. On one occasion Fleur missed Carl's initial disgruntlement at how she had directed him, imposing her own plan of action.

"Probably, if I had asked, "How are we going to work together today? How far are you? How are we going to approach this?" he would have been more involved in what needed to happen that day. He fed back to me, "You pull too much to yourself. You need to let go of some things. You have this idea that you need to organise it all yourself."

A tableau vivant of the narrative helped Fleur gain insight into the event.

"It's as if I'm pointing him in the direction I think he needs to go and that's what I did, in fact. I'm looking the other way. I'm attached and pointing to the direction I want him to go ... somehow I don't see myself in conversation with him here [in the tableau vivant] and that was the case." (CN Fleur's CCRI - Story 8)

Sometimes, contextual pressures and/or not having fully embodied person-centred leadership can throw the less reflexive leader back into traditional styles of autocratic leadership where monitoring and control are considered the best way of 'getting things

done'. At other times, contextual pressures require a conscious choice to lead from the front/side line.

"... sometimes it just happens too fast and it's too hectic and I think, "Ok, now I have to just organise (people), because I can't be coaching people every minute of the day"... But I am aware of that ... you can't just lead and coach. Now and again things just have to be arranged. People ask for it too... Take today [busy and short staffed], for instance, I thought, "Damn, this was a day where I could hardly coach in a person-centred manner."" (Post-observation interview with CN Fleur)

Past experiences and socialisation leave their mark on leadership styles. Reflexive leaders who want to become more person-centred and who believe in respect, equity and shared power are more likely to be able to transform self and context. Loes felt that she had been expected and/or allowed herself to be moulded into a near replica of Anne, the CN in post when Loes began as a CN. Loes never felt able to develop her own style of leadership until after Anne changed posts from CN to clinical nurse specialist. After Anne's departure as CN, Fleur was appointed as CN and Loes now found herself in the similar position as Anne was all those years ago. However, Loes had already started to reflect on how she could be more person-centred towards Fleur than she herself had experienced from Anne.

*"Shaun: And did you want to work Fleur in differently to how Anne went about things with you..?
Loes: That was my plan, yes ... with Fleur I want to try and let it be equal in the end ... that we become of equal value ... I don't think that Fleur is copying me. She really does have other ideas and other insights. She interacts with people differently ... If I hear her talking then I think, "That's great how she picks that up and how she tackles things." ... She'll look at how I approach things, but, I also look at how she approaches things, "Oh? Do you do it like that? That's good too ... That's a possibility too.""* (Post-observation interview with CN Loes)

As well as reflexivity, leading from the front/side line requires criticality, communicating clearly and honestly available options as well as rationale for choices in ways an associate can comprehend. PN Chloé learnt this whilst working with an experienced nurse Carl who had issues with the new nursing system. He was reluctant to let go of the idea of dividing patients and instead work as a duo. In a brief conversation with me one morning Chloé shared how she was struggling with how to organise the ward round for her six patients and Carl. Her proposal was that she would go with Carl to the ward round meeting and whilst each presented the three patients they had been caring for, she would be present for all six. I invited Chloé to explore the consequences of her proposal, offered an

alternative and suggested she discuss the issue openly and honestly with Carl. Later she wrote a reflection on the outcome.

"Later that morning, Carl and I discussed the dividing of patients again. I explained again why I wanted to hear what was said during the ward round. I noticed that I was struggling with this. I didn't want to give him the feeling that I felt I needed to be present to ensure everything was discussed. He said that he had no problems with me being present, but he did have problems with the fact that this may disadvantage our patients because neither of us would be present on the work floor for that period. I then suggested that we discussed the patients before and afterwards, with a view to long term issues. Carl found this idea OK. We discussed the cases beforehand and I named a few points that I felt were important to be included in the ward round."

(PN Chloé's written reflection)

4

The transition from managing people and contexts to being person-centred was not easy for the CNs. As they become aware of their tendency to take control, they worked hard to experiment with other stances and, more importantly, reflect on why they decide to lead from the front/side line.

"I've noticed I'm more the manager than leader, on a day like this [few qualified/experienced staff] ... I think that it's because I want to keep a hold of the reigns. I want to have an overview of the whole. I'm finding it difficult to let go ... I trust my colleagues who work here, the things they do ... direct patient care. I understand that they can do that, that's all fine ... But, whether or not they see the whole picture, and the links and connections ... I feel that I have to be more on top of that. So, I arrange and fix more, watching and setting people tasks ... I listen ... I want more information, but, I do impose tasks upon them, what to do and how it should be done ... that is my choice. It makes life easier for me, to be able to have an overview of both sides [of the ward] on a day like this ... if I only had one [novice] that would be easier to handle ... I'm looking at how well things are being done, and that they can work on their own stuff [learning objectives], that they get satisfaction from what they do. I want to see whether they are working with pleasure and being attentive. That there is a good workplace atmosphere for them and that they can have a sense of fulfilment and achievement. I try not to pull everything away from them, so that everything lands on my plate. They have to be able to use their own expertise and keep hold of the space they normally have, it's not supposed to be a case of them coming to ask me about everything."

(Post-observation interview with CN Loes)

Leading from alongside and behind

Leading from alongside/behind, the leader aims to enable rather than direct, offering challenge and support to overcome barriers, or step back and create space for associates to 'move on' independently.

Angela was a part-time staff nurse who loved nursing. She was prepared to attend the internal education programme, but had three small children and a husband who worked long hours. She announced that she could not attend the programme as child-minding fees were too expensive. The leaders had not considered the issue of child-minding for working mothers before. They were prepared to work with Angela to find a solution, but also felt that she should take responsibility for action too. They suggested she collaborate with other working mothers on the ward to child-mind each other's children and they were prepared to review the programme in terms of which lessons were vital/minimal for Angela to attend. Later, Angela confided that problems at home were also contributing to her depressed mental state. Interpretations of the CCRI tableau vivant (see Figure 18 p.122) revealed how Loes tried to enable Angela to free herself from the burdens preventing her from nursing.



Figure 18: Freeing Angela – a tableau vivant of CN Loes' CCRI

"Loes: She [the leader] makes herself small in relation to the nurse. this represents making the burden seem less, so that it isn't experienced as being so big by the nurse ... in the talks I had with her I tried to grasp the main problem and reduce it in size, by placing it within a larger context ... Betty: But goal orientated, towards patient care and work. Not to solve the problem for her, but to connect her back to the patient again.

... ..

Loes: I did give tips ... She found these tips useful."

(CN Loes' CCRI – story 4)

A second tableau vivant (see Figure 19 p.123) revealed someone standing in the background of the photo. This instigated a dialogue on leading from behind. Although distancing is sometimes unavoidable as the leader contends with contextual demands, it is a conscious move, often interwoven with presencing.



Figure 19: Distant yet connected – a tableau vivant of CN Loes' CCRI

4

"Shaun: I saw half a figure in the background. I saw 'leading from a distance', letting someone think, being there in the background, not being dominantly present ... letting her think about how she's going to organise her work and home ...

Loes: On the other hand, it is a lonely battle and one that she will have to fight on her own. You can offer her a helping hand, but how she handles the situation further is up to her ... I have noticed that she does do something with the helping hand ... At the moment it's going reasonably well ..."

... ..

Fleur: ... Being there for someone in some way, just as Loes said, listening, sympathising, offering tips and helping them find solutions. But, at the end of the day she still has to fight the battle alone ... Creating distance is part of it too, because you still have other things keeping you busy. It requires a certain degree of professionalism, that you can distance yourself.

Betty: And creating distance to give the other person a chance to do something. If you are continuously on top of everything the other person can't do anything for themselves. They need the space to be able to take responsibility.

Fleur: And yet she knows that you are there and that she can find support in you."

(CN Loes' CCRI - Story 4)

Inviting an associate to share their narrative of an event is often a good starting point for understanding their perception of events. This understanding is used to pose critical questions aimed at enabling (new) insights. Anne practised this thinking about doing when associates approached her regarding (complex) patient discharges. Her ultimate aim was to enable them to see the older person in context, the complexity of the situation, the care pathways involved and the social network at hand, as well as raise awareness of their own capabilities and the tools available to them.

"I find that it does still depend on the person, whether I have a student before me ... or a Mandy [experienced permanent staff nurse] ... Then I would ask more questions. Ask questions back or carry questions through, instead of immediately 'wham bam' having my answer ready ... Enabling them to gain insight ... into how things work..."

(Post-observation interview with CNS Anne)

Supportive and challenging strategies used included: actively thinking with the associate; inviting others to dialogue and think with the associate; offering suggestions and advice; guided reflection; encouragement and persuasion; stimulating the use of sympathetic imagination and/or sympathetic presence; negotiating; and changing existing structures and processes in order to prevent relapse into old ways of being. Invitations here are not for associates to follow tips and advice, but, to think about the thinking behind their doing and act more autonomously. Betty reflected that posing 'how' questions was a useful strategy.

"Betty: By asking open questions ... introducing it, 'I notice myself, and you ... that we need more structure in the meetings. How can we give that some form?' So, I think, 'You put a 'how' question into the discussion, and then see (what happens).' And then something will come from them, I'm certain of that. Then we can look further, 'What have we got and how can we design it?'"

(Post-observation interview with UM Betty)

As the concept of person-centred leadership became more embodied, I observed more examples of leaders questioning rather than telling. When a temporary nurse asked Fleur whether a patient needed to be dressed before going to the 'breakfast club', she replied, "I don't know, what would she like to do?" The leaders' aims in asking questions was to stimulate critically reflected choices, find solutions that feel right and suited the associate, and to enhance associate self-efficacy so that they would gain a sense of achievement and fulfilment after taking action. Betty would ask facilitative questions during meetings with the CNs such as: "What do people need in order to move on and grow? How are we going to do this? How can we facilitate it happening?" She used pauses after each critical question, providing space for the CN to think before answering. Any advice offered was followed up with, "What do you think about this?" which encouraged contemplation and reduced the risk of uncritical followship.

Leading from behind not only requires understanding and knowing the associate at that moment in time, it also requires a willingness to accept that their action choices may be different to one's own.

"Betty: I tried to connect with where she was at, that makes it person-centred. Also, 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. I can also leave things to the last minute, but... people would have been informed. Loes choose not to do that. I could never have accepted that in the beginning ... 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 that makes it much more person-centred and I can continue from that point."

(Post-observation interview with UM Betty)

The depth and extent to which strategies are employed is determined by the leader's knowledge of the other and reading of them in a specific context. Strategy choice may also change as their reading of an event evolves. The leader's moral intent is pertinent to thinking with, rather than thinking for, the other. This was raised during a dialogue about 'giving' or 'enabling' insight. Anne had tried hard to enable a panic stricken Jo to gain insight into why the internal education programme was beneficial. Knowing Jo, Anne was convinced that the fear would subside once Jo attended the first lesson. However, during the CCRI in which this story was shared and analysed, the morality of persuasion was raised.

"Betty: I didn't find it person-centred because there was a strong persuasive force being used ... I feel that if you try to persuade...

Loes: You try to impose your opinion.

Anne: But I had tried to give her insight, because I think that she [Jo] needs to follow a number of lessons first and then to look further.

Betty: That's where you end, but if I look at where you started, then you immediately start to explain why ... I don't see a question of, "Why do you [Jo] find this so difficult?" or "What's bothering you?"

(CNS Anne's CCRI - Story 3)

Working alongside experienced and trusted colleagues can make it easier for a leader to step back and observe an associate in action. This stance can vary spatially and temporally. Where there is a sense of connection, negotiated flexibility within the working relationship can create a stronger sense of shared power, responsibility and increased associate action, creativity and productivity. Betty found that physically distancing herself from the ward lowered the temptation to intervene and so created space for the CNs to find their own way in handling everyday issues. However, ad hoc, informal moments of 'checking-in' as well as regular structured meetings, were needed to retain a sense of connectedness.

Based on the evaluative information gathered during contact moments, the leader may decide to change stance, moving forward again to lead from the front/side line. The decision is a conscious one, and the leader is aware of the potentially negative effect(s) on associate growth.

"... I also intervene now and again, to give them the feeling that they are not left swimming [alone] either, because I do see them swimming and then I think, "OK, it's lacking a sense of direction now," ... and then I start to direct because I feel that it is needed. Or at least, I think about it carefully. I do understand that this can have a negative side ... whereby you deprive people of something. I see that just as clearly ... the fact that they could have taken that initiative themselves, or that they could have thought of a solution themselves, or would probably have come with a solution themselves. And that doesn't happen then. So I think that you've deprived them of that opportunity."

(Post-observation interview with UM Betty)

Reflecting-in-action, a leader may also choose to delay certain interventions, but learning to step back is challenging for leaders accustomed to traditional styles of leadership. Used to having a need for/sense of control over situations, it requires courage to relinquish that and trust in the reciprocal nature of a person-centred relationship. PN Tess was also starting to explore ways of enabling others to come into their own during ward rounds, experiencing similar challenges but making progress. Joan had been qualified for 6 months. She and Tess had agreed that Joan would take the lead during the ward round whilst Tess sat and observed.

"Physician: ...last week it didn't go that well because she [Tess] said everything. She didn't give the other person space to talk. But now she lets them do most of the talking and she doesn't really interrupt, only when I ask her a question. Now she [Joan] can be more active, I think.

... ..

Tess: I find it difficult to keep my mouth shut. Or ... I automatically jump in sometimes. And if you think, "Did I enable Joan to come into her own?" then I think ... maybe I should have let go more, stayed more in the background, as far as those patients were concerned."

(Post-observation interview with PN Tess and unit physician)

Summary

Stancing is the process of using knowledge gained through sensing, contextualising and balancing to position self in relation to the associate. The aim is the enabling of associates' transition to (self-determined) continued action. It is characterised by an 'invitational' attitude and whilst there are four basic stances, the leader may use more than one in each situation as it evolves.

Leading from the front and/or side line entails 'doing for' or 'directing' the associate with an intent of doing the right thing rather than making sure things are done right. Reflexivity, criticality, communicating clearly and honestly, as well as offering a rationale for choices in ways the associate can comprehend, are skills the leader uses.

Leading from alongside/behind is more focused on enabling self-determined action through high challenge and support when leading from alongside, or stepping back and

creating space when leading from behind. Inviting an associate to share their narrative of an event is often a good starting point to deciding how to enable the associate. The offering of tips and advice is to stimulate thinking about doing and moral intent is evident in the leader 'thinking with' rather than 'thinking for' the associate.

Presencing



Whilst standing is an action-orientated process, presencing is aimed at supporting the other in their 'being'. 'Thinking with' the associate may be as simple as offering alternative perspectives, hope, shared responsibility, plausible explanations, or practical and concrete advice/solutions. Acknowledgement of the other in their being is essential.

Soon after Chloé and Tess joined the CCRI's, a move that was intended to offer them a supportive environment to develop their role as bedside person-centred leaders, Chloé shared, during the evaluation, how the meetings were not meeting her expectations. She was able to clearly articulate what she wanted and what she wasn't getting, but became emotional. Whilst not in total agreement with Chloé's opinions, Loes, Fleur and Betty acknowledged her fears by: showing sympathy about how it must feel for Chloé; offering concrete solutions to issues raised by Chloé; offering hope for better times; sharing responsibility for what had gone wrong; and offering alternative explanations. Presencing is not about doing for or resolving issues for the other, it's about being and thinking with them, as Fleur described whilst reflecting on a tableau vivant (see Figure 20 p.127) of Angela's story.



Figure 20: Being there- a tableau vivant of CN Loes' CCRI

"It shows an opposing balance to the loneliness depicted in the other pictures [see Figures 16 p.113 and 17 p.133], 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 themselves to resolve a problem." (CN Loes' CCRI - Story 4)

Presencing can be (positively) affected by relational history and the degree of openness and regard for one another. Not spatially or temporally bound, (connected) distancing in presencing may even be beneficial, as long as authenticity is felt.

"Loes: I have an advantage with Angela in that she looks up to me somewhat because I have four children and am quite a bit older than her ...

... ..

"Betty: The nearness is not only physical. Even if the leader leaves physically, that doesn't mean to say that she leaves the nurse.

Fleur: So, in some way close and yet not too close. That there needs to be a certain distance.

Loes: Maybe Angela isn't receptive either.

Fleur: It may be that she keeps her distance, but also, that the leader doesn't want to get too close.

Shaun: As long as the nearness isn't tokenistic or "I'm doing what I'm supposed to do as a leader".

Betty: It didn't feel like that when I was sat there. It didn't feel as if I would spend an hour sitting there, but I didn't feel, "Get away as soon as possible" either. I also feel that you should give the other space.

Loes: ... It is definitely an interaction between two people, the extent to which they are willing to come and stay together." (CN Loes' CCRI - Story 4)

The evidence suggests that attentive listening, sympathetic, non-judgemental understanding of the associate in context and offering alternative perspectives/advice, can support the associate as they feel recognised and understood. The emotionally intelligent leader acknowledges and sets aside their personal emotional responses to a situation, as Anne discovered when dealing with her own frustrations at Jo's initial resistance to the internal education programme. Even when confronted with emotional and negative responses, the leader tries to remain other-centred and not react defensively, asking themselves, "Where is this negativity coming from? What is the fear behind/driving this?" Inviting the other to tell their story creates space for the leader to discover underlying fears and any role they themselves may play in this. Once identified, appropriate decisions and actions can be undertaken to relieve fears and enable the associate to 'move on'. This came to light during Fleur's reflection on an incident with Karen.

Student nurse Karen had been ill and when Fleur rang to inquire how she was and whether she would be returning to work that Thursday evening, Karen initially stated that she only felt able to work until 21.00hrs. After seeing her doctor on Wednesday, Karen then stated that she would only work 'therapeutically'. Fearful of not being able to find cover the longer she did not know whether or how long Karen would be working, Fleur asked, "Will you be working Thursday evening or not?" Karen became negative and remained vague about the hours she would work. Sensing fear, Fleur posed open and explorative questions. As the narrative unfolded, the larger contextual picture emerged. Karen's mother was unconvinced that her daughter was adequately recovered, and did not want her to return to work. However, Karen faced the prospect of a postponed graduation if her sickness record increased. She had interpreted 'therapeutic' to mean being able to leave work at any moment she physically felt she needed to, without incurring sick time.

Presencing is not maternal, wanting to protect the other. Such sympathy may lower instead of enhance associate self-efficacy. Reciprocity helps create desired mutual (sympathetic) presencing where neither leader nor associate need be fearful of showing vulnerability whilst sharing personal narratives. Being able to relate to the other's story also aids understanding, whilst at other times sympathetic imagination may be necessary. I observed presencing during talks, meetings, brief encounters in a corridor, even during a clinical lecture. The CN's frequent 'checking-in' with associates felt supportive as they worked through troubled and/or joyous events. 'Being with' the other required attentiveness. Particularity often influenced strategy choice. Inviting an associate to share their narrative, not interrupting their flow of speech and accepting pauses, showed respect for the space a person may need to collect their thoughts and/or their choice not to divulge details. Facial expressions/gestures or light touch/embrace can convey sympathetic presence, whilst (unintentional) absence of such gestures can be detrimental.

Summary

Presencing is the process of 'being with'/'thinking with' the other in their 'being', and is not necessarily action-oriented. The sense of the leader being there for an associate is not spatially or temporally bound, but should be authentic. Presencing is not a maternal attitude of wanting to protect and requires emotional intelligence. Attentive listening and sympathetic imagination support the associate as they feel recognised and understood. Relational reciprocity helps create mutual presencing whereby both leader and associate feel acknowledged and supported, able to show vulnerability without fear of judgement.

Creating safe critical learning/communicative spaces



The process of creating safe, critical communicative (learning) spaces is a conscious leader activity intended to enable individuals/groups to develop and come into their own. Practical skills, as well as awareness of factors influencing daily practice (decisions) of self and others, are developed. These spaces enable shared visioning, shared-decision-making and

action planning, and offer the leader new data about where each and all 'are at'.

Participant observation during the orientation phase revealed a cultural norm of Betty and the CNs making most logistical decisions. Whilst staff often complained of feeling 'unheard' when such decisions were announced, I often observed them asking the CNs for instruction or waiting for CN decisions on issues they could easily have made for themselves. Leader dependency was an issue the CNs wanted to address.

Cultural traditions and learner stance had been limiting potential learning. For instance, there was a passivity about student nurse Tracey that I recognised in other faculty students. Even though attending the ward round was a learning need, it was Loes who suggested attendance. Even though Tracey had heard all that needed to be done, she still asked Loes what she should do. Such passivity was not only evident among student nurses. After the introduction of primary nursing, with decentralisation of daily leadership, the PNs were starting to notice the same dependency behavioural pattern observed in the orientation phase. Influences from the personal, local and/or professional sphere of being may have been inhibiting an active learner stance and/or encouraging a "tell me what I need to do, then I'll do it" attitude. As an educationalist I sympathised with how such passivity can encourage a response of telling, rather than exploring with the learner. As a nurse I recognised this passive stance as a by-product of being socialised within a task-orientated, technically focused ward that promotes strong autocratic/directive leadership.

At the end of a post-observation interview, Loes asked me for tips. I suggested using more open questioning and stepping back to allow others to take on more responsibility so that they can discover what they are capable of. Loes' concern about staff competency levels made me consider how this may have been preventing her from daring to step back and create space for associates to learn and develop. Fear for patient safety and/or being held accountable for any mistakes were plausible explanations. A circle of influence appeared in my mind as I reflected on why creating safe critical learning spaces was so difficult for leaders (see Figure 21 p.131).

Breaking the circle required leaders to focus less on checking ("Do you know what to do?") and more on challenging ("What is happening here? What could you do? Is that the right thing to do? So, what are you going to do?"). This was currently lacking and a post-observation interview with student nurse (Sn) Tracey led me to consider the importance

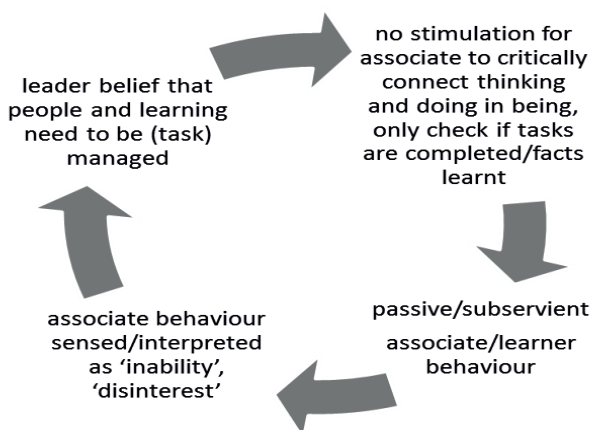


Figure 21: The circle of creating learner passivity

of preparation for learning, as in identifying potential learning opportunities as well as exploring the type and degree of relevant challenge.

"Shaun: ...Imagine that you were Loes today and there was another student in your shoes. How would you have approached the situation?"

Tracey: If it was exactly the same as today? Then I think I wouldn't have done it any different. I may have tried to gain more time from somewhere, so that ... things could have been better explained ... like, "This is how the ward round works ..." So that I had a better idea of what it would entail beforehand ... if there had been time, I may have found that very useful. But, then right at the beginning, before the caring started, because then I may have looked at people differently."

(Post-observation interview with Sn Tracey)

Interestingly, when asked, Tracey shared how she felt that explaining things to a learner before commencing patient care would be a useful strategy and yet she had not requested such explanations from Loes. The local cultural norm seemed to be 'doing before thinking', where learning was also considered an activity separated from direct patient care. Thinking about and briefly discussing what and how care should be provided would potentially improve the quality of care and highlight potential learning opportunities embedded within that care.

Gradually, leader attitude and behaviour towards learning changed. Betty shared a narrative during a CCRI on how she had invited two staff nurses 'in charge' of the ward to decide whether or not an extra bed could be opened that evening. Her aim was to "stimulate, support and help them think more abstractly [from a different perspective] than from the bedside."

"... I thought to myself, 'How am I going to approach this? Really and truly you want to work towards shared responsibility.' ... I think that I chose a relatively safe situation, both for them and for myself ... safe enough for it to be a good experience in decision-making ... I thought that I had maybe made the situation too safe, that I had given them an easy ride, but that wasn't the case. The challenge was just right ... Both Diana and Tess did not feel that I had insinuated that it would be easy ... They felt free to make a decision." (CN Betty's CCRI - Story 2)

The process of creating safe, critical communicative (learning) spaces is a conscious leader activity intended to enable individuals/groups to become less dependent and develop and come into their own. Practical skills as well as awareness to factors influencing daily practice (decisions) of self and others are developed. They enable shared visioning, shared-decision-making and action planning, as well as offer the leader new data about where each and all are at. Examples observed included:

- now working in duo's, PNs and associates had to learn to discuss issues and expectations before agreeing a plan of action for the day, often triggering the identification and planning of learning opportunities.
- physician-primary nurse case study meetings were instigated, aimed at creating/renewing shared visions of care, after several incidents on the ward.
- the daily ward rounds were often a space for student nurses to learn about medical conditions and treatment, and for PNs to critically discuss care with (junior) physicians.
- the 15 minute daily evaluation sessions became a space for storytelling and sharing observations.
- biweekly PN evaluation meetings created space for cyclical evaluation and action planning by the PNs.

Capitalising on opportunities requires 'seeing' them, 'matching' them with associate (learning) needs and readiness to learn. Nathalie was a temporary state enrolled nurse who regularly worked on the ward after recently returning to practice. She was not familiar with the computerised drug administration system which meant that others needed to administer medication to her patients. Actively inquiring after her (learning) needs at the start of their shift together, PN Chloé created a safe learning space.

"...the fact that she can participate a few times, observing someone and then someone observing her, means that she can administer medication herself afterwards. The knife cuts both ways then ... I think she comes into her own because she said that she wanted to do it a few times under supervision. And then I created the space, so that we make sure she feels safe, being able to do it under supervision ..." (Post-observation interview with PN Chloé)

Leaders are better able to see (potential) learning spaces when they are not overly distracted or burdened by workload, when they value learning in and from practice and/or

know (individual) associate needs. Having found a balance in dividing their time between their PN role and office duties, the CNs were experiencing more space to attend to the learning needs of others, such as when Fleur left the office one day to cover for others on the work floor so that they could attend a clinical lesson.

“Fleur: ... A good planning brings calm to the floor. Having sufficient quality [of nurses], gives people time to work on other things because we’re more on top of things now ... In fact, you radiate more calm yourself as well, and you can give other people more time. My impression, a feeling, is that it’s all starting to come together. The time that’s emerging now ... Otherwise I would have had a feeling of, “Oh, I’ve still got so much to do,” but I haven’t that feeling anymore. I’ve got things in order there [points to the CNs’ office], it’s fine ... I’m better able to prioritise things. It’s not such a mountain anymore.” (Post-observation interview with CN Fleur)

Being creative and flexible towards habits/routines can create learning spaces too. Fleur decided to diverge from the tradition of dividing patients equally between her and the associate when she learnt that student nurse Tony’s learning needs included caring for high dependency patients and so she divided the case load 4:2. Sometimes a quick response is needed, as was the case when Fleur arrived on the ward for a day in the office and saw that Tess’ planned day away from the bedside had been cancelled due to a staff shortage. She immediately decided to relinquish her office day and relieve Tess.

Not all learning spaces for reducing dependency require active leader intervention. Sometimes holding back and observing associates step into their own pitfalls creates a learning opportunity. Whilst the decision should be morally responsible, with consideration of consequences, follow-up guided reflection-on-action enables the associate to link their thinking and doing and so influence future being. The content and focus of guided reflection is tailored to the individual person, personal (learning) needs and interests.

“You see the potential pitfall and you make a choice, “Do I do something about it myself? Or do I let it happen?” And I chose this, and that was a conscious decision ... I do that [facilitating tailored learning] in individual [one-to-one] discussions ... it’s about that person in that situation and I want to discuss that ... to unpick it.”

(Post-observation interview with UM Betty)

Several leader attributes were positively associated with creating and tailoring (potential) safe, critical spaces for individual learner needs: treating the learner as someone of equal value, being attentive towards the learner regardless of contextual demands, being knowledgeable and sharing that knowledge. Learning/communicative spaces enabled the sharing of multiple perspectives, broadening of horizons, balancing interpretations,

shared responsibility and power, especially when consensus was sought. As the PNs evaluated and explored their role development during biweekly meetings, they too found new and different ways of stepping back and creating spaces for self and others to learn.

"... Now we've actually reached a point of, 'If you leave for your days off, how are things when you come back? What has happened in the time you were away? How did you hand over the primary nurse role responsibilities? How do you hand over for the evenings and weekends?' It was mainly Chloé who found that difficult, and now that she's not in top form and had to let things go [take time away from bedside activities], she's starting to notice that she has more space for other things and that, in fact, everything still carries on ... And Tess is busy with, 'Do people understand what I write?' I asked her, 'OK, what are you going to do about that?' It was she who then came up with the idea, 'Maybe I should ask for feedback. This is what I did, is that clear? What do you think about it?' I also said, 'Maybe you should also ask ... if there was still space for the other? Or was it all so tightly planned that the other didn't have to think?'" (CN Loes' CCRI - Story 11)

Of utmost importance to effective learning is safety. Whilst some learning can take place in a public space, sometimes privacy is a better option, for instance, when lessons can be learnt from conflicting views. Trying to meet each other at cognitive and affective levels is important here, as Chloé pointed out after listening to Fleur's conflict with staff nurse Carl.

"Chloé: I felt that you both landed in a discussion with rational arguments. I didn't hear, in the story, that you exchanged how you 'felt'... I think you weren't able to meet each other at an affective level, which you both missed ... You didn't say, 'I don't want this,' ... but, he didn't say, 'I missed you and we weren't able to work together.'... whereby you kept trying to persuade each other whether or not it was possible [for a CN as PN to leave bedside care] ... you don't meet each other..." (CN Fleur's CCRI - Story 8)

Summary

Creating safe, critical communicative/learning spaces requires leader attentiveness to learning needs, objectives and opportunities. Enabling coming into own can include the associate and/or leader learning new practical skills, or exploring factors influencing practice. It involves facilitating the learner in connecting their thinking with their doing in order to influence their future being. Facilitating learning offers the leader insight into where associates are at and/or want to be. The leader needs to see potential learning opportunities and match them to associates' needs and readiness to learn. Being creative and flexible with regards to standard practices and routines can also help the leader and associates find time to create learning spaces, and not all learning requires active leader intervention.

Communing



Communing is the process of communicating at a more intimate level, finding the common ground, shared vision and making shared decisions. Whilst being visionary is a commonly acknowledged leader attribute, creating shared visions is more complex. Within a communicative space the leader makes clear their own values and beliefs, explicates the goal of finding a common ground and the value of respecting (differing) opinions. Showing understanding and accepting difference is of greater importance than consensus. Communing is not a power game. It requires self-knowledge and skilled facilitation if people are to feel safe enough to fully participate. Reflecting on her conflict with consultant physician Fiona, Loes came to appreciate these attributes.

"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. That is on the one hand. 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."

(CN Loes' CCRI - Story 7)

The evidence and our interpretations of it suggest that as a leader listens to the visions embedded in the narratives of others, they should not question 'why', only challenge the narrator's position by offering opposing visions or drawing attention to existent policy, observed inconsistencies, incongruences and inaccuracies. This can be confrontational and so the leader needs to sense when and how to challenge, observing associate receptiveness, rather than pushing through resistance. When searching for the common ground, a deductive route, moving from abstract to concrete, is advisable as the point of divergence usually emerges at the concrete level. The risk of working inductively is that differences emerge early on in the process. This was evident in a conflict between the CNs and the social activities committee. Whilst the CNs had a vision of no temporary staff being invited to ward social events, the organising committee decided on an exception and invited Denise, a self-employed nurse who they frequently socialised with. As discussions started at the level of the concrete incident, it never rose to a level of abstraction where they could agree on a shared principle.

Creating shared understanding is more important than 'selling' one's own vision, but a passionate visionary leader can easily succumb to 'persuading' others or referring to (unwritten) codes of conduct in defence of their vision. During an incident regarding symptom management of a terminal patient, Fiona's hierarchical stance and Loes' reduced

receptiveness for alternative visions, reinforced power imbalances and communing failed to take place.

"... you don't begin by saying, "We don't do it like that here." You start by asking, "Fiona, why do you want to check the glucose? What are we going to do with the results? You've stopped all medication and now we're going to start giving her insulin ... and, besides that, it's not unit policy for people in the palliative phase to keep having their sugar levels checked. That's a general rule that the geriatricians follow."

(CN Loes' CCRI - Story 7)

An authoritative stance and/or leader inconsistency/incongruences negatively affect believability. Whilst knowing and sharing one's own vision is important, being aware of and open to alternative perspectives is equally important, as it demonstrates willingness to review one's own vision. Valuing respect, trust and equity, initial differences or competing visions are dialogued until commonality is found. Once identified, new shared values and beliefs can be used as a touchstone for future decisions: "How does this contribute to achieving our (agreed) goal?"

The person-centred leader is a skilled facilitator of communicative spaces, unearthing expectations so that (in)congruence's can be identified and addressed. People and contexts change, as do values and beliefs, so regular reference to shared visions is needed to keep them up-dated, embedded within the idio-culture and help newcomers become aware of local visions. Regular, safe, critical communicative spaces help create and maintain shared visions. Such spaces were proving effective in building mutual understanding and shared visions on small everyday events, for instance, how to work collaboratively for a shift or approach a common problem. The importance of communing was raised during a reflection on Loes' conflict(s) with Fiona.

"Loes: Where I started from, in terms of approaching the conflict, was simply to meet with her once a month, which I had stopped doing. Now, every first Monday of the month we retreat, to discuss our 'ins and outs', what we are running up against.

Shaun: ... you could start with ... "OK, let's get the story clear first. What do you mean?" You try to find a common goal ...

Betty: ... you have to move to a higher level of reflection.

Shaun: "What do we want to work towards?" ... "And is this going to help us achieve what we want? What does it mean for you? What does it mean for me? Because, we're in this together." ...

If you then have moments in which you have to discuss things, you repeatedly ask, "OK, does this decision help us move towards it [shared vision]? What are the consequences for you, Fiona?

And what are the consequences for me and my team?"

(CN Loes' CCRI - Story 7)

The degree and scope of participation in communicative spaces may vary, dependent on the subject matter and context. Sometimes, only information gathering from various stakeholders is needed for later blending. At other times, full participation may be warranted. Creating communicative spaces was new for the CNs but one they embraced, evident while reflecting on annual appraisals and the issue of acceptable nurse competency.

“Loes: As a unit, we should talk about this ... [what is the] basic requirement to be able to work here ... What our expectations are.

Fleur: How we see each other, and how you can arrive at somewhere in the middle.

Loes: ... What do we, as a unit, agree the norm should be? I think that that is important too. And what do you do then [if someone does not meet the agreed norm]? It's good that we reason these things, think about these things. What is our norm now and what do we think it should be. Does everyone have to meet that [norm], or can someone sit on the edge, close to that norm. It's good to discuss such things.”

(CN Loes' CCRI - Story 13)

The morality of doing the right thing as opposed to just doing things right, is maintained during communing, as it enhances connectedness. Other-centeredness is imperative, as Chloé told me when I asked about her role in leading others towards person-centred care: “starting from where the other is at, asking them what they feel is necessary whilst making known what the restrictions and possibilities are.”

Summary

Communing is the process of communicating at a more intimate level, finding the common ground to build shared visions and decisions. Showing understanding and accepting difference is of greater importance than consensus, but it does require skilled facilitation if people are to feel safe enough to fully participate. When searching for the common ground, a deductive rather than inductive process is advisable, moving from abstract shared principles to concrete examples. Visions are dialogued, not ‘sold’, and regular communing helps maintain and embed shared visions within idio-cultures.

Coming into own



‘Coming into own’ was an expression frequently used by leaders to describe the aim of person-centred leadership. It captures those moments when leaders and individual associates were changing, shining, reaching their potential and/or being their authentic self. Moments when a person ‘feels good’ and things ‘feel right’, as Fleur explained:

"Fleur: Yes, that feels good, but that's also ... how I want it to be, you know? This is my way of doing things, when I can feel good about it ... this contributes to my leadership development ... only it doesn't always happen in practice ..." (Post-observation interview with CN Fleur)

New staff nurses (SNs) to the ward experienced leadership as different to what they normally associated with leaders, more collaborative, giving them a sense of being of equal value.

"Er, not really as a leader, not that I have a feeling of ... that I really look up to ... not a leader in the negative sense of the word ... a kind of leader, I suppose, but it's not that I see her as 'the' leader ... It's more ... working together. If you say leader, then I always have an image of someone standing above you and I don't have that feeling."

(Post-observation interview with SN Joan)

Transformations were starting to take place at the individual and group level. The pattern of associate dependency was changing as leaders learnt to use more stances and enable coming into own. Leaders started to feel relieved of the constant need to be in control and micro-manage the workplace context. Working life was feeling 'easier' for the leaders and their way of 'being' felt a personal choice rather than necessity.

"I notice a difference. I must say I'm calmer now ... I was more uncertain of myself then, about my performance and everything that happened here and whether I could cope and whether I wanted it ... I haven't that uncertainty anymore ... I think that I do it [leadership] better now, that I'm more confident about the things that I do, and that I reflect ... 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. And it will be my choice if I go and do something else ..." (Post-observation interview with CN Loes)

Working more collaboratively with associates, leaders' trust in their associates' potential and competency grew. This was shown by previously well-guarded CN tasks being handed over to associates. The PNs were not only starting to lead bedside care and take on non-bedside tasks, their scope of vision was expanding. They were becoming more critical and aware of their own growth and ambitions, as well as the qualities of their colleague PNs.

As the leaders created safe, critical spaces for associates to learn and grow, mutuality and reciprocity grew, reinforcing feelings of 'this is good/right'.

"Loes: Seeing them like this stimulates us to challenge them again with something new ... It's easier to involve them in decisions.

Betty: Yes, it's almost become the norm now.

.....

Loes: And it feels good for us too, to discuss issues together and set out a plan to follow through together ... And the moaning has stopped. Now everyone tries to look at the tight squeezes more positively, and think, "How should we handle this?" And, "What's wise?" Really and truly, there are only benefits"

(UM Betty's CCRI - Story 2)

Leader instigated collaboration and participation was met with reciprocity and associates became more attentive and responsive to the demands the CNs faced in their dual role as CN and PN.

"... and when I told her what my day would look like, she said, "Oh no, let me do those two patients too." So she took work over from me and I thought, "That's nice. I didn't even have to ask."

(CN Fleur's CCRI - Story 12)

The CNs became more apt at articulating their vision, values and beliefs, connecting their thinking with their doing and labelling their actions and emotions. They became most strongly aware of this during a hospital management development programme where they could compare themselves to other CNs within the same hospital. The ward was changing too. Betty and I increasingly noticed a calmness and sense of living, rather than running on a treadmill. The leaders recognised the peacefulness on the ward, attributing it to the primary nursing system and their being within it.

"Fleur: Yes, I can add to that. I too have a really relaxed feeling about the ward now. It's not that it hasn't been busy ... but there was still a relaxed feeling in the background. Even if it is busy and hectic now and again, there's still room for a laugh and people can discuss things with each other ..."

Loes: I think that the biggest effect has been caused by the new nursing system. We have less patients under our hats, alongside the nursing staff who really feel as if they have been listened to now ... it creates a calmness in our heads and that makes it calmer on the ward. I also feel that we radiate that calmness now. Because we have the office week, the off-duty is finished earlier ... the things that need to be done are getting done and people can now be held accountable for what they are responsible for."

(CN Loes' CCRI - Story 12)

Summary

Coming into one's own is a sensation when associates and/or leaders feel that things are good and right. Working life feels easier, people experience equity within collegial

relationships and feel they can be their authentic self within the workplace, rather than having to conform to expected or imposed behavioural norms. Mutual trust and reciprocity grows as people start to believe in the potential of each individual. Interdependency starts to replace patterns of leader dependency.

CONCLUSION

Becoming more person-centred, participant leaders learnt to differentiate between ensuring that things are done right and trying to ensure that the right things are done. Their shared definition of leadership reflected a process independent of organisational hierarchy and they defined person-centred leadership as trying to 'enable people to come into their own whilst working towards a shared vision/common goal'. A conscious referral to 'associates', as opposed to 'followers', reflects a vision of leading others of equal value, on principles of participation, inclusivity and collaboration.

Enabling others to come into their own is achieved through: sensing where associates are at; seeing them embedded within contexts influencing their being (contextualising); balancing competing needs before making a moral decision about which stance to take. Leader-associate connectedness is enhanced by: being/thinking with the other (presencing); creating safe critical communicative spaces to learn; and finding common ground (communing) from which to move forward. Moments where associates and leaders come into their own, feel good, acknowledged and able to influence their own being, is the goal leaders are continuously pursuing.

**Developing person-
centred leadership**

Chapter 5





"We were all different people when we started 3 years ago, each starting a journey with their own suitcase, at least that's how it felt ... For me it felt like we were going to make a long journey and I didn't know where we were going. But, along the way it became a bit like, "My God, what are we doing? I don't understand a thing. The path is winding and there's so much ... I can't keep this up. I'm never going to learn this. I can't follow you." ... I thought, "OK, I'm going to let these cheeses

ripen, leave them be for a couple of years ... and then it started to simmer, and a glass of wine appeared and slowly it all started to fall into place, and I began to understand it and began to like it, and it became more Burgundian and those cheeses were tasty now, and there was some fruit and I thought, "Yeah, it's getting better." ... and the cogs started to fit into each other, it all started to turn, and in the right direction, and it made me happy and in the end there was my wishing tree, with all the wishes hung up..." (CN Loes, 20/10/2010)



INTRODUCTION

Developing person-centred leadership takes time. Time for participants to become accustomed to the concept of inquiry and action research process. Working with personal narratives in safe, critical and creative communicative spaces was experienced as the most effective means of enabling transformation.

"Starting those [CCRI] sessions and using them myself, it started to become clearer where we were heading." (CN Loes:16/12/2009)

This chapter presents a thick description of the developmental journey, as experienced by Betty, Anne, Loes, Fleur, Tess and Chloé. My own voice and experiences are more evident in this chapter as a leader of the action research project and facilitator of change. Although all our narratives formed the primary data set, secondary data have also been included where relevant, to enhance scope and robustness. The journey narrative has been structured by categorising (sub)themes into a framework of facilitator/leader attributes, processes employed, context influences and outcomes.

ATTRIBUTES

Critically and creatively reflecting on our own lived experiences, we concluded that a person-centred leader should be authentically other-centred and caring, self-aware, patient and open, interpersonally intelligent, as well as reflexive.

Authentically other-centred and caring

Whilst some attributes can be learnt, the person-centred leader should genuinely want to be and experienced as being other-centred, trustworthy and caring.

"Loes: These are characteristics that you need to have and you can't learn them all. You have to want to be 'other-centred' ... it is a kind of natural being that you need to have ... if you really want to be person-centred, if you want it to be trustworthy and come across as authentic ... [you can't learn] the affective, your intuition, to be experienced as trustworthy ... Others have their 'feelers', don't they? That authenticity must be felt by the other." (CN Loes' CCRI - Story 4)

This is the 'weft/woof' or fabric of person-centred leadership. The leader asks questions such as: "What does the other need? Where/when/how can the other come into their own? What can I offer?" It involves knowing the associate in context, their strengths, weaknesses, idiosyncrasies, capabilities and potential, as well as respecting their narrative of lived experiences.

During the orientation phase, associate complaints about workload, and conflict in leader/associate perceptions were major issues consuming a lot of leader time and energy. I worked with the CNs to create a simple patient dependency scoring system and a creative work pressure measurement tool. The CNs ran workshops in which team members drew up descriptors for three categories of patient dependency. This created insight into workload trends. Work pressure was measured using three colour coded wooden tulips which each member of staff chose and placed in a vase each lunchtime. This visualised the mix in perceived work pressure and a way of monitoring daily trends. The point here was not about the tools, but the precedence I gave to facilitating a resolution of this issue that was dominating their world. The authentic other-centeredness this facilitation demonstrated fostered trust and a sense of connectedness, as well as introduced them to creativity and using participation whilst leading others.

"Loes: He [Shaun] was searching too, what suits us and what doesn't. What can he do and what not. He was very person-centred in this, so he connected with us ..."

(Workshop to evaluate Shaun's leadership, November 2009)

Self-awareness

Becoming and continuing to be a person-centred leader requires conscious effort and a self-reflective leader learns how personal values and beliefs may help or hinder their becoming. During an annual reflection Betty described her personal journey from an age of 'dinosaurs and autocratic leadership' where she did not feel at home, to an age of 'astronauts' and a sense of freedom. Freedom to move was an important and recurrent theme in Betty's interpretation of person-centred leadership, most evident when she felt the physician and sector manager trying to control her and restrict her freedom.



"... send people on a journey, a journey of development ... they determine where they fly to, dependant on the winds and other factors ... you've given them enough basics to look after themselves ... if you try to control them, you kill them, so you have to grant them their freedom ... not spoon feed them, but let them discover the world for themselves ... autocratic leadership doesn't suit me ... even in primary school, if the teacher tried to make me listen, I wouldn't ..."

(UM Betty's annual reflection, July 2010)

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I made a conscious effort to be aware of how my 'being' was affecting interpersonal interactions. A colleague had previously told me how my 194cm length, 100kg weight, male gender and tendency to ask direct, to the point, critical questions could sometimes be experienced as intimidating. Although I could not reduce my physical height or change my gender, I made a conscious effort not to be intrusive, to listen attentively and acknowledge the other.

A person-centred leader also needs to be aware of and work with their own values and beliefs, as well as those of others. I believed in building shared understandings, of not imposing my own, and so made a conscious effort to be respectful of participant's ways of thinking and doing.

"Anne: ... [Shaun was] very supportive in helping you become aware of things ... in the beginning I experienced him as someone who walked behind us, and I had a strong urge to say, "Walk in front! Say what you are thinking." Now the footsteps are more alongside. He never imposed competences ... but creates the space for you to discover them for yourself."

(Workshop to evaluate Shaun's leadership, November 2009)

Whilst beliefs may at times clash, the person-centred leader needs to remain open and inquire after the rationale. Fear is often a cause of negativity and Loes recommended meeting negative 'Yes, but...' reactions with a positive 'OK, what can ...?' response. By doing so, the leader acknowledges associate concerns/anxieties whilst inviting a change

in focus. As trust, connectedness and associate self-efficacy grow, so can the feeding back of observations and posing of challenging questions.

"Loes: ... recently you get more feedback [from Shaun], because I think we can cope with it better now. I can hold onto my own [values and beliefs] better now when I receive feedback from Shaun. Two years ago I may have been more inclined to take on board his methods rather than do my own thing." (Workshop to evaluate Shaun's leadership, November 2009)

My own preferred style of learning is divergent/assimilator, which contrasted sharply with participant leader preferences to do and discuss rather than read and apply. As I became more comfortable with the theoretical underpinnings of action research and person-centeredness, I was able to relax and be more patient when I could not follow participant thought processes or link these to theoretical frameworks familiar to me. I learnt to balance our learning preferences and needs, knowing when to step back and create space for the new learning to emerge.

"Betty: ... There was something which he [Shaun] did not completely agree with, but he let it go and said, "OK, it's clear for you, so, OK." Before, he would have bitten hold of it because it wasn't completely clear to him and not completely as he wanted it to be. His frame of reference is different and has changed in time too. We've grown towards each other.

Loes: I think so too. It's more trusting, easier ...

Anne: Clearer too. Providing more insight into him, and to us

Betty: And you change, and you learn, and you notice it's more effective. You do it together."

(Workshop to evaluate Shaun's leadership, November 2009)

I valued structured ways of working and was often struck by the lack of consideration given to structure. Whilst I consistently role modelled structuring meetings, I noticed that this cultural norm was hard to change. For instance, whilst I had diligently prepared questions and case study scenarios for the PN interviews, both Loes and the consultant physician (Rachael) arrived with blank pieces of paper. I shared my preparations, opened a discussion on how we could structure the interview in terms of who asked (which) questions when and moved flexibly during the interview, so as to keep a flow. Being aware and living my values whilst being flexible in working with others, I felt I was able to exert influence positively.

"Loes: A good example was your preparation for the interviews with the primary nurses ... I thought, "Pfff"... Rachael and I really had too little, but you [Shaun] had it all organised ... it was funny to see that there was such a big contrast between you and me.

Betty: I don't even find structure a hindrance anymore ... I'm slowly getting more structure in my work, but am continuously fighting against killing spontaneity. Structure and spontaneity seemed opposite poles and for me [and] spontaneity had greater value. It was difficult to overcome that, but, it's going quite well now ... the same with the [CCRI structure] stories ... It didn't hinder me as much as give me a lot more insight into myself.

Loes: It gave me a grip. Sometimes I found the structure good because it gives a framework in which you do something. (Halfway evaluation, March 2010)

Patient and open

I had a reasonably clear vision of what person-centred leadership meant to me and tried to embody the attributes of being other-centred, respectful, inclusive, collaborative and participatory. I had learnt to be patient and build shared visions. Making time to listen attentively helps an associate feel that the leader is there for them, in the moment, treating them as one of equal value, as a student nurse explained after working alongside Loes.

"... 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 with Sn Joanne)

The leader is calm, friendly, invitational yet clear in their requests, as another student shared after working alongside Tess.

"Very peaceful. No pressure that I still had things to do, or that I had forgotten things ... Good consideration to who was going to do what. I enjoyed working today ... it was more like, "You could do this." She doesn't force things upon you, so to speak, it's just open, "Have you done this?" ... just in a friendly manner, that you don't notice a difference between you ... she makes time for you. She's just clear in the tasks that need to be done. You don't feel like you're too much for her, so to speak, that she can handle having you there." (Post-observation interview with Sn Pam)

Being receptive, a person-centred leader invites feedback. During the evaluation workshop where participant leaders used animal cards to describe my and their ideology of person-centred leadership, I was pleased to hear of commonalities between the two: the spider who holds everything together, the owl who is wise and keeps an eye on things from a distance, the meerkat who monitors and represents variety and team work, and the dolphin who is other-centred, powerful, therapeutic, liked by all, intelligent and swims with the current.

Sometimes it is wiser to keep certain thoughts to oneself, whilst at other times showing vulnerability enables a leader to incite dialogue on delicate issues. As our relationship grew I felt more comfortable sharing my perspective of the journey we were making

together. My openness was appreciated and they accepted me for who I was, creating a sense of connectedness and mutuality.

"Betty:... His [Shaun] search is just as large as ours. It has been a shared search and I felt that from the beginning. We were companions ... He's allowed to fall out of his role now and again, even as a person-centred leader, that's just being human ... I can't really say whether or not he lets you see everything of himself ... And that is not necessary in order to be a person-centred leader, because it doesn't block the openness of the person. It's about being open and honest, transparent in the way you relate to people, and that happens. And I think, "whatever you do, retain your individuality, keep some things to yourself."

(Workshop to evaluate Shaun's leadership, November 2009)

Interpersonal intelligence

Whilst exercising emotional intelligence can involve controlling negative emotions such as frustration, being honest and open in one's failures is equally important. Person-centred leaders try to gain/retain a sense of connectedness with associates at a rational and affective level, using emotional intelligence to move seamlessly between different levels of engagement. Whilst being present and showing sympathetic understanding is a close level of engagement, distancing helps take stock to see the bigger picture and/or prevent oneself from becoming too involved, overburdened or negative towards the other.

"You also have to be careful that you don't get sick of it, because then we'd be doing her an injustice, because we ourselves are like, "OK, this is taking too long, it's going nowhere"... you become negative, like, "Oh, her again." You have to be careful ... you have to be sympathetic, but not lose your objectivity, and you have to keep trying to see the bigger picture. The individual in the centre, definitely, but also the ward around them."

(CN Loes' CCRI - Story 9)

Whilst being inclusive, collaborative and participatory felt right, being other-centred also resulted in matching level of participation with associate ability and desire, as Fleur explained.

"Fleur: This is my way of doing things, when I can feel good about it ... then it doesn't even feel like you're leading, it feels more as if you running the ward together ... collective thinking ...

Shaun: You said, "That was possible with Mandy because you need to have that trust." What did you mean by 'trust'?

Fleur: Trust in someone's qualities and their experience ... some people don't function in the same way ... at the level at which you can hold this type of conversation. I don't mean that derogatorily. You can't expect it from everyone either, do you understand? A lot of people are not

that far yet ... and they don't want to carry that [responsibility] yet, not think about that yet, and can't handle that as well yet ... you look at who you're working with."

(Post-observation interview with CN Fleur)

Using interpersonal intelligence, the leader does not sell or impose their vision, they share it. In doing so, they are seen as supportive and an authority, not authoritative. Someone who shares knowledge and beliefs that associates decide for themselves are believable and worthy of listening to.

Reflexive

Reflected upon action with a moral intent occurs continuously as the person-centred leader deals with both large and small everyday dilemmas. An inquiring mind, analytical thinking and listening to one's intuition before critically questioning it or proposed action, aids reflexivity. Gathering extra relevant information where possible is also useful. The morally inclined leader poses phronetic questions⁷ such as: "What is happening here? Is it desirable? Who gains, who loses? What should I/we do?"

Being reflexive can sometimes lead to confrontations with one's own values and beliefs. When Betty was removed from her post as UM by Clive (physician manager) and Mary (sector manager), I was deeply troubled, angered even, by what I interpreted as being management using hierarchical power to enforce subservience and thwart the empowerment of nurse leaders. I was concerned that my own agency in trying to enable participant leader empowerment had in fact made things worse. Contemplating a reaction I used my own action learning set, researcher journal and supervision sessions for guided reflection. I consulted Betty on whether and how to react, however, she was convinced that participating in the study was not a cause for her displacement. It had only surfaced suppressed tensions and power imbalances. She was keen for the study to continue and felt that any intervention could jeopardize this, and so we agreed that I would take a passive stance.

After Betty's departure, I felt unease and distancing from the CNs as Clive reclaimed control of the ward. Instinctively I wanted to react, but again, reflecting on possible negative consequences for the CNs and Betty, who was still working within the hospital, I decided to remain passive. There was also a wider political context to consider, such as future collaborations between the university and the hospital. During my reflections I was reminded of the vibe cards (see Figure 22 p.150) I had chosen during an annual reflection. I had done my best to try and 'path the way' for participant leaders to empower

⁷ Phronetic questions stimulate rational contemplation on whether social actions are good or bad for humans. They are derived from the Aristotelian concept of phronesis meaning practical judgement, common sense or prudence.

themselves, but now I needed to be 'patient'. I decided to step back and observe, hoping they had sufficient grounding to continue the journey alone.



Figure 22: Vibe cards chosen during an annual reflection

Summary

Whilst some essential attributes of person-centred leadership can be learnt, other-centeredness and caring should be authentic. (Developing) Self-awareness enables contemplation of how the leader's own being influences interpersonal relations and change. The leader who is patient, honest and open to feedback, holds the whole together. Using intrapersonal intelligence, a leader moves between different levels of engagement, building shared visions and retains a sense of connectedness. Being reflexive, the needs, values and beliefs of others and self are considered before (not) acting with intent of doing good.

PROCESSES

The vibe cards 'clear the path' and 'decide' (see Figure 22 p.150) capture the general mood of the processes used to develop person-centred leadership. 'Clearing the path with and/or for participants' captured the emancipatory intent of removing barriers to becoming more person-centred. 'Decide' captured the shared decision-making activities undertaken. As well as using all the person-centred leadership processes described in Chapter 4, creativity played an important role in safe critical communicative spaces.

Taking the time needed

Changes can be implemented fairly quickly, but the problem facing most change/implementation projects is sustainability. Transformation implies embedded and embodied

change, a state of being where regression to a previous way of being becomes impossible. Transformational journeys can be confrontational and require balanced challenge and support during the transition process. The culture workshop conducted during the orientation phase showed a workplace culture showing characteristics of a family. Families have a nature of being self-protective, and while connectedness between 'family members' was valued, there was also concern that this was at the cost of self and criticality. This indicated an openness to change.

When asked, "take your time" was the advice participant leaders would give to other researchers undertaking a similar study. It took time for the leader participants and me to get to know each other and build safe, trusting relationships. Engaging in the various action spirals also enabled them to become re-acquainted with each other at a deeper level as they discovered things about self and the other that they had not taken the time to get to know before. Whilst participant leaders felt that taking time to know who will be change champions and be catalytic to the change process, I felt that perseverance in creating opportunities for stakeholders to participate and undertake action was also an important lesson.

"Loes: despite our enormous work pressure we took time to listen to what people were saying, to really hear the team. How are we going to approach this and how are we going to do this together? That is also very person-centred towards the team, and eventually you build a framework around it ... look at the people you are working with, and adjust yourself to them first. Look at where there is a need and try to focus on that, but see the people who you are going to work with first, hold some distance and let people get used to you first whilst you're walking around. That it feels safe. So, take your time ... and look at the tempo they can work at. Some are quicker than others.

Betty: I think we could have looked more closely at who we involved. You [Shaun] had the tendency to say, "Let it come voluntarily" ... in terms of the group dynamics we could have invested more in looking at what people we needed in the beginning, for it to be successful.

Shaun: I think my advice would be to keep creating spaces for people to undertake action, and even if they don't, don't give up ... eventually, when the time is right for them, they'll undertake action ..."

(Halfway evaluation, March 2010)

Creating safe, critical and creative communicative spaces

Creating safe, critical communicative spaces to share lived experiences, claims and concerns, followed by reflection, contestation and debate were important to maintain change momentum. Safety is important for communicating honestly and critically. For instance, I felt able to raise concerns about the slow pace of development at one stage, and after they had heard me and I had listened to their responses, we were able to use the insights gained to resolve perceived barriers. Sometimes solutions were as simple

as being patient, such as waiting for the CNs to feel confident enough to start facilitating storytelling sessions. At other times, raising awareness to alternative perspectives or ways of being renewed enthusiasm for action. For instance, there was reluctance to include Fleur into the CCRI's when she was temporary CN, and the PNs after they had been appointed. Posing critical questioning on whether leadership was only enacted by hierarchical leaders, the leaders' thinking rose from a focus on details and tradition to a more abstract level and, in addition, to the benefit of inclusion, not only for the group, but for the new members themselves and our research goals. Actions such as a preparatory workshop to relieve concerns about new member ability, also helped.

Thematic analysis of participant evaluations revealed that "participating in CCRI was both challenging and beneficial in terms of becoming other-centred, creating a safe environment, using creative expression, remaining critical and balancing contextual demands with development needs." (Cardiff, 2012, p. 615) as well as "feeling supported in becoming person-centred leaders and transferring this becoming into transformative action, as leader group cohesion strengthened." (Cardiff, 2012, p. 618).

The authenticity with which people engaged in the annual reflective inquiries demonstrated that we had been successful in creating the safe environment needed for deep, sometimes challenging self-inquiry.

"Loes: Thinking back on this period brings back how bad I felt then, and I didn't realise that it had made such an impact on me ... A little bit confrontational for me, the emotions that were recalled, but I enjoyed looking at the development made and being able to speak so freely among ourselves. It was a safe environment."

(Annual reflection, January 2009)

"Betty: ... I never really wanted to stand centre stage, that was never important to me, but, I could never really keep my opinions to myself, and I've now managed to achieve that ... I often keep my mouth shut now and by doing so I think I say more ..."

(Annual reflection, July 2010)

By participant request, I both facilitated and participated in these inquiries, which was appreciated by them and beneficial for me.

"Loes: Nice to see the development again and to hear how everyone is changing and gaining from this ... and that you yourself [Shaun] have gained something from this too, which is important."

(Annual reflection, July 2010)

Trying to be critical and enable criticality, I would question assumptions and offer alternative perspectives to maintain dialogical flow before encouraging decision-making for reflected upon action. For instance, during the implementation of the PN role a discussion

arose about whether it was necessary to dialogue and agree ways of working together with associates each morning.

“Chloé: It takes a lot of time, maybe that’s the problem.

Shaun: Is it an investment or is it just time consuming?

Chloé: It’s also an investment, yes.” (Primary nurse evaluation meeting 4/1/10)

Facilitating such spaces, my intent was to help participants connect their ‘thinking’ with their ‘doing’ which would then influence their future ‘being’.

“Loes: I found the meetings we had, for different situations, also helped me view things differently, to think at a different level, whereby I started to change. Your arrival and questioning helped me to start questioning, “What are we doing actually?”... I’m more aware of how my take on things is changing.”

(Annual reflection, January 2009)

During the orientation phase I made a conscious decision to refrain from sharing my thoughts and opinions freely, fearful that the cultural pattern of leader dependency I was observing would be reproduced in my relationship with the leaders. The CNs were expressing concerns about how associates tended to ask questions about anything and everything. As well as verifying my observation, they agreed that my initial stance of holding back was effective. Although they were curious, they did not ask for feedback and any feedback may have initially been interpreted as critique or feel intimidating. As relational trust grew, I noticed participant leaders asking for feedback and my opinion on things. I felt that the time was right to introduce challenge as well as support. For instance, when Loes shared how she had dropped everything one morning to rush and supervise a staff nurse conducting a student assessment, I challenged her assumptions and action. The CNs were trying to break a pattern of staff dependency and Loes’ language implied that she viewed Angela as a ‘very young girl who needs mothering’, a perspective that would not help break the dependency pattern.

“Loes: I arrived and saw that Angela is still a very young girl, so I understand that she forgot [to include me].

Shaun: A young girl? She’s a qualified staff nurse who has already undergone 4 years of such assessments herself ... You could have suggested coming for the last five minutes, the conclusion, that would be a solution ... that would have balanced the different needs. There’s a danger that your response encourages a ‘you ask, we perform’ pattern.

Chloé: That’s what I meant, we still react too ad hoc.” (Primary Nurse evaluations: 4/1/10)

Conscious of balancing challenge with support for effective learning, I regularly evaluated the effectiveness of my facilitation using concrete questioning and a challenge/support matrix (see Figure 23 p.154).



Figure 23 challenge support matrix

Safety within communicative spaces was conducive to authentic dialogue and bringing people to the edge of/outside their comfort zones for effective learning.

"Betty: Feeling uncertain about things has actually helped me change ... I now believe in collectiveness, which has come from being open. We often talked about thinking that we know what the other is thinking/will think, but now I think, "Name what it is that you're thinking, and let each person say what they're thinking." 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 as well as bring uncertainty. At times I think, "Can I do this?" At other times I think, "I can do that.""
(Annual reflection, October, 2009)

Combining the principles of psychological safety with criticality and creativity was not limited to the CCRI's. For instance, on the morning that Betty was told by Clive and Mary that she was likely to be removed from her post as UM, she was quite emotional. Wanting to help I offered to facilitate her through a three phased process aimed at supporting her work through her emotions within the safety of her own office. Phase one involved observing the view from her seventh storey office window, moving her gaze hermeneutically from the whole to details and back again. Despite the dull, grey, foggy urban view, her eyes were drawn to the small red tail lights of a car driving off towards a horizon of street lights. She concluded that she could find joy in detail and that she needed to focus more on her own horizon. With the imagery still in her mind, she described her feelings using the basic four emotions: happiness, sadness, fear and anger. Her emotional responses helped identify her core values and a fear that the freedom she so valued

was now threatened. In phase three she reviewed strategies to maintain a sense of self-determination whilst continuing to work with Clive and Mary.

Related to the same incident, I later walked into a heated discussion between Loes, Fleur and Betty about Betty's displacement. The CNs were angry and whilst sympathetic to their feelings I feared that if this was not channelled into praxis (reflected action), cathartic actions could trigger negative reactions in a politically fragile situation. I suggested restructuring the planned CCRI into a workshop to explore their feelings and how best to react to Betty's narrative. In phase one, the CNs stood before a window and, whilst observing the view, actively listened to Betty's narrative. Betty could tell her story without distraction from the CNs' (non)verbal emotive reactions. In phase two, the CNs dialogued with self, documenting their emotions with the aid of a sentence: "I feel because" After sharing their emotions and finding commonalities they moved into phase three where they re-entered dialogue with self and considered what actions could be taken. In phase four, individual actions were shared, possible consequences explored and consensus sought on joint/individual actions in phase five. The CNs evaluated that they were able to articulate and confirm their feelings effectively during the workshop, emotionality had been controlled and they were now able to use strategic thinking to underpin reflected action.

The use of creative expression through various techniques proved to be catalytic in opening minds and explicating thoughts and feelings that would otherwise have remained submerged and/or have later emerged in disguised or deconstructive ways. For instance, having been asked by Nadine to facilitate a meeting between herself and Loes, following a conflict between them, I wanted to create a safe space in which they could dialogue and connect. After clarifying the aims of the meeting and characteristics of dialogue, I invited each to use image cards to express how they viewed their relationship. This enabled them to maintain emotional control and use less accusing language.

"Loes: ... this image, it's pleasant countryside but there are barriers. I thought we had planned the route well, but then you run up against a gate and it takes time before you've moved around it or over it ..."
(Meeting SN Nadine and CN Loes, part 1, 29/3/10)

Working with creative expression required sensitivity as some took time to become acquainted to expressing themselves creatively. Offering a range of methods helped each find a method that suited them personally.

"Loes: Shaun took us a long way in the workshops, in his own way with that creativity and cutting and pasting, but was attentive to our needs. A lot emerges from the creativity, that's not the problem ... it took me two years [to feel comfortable using creativity]. He took that into account because he did think of other things, for instance, I really liked the image theatre."

(Workshop to evaluate Shaun's leadership, November 2009)

Using creative expression helped develop shared understandings and a feeling of connectedness, evident in the visioning workshops for primary nursing. Although participants felt that they were away from the ward for a long time, it was time well spent and resulted in their first vision statement. Generally, participants felt that the use of creativity was catalytic to achieving consensus.

"Chloé: Personally I find that the visualisation helps ...

Betty: ... It does work, it lets you think deeper about a concept, more than you initially could have done in words.

Loes: I think that you get more results by doing it like this. You empty your mind with the creativity and tap into more new things than if you were alone. Looking at [the work of] others and setting out your own thing.

Chloé: Sculpturing is an immediate result and I can do something with it straight away, while I found making a collage more difficult.

Tess: For me it was the other way around, I find sculpturing more difficult than taking your time to make a collage.

Fleur: I had a strong feeling of togetherness and that was really nice. We listened to each person and everyone came into their own, and I had the feeling that everyone contributed."

(Visioning workshop, September 2009)

Whilst Betty had always been enthusiastic and willing to use creativity in activities with associates, it took time, role modelling, support and gentle encouragement before the CNs showed initiative. By the end of the study, Loes was enthusiastic about incorporating photos of their creative expressions in her presentation on leadership vision for the management development programme she was attending, and Fleur facilitated a creative culture workshop with the unit team using digital photography.

"Betty: Fleur has always valued creativity, but suppressed it, and because I let her be herself and reinforce that it's a good way of bringing messages across, she's gained more self-confidence and dares do it now. ... you emphasize that she's allowed to be different, and the more of herself she puts into it, the better. Alongside that, you keep inviting her to do it, to give her a role in it and gradually build on it ... I didn't even have to ask Fleur to facilitate the (culture) workshop, she did it spontaneously ... and she said I didn't need to be present for the presentation either, because she'd be presenting it."

(UM Betty's account of culture workshop, March, 2010)

Role modelling

I used role modelling for participants to see and experience alternative ways of being, such as agreeing agenda items and a time frame for each meeting. At other times I offered suggestions, such as using a claims, concerns and issues structure during the PN meetings and daily evaluation sessions with associates. A poster was made of the Person-Centred Nursing framework and hung in the CN's office for easy reference. I also tried to use every opportunity to identify and illustrate the processes of person-centredness.

Explicit role modelling and material reminders were ways of illustrating alternative perceptions and ways of being. Communing with participants I tried to balance support with challenge, showing sympathetic presence yet raising awareness to misconceptions.

"Shaun: But, on the other hand you [Loes] were open and honest and acknowledged that you were angry ... I find it impressive use of your self-knowledge that you can say, "Equality is so important for me." ... from what I hear in your story, it's not so much about them [social activities committee] making a decision as about reversing a [shared] decision without consultation ... it's disrespectful to the person with whom you make a shared decision to break that decision in a non-crisis moment."

(Interview with CN Loes, 29/3/09)

5

Sensing, presencing and stancing

Sensing where others 'were at' was important for me to be able to decide how best to enable their continued development. During a meeting four months after my departure, Fleur entered the room with a tired, troubled look on her face. I recalled how she had shared feeling uncomfortable at the previous evaluation, because no one on the ward knew we were meeting. If we were to make the most of our time together, I needed to rekindle the sense of safety and openness characteristic of our collaboration in the past. I did not want to create discomfort, so I casually asked if she was tired. The ice was broken, the old Fleur returned, and I was able to check that she was comfortable with this meeting.

Presencing as a supportive process was enacted in various ways. Sometimes just being physically present was sufficient challenge and support for participants to become more aware of their thinking and doing. At other times, attentive, non-judgemental listening and sympathetic imagination helped show that I understood what they were experiencing.

"Anne: ... very much accompanying you ... and able to sympathise with nurses. I found that always very evident ... I notice that if Shaun is present you're very aware of what you say, you listen to yourself and think, "Am I saying this right or not?" If he's not there, or not facilitating, then we just fall back into our old ways of talking to each other."

(Workshop to evaluate Shaun's leadership, November 2009)

I used all four stances of person-centred leadership during the study. Leading from the front and side line I prepared and facilitated most activities we undertook, presenting proposals and inviting input to refine details. I was particularly aware of leading from alongside, which taught me to 'take my time' and be consistent in offering support and challenge until participants were ready to take action. Choosing to step back and lead from behind was often related to being flexible, patient and balancing needs, as happened when I gave precedence to the workload issue the CNs were struggling with.

"Loes: Did the workload in the beginning ... slow the process? We started with the workload measurement tool and all our energy went into that. That was a considerable amount of time, but we had little [head] space to be busy with you [Shaun]."

(Halfway evaluation, March 2010)

There were moments in which leader opinions on what to do differed from my own and I had to balance needs and consider which stance to take. For instance, facilitating a workshop to determine an evaluation strategy it became apparent that the participant leaders had a strong preference for a Likert scale questionnaire. Aware of their limited research skills, the short space of time available, a relatively small research population and the risk of poor response, I foresaw validity problems. However, their argument that higher management would only acknowledge quantitative data and that all elements of the original project assignment would need to be 'measured', encouraged me to step back and observe. The questionnaire response was relatively low, 39% ($n=15$). Moving forward to lead more from the front, I suggested using the mean and modus scores, along with range, to categorise results into one of three options: a tendency for respondents to be in disagreement/ambivalent/agreement with each item.

On some occasions stepping back provided me with new insights. Whilst we had agreed that the staff storytelling sessions would focus on patient stories, in practice they were often about team relationships. Listening to these narratives gave me the opportunity to see how the Person-Centred Nursing framework could also be used to analyse associate-associate relationships. As the CNs facilitated associates in resolving issues embedded within these narratives among themselves, they were in effect breaking the tradition of associate dependency on leaders.

"It wasn't a patient story, but, [SN] Mandy's annoyance with the situation, which she had mentioned this morning, didn't end up on our plate this time ... As a leader you are inclined to think, "Oh, we'll have to do something about this now." This is another way of doing something about it ... I had the impression that it was a very productive 15 minutes ... trying to be person-centred towards them by allowing them to take responsibility, and person-centred towards each other by thinking about, "How do we interact with each other? How do other people feel if we work in a

certain way?" And I wasn't seen as the resolver, I don't have to have that role. I hope by doing this I can break that pattern. The leader can stand among them and be supportive, having a coaching role ... and let them see that they can search for a solution to this problem. It's actually better if they do it themselves." (Post storytelling interview with CN Fleur, 22/3/'10)

Reflecting on evaluations and observations

Associate experiences of CN leadership were collected using animal cards, transcribed, re-presented and member checked. PN experiences of leadership were also collected, in a different workshop. These evaluations were offered to the CNs. Loes and Fleur found it interesting how the PNs saw individuality whilst still experiencing a sense of leader unity. There were extracts that they did not agree with or found confrontational. I tried to show sympathetic presence and suggested they re-read statements or reminded them of the context in which things were said. This aided the acceptance of the feedback.

I observed participant leaders in practice, both during formal planned participant observation and informally. This provided me with opportunities to observe events of potential significance to understanding person-centred leadership and I would sometimes suggest certain incidents be presented in a CCRI. The CNs started to use the same strategy when facilitating staff storytelling sessions.

"... now that we've started with the patient stories I'm more alert ... if you don't do that [suggest that an incident be shared in a storytelling session] you save things up, but, they are just as quickly forgotten. Now we're on the floor the whole week, working with someone, I can think, "She could easily tell a story about this." (Post storytelling interview with CN Loes, 15/3/'10)

Participant observation took the form of 'shadowing' participant leaders, and post-observation interviews offered insight into the thinking behind their doing as we reflected on what I had observed. On occasions I also interviewed those working with the leader and, after consent had been given, offered this data to the CN to aid their understanding of the effect their leadership was having on others. Whilst the CNs were not accustomed to being explicitly observed in practice, they appreciated how it raised their awareness to aspects of their being and the context, aspects that they would not normally question.

"I have never really had to reflect on what I was doing with someone really watching what I was doing ... I often think that I'm doing everything, but is that really the case? It's an eye opener and a development that is really great to experience. Shadowing is very direct, the questions afterwards and the evaluation." (Post-observation interview with CN Fleur)

A variety of techniques were used to support reflection-on-action. For instance, after observing a storytelling session, Fleur shared how she was finding it difficult to move

the process on from a descriptive into a reflective phase. She was also not aware of how many closed questions were being posed. I suggested listening to the recorded session together, pausing at regular intervals to reflect on what was happening.

"Fleur: Yes, I found it useful to listen to it again. I learnt something from this.

Shaun: Is it an idea to tape the sessions yourselves in future?

Fleur: Yes, then you can play it back and listen, but, it's also good to listen to it with you, like we just did."

(Post storytelling session interview, 7/6/'10)

Using theory

Participant leaders were not as eager to seek and apply theory and theoretical frameworks as myself. Initially, I introduced the whole team to the Person-Centred Nursing framework in an interactive workshop. In hindsight, the leaders felt that this may have been premature. The concept and theoretical framework were totally new for them all and all available literature was in English. As our primary focus was exploring person-centred leadership, the Person-Centred Nursing framework was not used with associates until the storytelling sessions started.

Despite various strategies to help the leaders become better acquainted with the framework, their comprehension of it remained poor. I referred to it and role modelled how to use it frequently during CCRIIs and other relevant moments. I offered English language articles and book chapters on the framework and we even agreed that Betty would translate one article into Dutch, which, despite reminders, never materialised. Only Fleur ventured into propositional knowledge. Joining the participant leader team late, she felt that she was lagging behind the rest which did motivate her to read everything and start surfing the internet.

"Loes: Reading the articles was just too much. After working for so long and being here for so many hours, I come home to a family with four children and everything that entails. I've already cancelled a lot of things that I used to do, and it was too much ...

Betty: ... and if it's from a scientific perspective it really doesn't interest me ...

Fleur: I needed it to come a bit closer to where you were. They were all terms that I didn't know so I looked them up ..."

(Halfway evaluation, March 2009)

The participants attributed progress in exploring and developing person-centred leadership primarily to our communicative spaces. The CCRI guidelines and articles, with some in Dutch, on related concepts such as primary nursing, skilled companionship and presencing in nursing, also helped. Initially, the term person-centeredness felt abstract and alien. Their need to gain experiential knowledge of it before they could contemplate

a theoretical understanding indicated convergent/accommodating learning styles, starting with doing and feeling before moving on to watching and thinking.

"Betty: ... It [theoretical framework] was absolutely of no use to me, but no model was. I wasn't that far. I spent a long time in, "What should we be demonstrating?" and if you hang it on a model then it's as if it's already determined, and for me it took a long time before I had the idea that that was what it was ... I can't use a model to develop something, I have to develop it and then stick it on a theoretical framework ... and it's not that I don't think theory is important, it's just that the penny is only now stating to drop, and I look and see, "Oh yeah, that's exactly what we did..."

Loes: We've been busy for three years and it's only now that I feel that I'm starting to understand it 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."

(Halfway evaluation, March 2009)

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This was in contrast to my own divergent/assimilating style of learning that starts with watching and thinking before moving into action. I felt a need to understand the Person-Centred Nursing framework and related theories/frameworks before I could facilitate participants. Choosing the right moment to introduce (what I felt were) relevant theories and frameworks/tools was important. As Loes said, "It wouldn't have been very person-centred if you had imposed the theoretical framework [too early]." An example of introducing theory 'just in time' was during the conflict between Loes and Nadine. After the first meeting I introduced Loes to John Macmurray's (1961) existential humanistic theory of relating. Using experiential knowledge from the conflict with Nadine and previous meeting, she saw the model in action and how she could have acted in the situation. The Person-Centred Nursing framework process of engaging at different levels suddenly made sense.

"I think that I retracted into that negative [modus of being], that's true ... I was so cut up by it [the conflict], I needed time to let it settle. It's not such a big thing, but I need time to let it be ... and then we'll both come back from a positive modus. Which is, after all, what you want..."

(Meeting with CN Loes, 17/5/10)

Summary

Time and perseverance is needed for participants to feel safe and develop the self-efficacy needed to undertake transformative action. Sharing lived experiences, claims, concerns and issues within safe, critical and creative communicative spaces supports and enables participant development. Sensitive feedback and criticality enables the connection of

thinking with doing in order to influence future being. Challenge and support strategies should be experienced as high yet balanced so that they remain effective in enabling learning, authentic being and profound reflection. Exploring different means of creative expression offers individuals alternative means of dialoguing and discoursing, unveiling pre-conscious and embodied insights and finding a common ground. The facilitator/leader uses every opportunity and various strategies to illustrate being inclusive, collaborative, participatory and person-centred. The same processes of sensing, presencing and stancing are applied to developing person-centred leadership as enacting it. Whilst theory and theoretical frameworks are needed, this may follow experimentation for those with a convergent/accommodating style of learning.

CONTEXTUAL INFLUENCES

Contextual influences came from different spheres of being, supporting and/or slowing the exploration and development of person-centred leadership. At the micro level, personal history, ability, values and beliefs, as well as commitment and opportunity to compare own development with that of others, influenced progress. At a meso/macro level, idio-cultures and traditions played a role too.

Personal history, ability, values and beliefs

I learnt how each individual has a unique history that can influence their being at any given moment in time. Loes had been a staff nurse on the ward for a relatively short period before she became CN. The early years were challenging and learning to lead took place during significant organisational changes. On several occasions Loes reflected on this period, sharing how she had experienced letting herself being moulded into a style of leadership that did not feel was her own choice. However, she used these insights to help her facilitate Fleur differently.

"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 was never strong enough to seek a good collaboration with her. I let myself lean back too much. Then she left, and that was a difficult time too, but I learnt more about myself then ..."

(Halfway evaluation, March 2010)

Some personal values and beliefs were catalytic to transformation and other personal values changed gradually. From the very beginning Fleur valued showing vulnerability, collaboration and having a sense of connectedness with others, which was experienced by those she led.

Collective staff description: "More than the others she [Fleur] radiates warmth, a cuddle, a warm nest, "Come to me for a moment and tell me what's going on." Without judgement ... you experience the engagement ... Fleur can feel what people mean, put her finger on the salient point. She understands exactly what you mean ... She's also comfortable in admitting when mistakes have been made or that the situation is difficult. In doing so, you feel acknowledged when you raise an issue."

(Workshop to evaluate unit leadership, March 2010)

Loes was a more reserved person who valued her privacy, leader strength, decisiveness and immediate action. Whilst associates seemed more than willing to tell her their problems, and I often observed her being privately sympathetic towards their situations, she was also perceived as being 'reserved'. Reciprocity was lacking in her relationships with associates. Throughout the three years Loes struggled to find a degree of openness she felt comfortable with. A turning point came during and after the conflict with Nadine, where she showed her vulnerability and heard how people missed that in her.

"Loes: I'm very strict in keeping work and private life separated ... recently I have been more agitated [starts to cry] ... I have a big problem with the fact that you have a problem with me ... I'm your charge nurse and I feel that I have to be there and be the role model and that if something explodes we have to talk about it, but sometimes I just don't have the space to do that ...

Nadine: I saw that you had a lot on your plate with your father's death] ... maybe I missed you sharing that...

Loes: It doesn't work like that. You can't just say, "I'm having a bad day today."

Nadine: But you have built a wall around yourself. I've never seen you as you are now. I don't like seeing you in tears, but putting it bluntly, it feels good that I can think, "There is feeling in there." I've not often seen you vulnerable ..."

(Dialogue between SN Nadine and CN Loes, April 2010)

The administrative side of Betty's management role was her weakness. Clive was voicing critique that there was no clear written plan to Betty's developmental work on the ward. Indeed, Betty also felt she needed some documentation that would tie past, present and future together. I suggested Betty formalise a vision statement and develop a project plan, but there were no standard frameworks within the hospital she could use. Clive was very critical of the final document and used this weakness as one reason to remove Betty from her post. Although the nursing (leadership) culture was transforming, organisational and other discipline cultures and traditions started to pose barriers to change

Culture and tradition

As the leaders became more person-centred, leader-associate relationships improved with increased acceptance and support. However, their style of leadership challenged the workplace cultural norms on hierarchy and power.

“Betty: I value empowerment now ... [I] want to see others grow and I see a group of individuals now, instead of a group versus individuals ... I’m more focused on acceptance, support and collaboration with the team, but I have other forces to contend with, such as embedding changes in the organisation and how can I portray what we are doing in a way that others are able to comprehend, because I feel that I am moving into other cultural norms that not everyone can, dares or has had time to get used to ... I’m searching for a new identity and self-assurance that no longer rests on or is protected by hierarchy.”

(Annual reflection, January, 2009)

The aims of this study were to explore and develop the concept of person-centeredness within clinical nurse leadership and leader being through action research. Action research is not a popular methodology in The Netherlands and certainly not within the medical profession, and the aims did not include a more traditional focus on associate performance and/or workplace culture. This alternative approach seemed difficult for the physician team to comprehend and/or accept. During the orientation phase I met with Clive, presented the research proposal to the physician team and held an interview with one physician consultant (Rachael) in order to gain their perspective on nurse leadership. I was explicit in offering to include and work with the physician team on exploring person-centeredness, if they so wished. No requests emerged and it became clear that the physician team were not receptive to an action research methodology.

“Shaun: I think that they didn’t understand the research methodology.

Betty: And they didn’t want to. They wanted a quantitative study, that was very clear.”

(Halfway evaluation, March 2010)

Passionate about nursing as a profession in its own right and believing in the value of person-centred nursing care, I was often despondent by the lack of intra- and interdisciplinary recognition nurses and nursing received. I observed a historical subservience of nurses and nursing to the medical profession, poor knowledge of nursing science and a lack of nursing leadership within higher management. I was trained in a culture where physicians did not interfere with or try to control nursing teams. This influenced my interaction with Clive and the physician team. Whilst I espoused a willingness to collaborate, I did not actively seek it out nor feel accountable to them.

Betty met weekly with Clive and so agreed to keep him informed of project progress. They had discussed reviewing the nursing system and formalised this into an assignment.

After the think group advice had been accepted by them, and the PNs had been appointed, critique started to emerge from the physician team about the research and, in particular, my role and influence. Betty felt her way of interacting and communicating with the physician team may have exacerbated the situation.

"In meetings with the physician team, when I talk about what we are doing, Karl [consultant physician] is the one who says, "Yeah, I can't object to that ... but it is so intangible for me." So that is where the pain may be, and that is maybe a learning objective for me. I may need to approach it differently. Too often I presume that what is discussed in 'corridor discussions' is accepted. Maybe I don't formalise it sufficiently. That has something to do with my belief that if something has been agreed then, for me, it has been agreed, regardless of whether it has been put onto paper or not. But, for a lot of people there is a value difference in whether you have an official meeting and officially agree things together, or that you casually agree things ... You were introduced to them at the time and I thought, "OK, that's done, they know who Shaun is, they can also approach Shaun if they have questions, and it's not difficult to make contact with Shaun." And you had a meeting with Clive and with Rachael (consultant physician) ... so I thought, "I don't need to do anything extra.""

(Interview with UM Betty, 16/11/09)

Betty had suggested that I meet with consultant physician Karl to discuss the research and my role and it was in that meeting that I was reminded of an action researcher who once said to me, "With the empowerment of some comes the disempowerment of others."

"Karl: We had a research question from Shaun in the past ... we said 'yes' then, and afterwards it was unclear to us where the end of the research was ... We have the impression that Betty has a considerable form of reflection, support, or however you want to name it, from you, and is withdrawing from our sight ... So, it [Shaun's role] is a kind of leadership within leadership, but explorative ... it seems to us, to be of relevance for us, as the physicians here on the unit, to be told about that ... the second is your role during the interview procedure for the primary nurses. Is your role to give advice or just to study the process and selection choice? How did you come to be there?"

Shaun: I was invited, I did not invite myself. The reason given was, "We'd like to use your expertise in the selection." ... There was a 'think group' beforehand in which Rachael [consultant physician] and Pam [nurse practitioner] also participated.

Karl: And that didn't lead to a new role, so to speak?

Shaun: No. I do not make decisions about internal affairs. I facilitate the decision-making process, but, the direction in which decisions fall doesn't really affect me."

(Interview with consultant physician Karl, 16/11/09)

Reflecting on this meeting with Karl, I felt that poor internal communication and shifting power relations were creating unrest. Betty had explicitly asked consultant physician Rachael if she had objections to my participating in the primary nurse interviews, which she didn't. Whilst Betty presumed that Rachael would communicate this internally, it appears that was not the case.

"Betty: I discussed it [Shaun's participation] with the 'think group' and Rachael in particular, 'Is that a problem or not?' She said, 'No, it's no problem.' That's what happened. And Clive was upset that it happened without his knowledge. If Rachael's their representative, then she's the one who represents the physician team."

(Interview with UM Betty, February 2010)

Whilst support from higher management was evident in several actions, relations with the physician team became increasingly tense. After plans for the primary nursing system were drawn up and Betty had proposed an increase in the nursing full-time equivalent (FTE), the unit was granted an increase of two FTEs. After the primary nursing system had been running for several months, still in the pilot phase, an internal vacancy appeared for PNs on another ward. We interpreted this as our work having influence outside our ward. However, Clive felt that such changes were not related to the research project.

In November 2009 Betty was told that although she was a likeable person with many qualities, Clive found the way she managed the unit unacceptable, "too many people are involved in decision-making processes and there is too much sharing of responsibility". Betty had picked up earlier signs of a deteriorating relationship and the sector manager made known to Betty that she would not be able to support Betty if Clive demanded Betty leave the unit. No specific examples of poor performance were given or specific expectations. The rheumatology team, who Betty also managed, were satisfied with her performance and did not want to lose her, which confused the situation. Finally, in January 2010 a definite decision was made that Betty should leave her post. She was praised by Clive and Mary for carrying on as normal until her post ended in March 2009, but they also demanded she prepare an announcement of her departure and that they screened it before it was released.

It was a tense and unsettled period. Signs were appearing that shifting power relations were playing a significant role in the decisions being made. In February 2010, Betty and I were 'summoned' to a meeting with Clive and Mary to discuss the research and developmental work. Clive voiced strong concerns and accusations. Betty and I reacted appropriately and without emotion. For instance, in response to the accusation that I had imposed myself onto the 'think group' and PN interviews we were able to correct this misconception by drawing attention to the consultation with Rachael on the matter. Even though the research project was contracted until 31st August 2010, Clive concluded

the meeting by stating that 'he' would ensure I was able to continue gathering data until July, "but no longer!"

The critique of Betty's managerial competency was refuted in March 2010 by an independent competency assessment. The report concluded that Betty "possesses a number of strong competencies that match the post of Organisational Manager" including: stress resiliency; persistence; commitment; delegation; interpersonal skills; independence; professional presence; business-mindedness; client orientation and social skills. From her career values and interest profile it was clear the Betty "feels that it is essential that she actively participates in developing vision and mission statements, coaching and mentoring people, organising things, being able to start up new projects and be creative and inventive in her thinking and handling" (citations extracted from the final report with permission from Betty).

Nurses and nursing do not hold strong political power within The Netherlands. The CNs confirmed, on several occasions, the historical subservience of nurses and nursing, but they were also hopeful for change.

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

"Loes: The hospital is busy starting to call upon the nursing council and involve them more in decision-making processes ... There needs to be a nurse alongside the directors. We keep the hospital running, not the doctors.

Fleur: But that's not there yet, is it?

Loes: The hospital is busy with it and there's a national movement too ... but, we're not used to it. We're accustomed to listening to doctors, even though we haven't wanted to for a long time ... we've all been raised in that culture ...

Fleur: It's a culture that is prevalent in society too, everyone looks up to doctors, don't they? You look up to your GP, you look up to the consultant ... if I go to see a consultant I look up to him too ...

Loes: 'Dependant on', isn't it? ... and sometimes it really throws you when, all of a sudden, Clive storms in and then is gone again... and we're sitting there thinking, "Uuh?"... but we can hardly feed that back [to him]. I gave him feedback recently and it cost me three days of stomach ache just to say, "That's really not on."

Fleur: 'If' you feed it back.

Loes: Yes, 'if' you feed it back. But they're just not used to receiving feedback about their performance, or their way of doing things...

Fleur: ... sometimes I think we talk too politely and they too offensively"

(Evaluation, October, 2010)

After Betty's departure I felt the CNs distancing. CCRI sessions and participant observations were frequently cancelled/postponed. Enthusiasm for continuing the developmental work was waning. It was clear they wanted to round the project off as quickly and smoothly as possible. In October 2010 they shared how this was related to the pressure they were experiencing, such as a barrage of questions and criticisms they received from Clive, Mary and the physician team during a policy retreat day. They had stood their ground, but still experienced close monitoring and control. For instance, Clive and Mary were prepared to 'grant' the CNs a planned evening to evaluate the project with their team, as long as they saw and agreed to the evening's agenda. In silent protest, the CNs cancelled the evening. They had little faith in the new UM's ability to carry the project forward, but neither did they seek Betty who was still working in the hospital. Having worked with Clive for several years, Betty could understand this.

"Betty: That's logical, they're on the front-line now and that's what went wrong with Clive and me. I wouldn't give in either ... If I had been more submissive it wouldn't have come this far either ... I think it's more difficult for them and I see it a lot. They barely contact me ... or there's something we coincidentally have to meet for, but very little. And I'm so certain that they have a need for contact ... I know them too well. I think that it's fear that prevents them."

(Evaluation, October 2010)

Crises

Sometimes, crisis and structural changes created opportunities for people to grow. Loes experienced this when Anne became the unit clinical nurse specialist and when Betty moved her office to a different location. Whilst she initially felt the pressure of trying to hold 'the whole' together, the space created and intention to become a more participative leader enabled her to come into her own.

Coping with crisis and change was related to where an individual 'was at' and their self-efficacy. For instance, Chloé and Tess did not feel in the right 'space' for participating in the CCRI's. They were more focused on the pragmatics and structure of their new role rather than the leadership component.

"Chloé: Tess and I have to reflect and want to reflect, but, in this configuration [CCRI], it's not working. It may be due to joining later and/or the fact that you're busy with person-centeredness at a different level to us. We're more focused on the [PN] role. I notice that it costs more energy than it gives. [Our] Expectations and the stories don't match well."

(Halfway evaluation, March 2010)

After Betty's departure, then mine, Loes announced that she would be leaving the hospital to start her own business providing day care for people living with dementia in the

community. Others started to leave too and, with little faith in the new UM (Ron), Fleur felt alone and unsupported in carrying the work forward. Her need for a critical companion was not being met.

"Fleur: ... I haven't anyone to coach me anymore, in my leadership role ... I mean, Ron doesn't see me, doesn't know me and, not to be negative, he can't coach me in what I need to grow as a leader. So, that's a fear of mine ... I don't think I'm the kind of person who can carry this alone ..."
(Annual reflection, July 2010)

"Fleur: I need someone like you [Shaun] for instance ... I can't do it on my own, I know that for certain."
(Evaluation, October 2010)

Commitment and comparing self to others

The CNs felt that commitment to the project was mainly due to the formal contract we had, and the fact that it was a PhD study. In addition, participating in a management development programme motivated them and enhanced self-efficacy as they compared their own development to that of other CNs.

"Loes: The mirroring of myself with other CNs helped me see that the ideas and opinions I had about issues raised were correct, because, they matched what the CNs were talking about. But, I also started to notice that my ideas and opinions were broader than theirs. They tended to stay stuck in the problems and issues of everyday ward life ..." (Annual reflection, October 2009)

"Fleur: ... I'm proud of myself ..."

Loes: We've developed a vision, haven't we? A vision that works for us ... a lot of people haven't got that, they do their thing autocratically ... "

Fleur: The last time I bought in a case, Miranda [programme facilitator] said, "You really have a good ability to reflect." ... We've developed that on the ward, to really look at ourselves as a CN."
(Evaluation, October, 2010)

Summary

Personal history, strengths, weaknesses, values and beliefs, learning styles, culture and crises influenced commitment and development of person-centred leadership. As new ways of being were developed they sometimes clashed with personal and organisational values and beliefs. Whilst the positive influencing of some stakeholders and other idio-cultures was evident, as participant leader empowerment increased it was met with historical hierarchical/authoritative power from the physician team and higher management who tried to suppress participant engagement in the research/development work. However, not all crises affected the work negatively. Some created new spaces for

personal and structural changes and development. Comparing themselves to others in similar posts enhanced participant self-efficacy and commitment to continuing to become person-centred leaders.

OUTCOMES

Outcomes of the leader developmental journey were evident at the personal, relational and cultural level. These are described in the eight themes that follow. Despite contextual barriers, changes in personal ways of being and the leadership style experienced, gradually emerged. The participant leaders started to lead rather than manage their team as they embraced the primary nursing system where no one person was 'in charge' and directed the care of all patients. Primary nurses as well as CNs in their primary nursing role negotiated how to work with associates each shift. The CNs were noticing that they were receiving support as well as giving it to others as reciprocity and equity grew. As the leaders' reflexivity grew, I started to observe the CNs using critical and creative strategies and processes to enable team learning and cohesion. Not only did we, as researchers, feel that the ward climate had improved, this improvement was also reflected in the results of the leader designed evaluation questionnaire where there was a tendency for respondents to agree with the statements that the climate was better and now perceived as being 'good'. As person-centred leadership became more embodied the leaders' transformation became more evident. By the end of the study, the participant leaders expressed that there was no going back to old ways, even if it meant having to leave the context.

"CN Loes: ... it's [person-centred leadership] under your skin ... you can't be any different, you've become so."

(Evaluation, October 2010)

They were pleased and proud of what they had achieved and felt that the steady growth 'in a low gear' had brought them to a place where they wanted to be and yet would not have been feasible if they hadn't persevered.

"Loes: it required commitment, it isn't something that you can do on the side. You have to put in time and energy, but it has rewards."

Anne: If we had not participated in this study we would have been 100 steps behind, and if I think back, if we hadn't have had this, then we would have missed out ... every ward could benefit from this..."

(Workshop to evaluate Shaun's leadership, November, 2009)

Personal change

I had learnt to be more patient, less negative, defensive and confrontational when things did not pan out as I had expected/hoped they would. Although change felt slow to emerge, regular evaluations with the leaders helped me see what we had achieved.

"Shaun: ... I ran up against myself, my own negativity and the difference between my ideology and reality. I really thought, "Oh, this will work," and, last week, Betty helped when she said, "Yes, but don't underestimate what you have achieved. Appreciate that."

Betty: Yes, it has only been the last few weeks that you and we are suddenly seeing what we have achieved."
(Annual reflection, July 2010)

Betty became more reflexive and focused, as well as comfortable with not knowing something about everything. She started to lead more from behind, take calculated risks and, even if she did not agree with them initially, observe how the CN's plans unfolded.

"Loes: In the beginning you [Betty] were very imposing towards me. I said something and I got so much back that I thought, "What am I supposed to do with this?" I wasn't finished talking and we were onto something new ... Later, that changed. It became more equal, problems were better laid on the table, like, "What are you having difficulty with? What's it due to?" And we started to unravel and analyse, and I learnt a lot from that."
(Annual reflection, July 2010)

Betty no longer associated leadership with hierarchy. She saw the person-centred leader role as identifying leadership qualities in people who have something worthy to say and enabling them to become an authority. I observed numerous moments where she consciously tried to be collaborative, inclusive and participatory. Some were subtle, such as a remark: "Who I want? It's who we want, isn't it?" At other times she was more directive, but explained her reasons for action. For instance, although the CNs wanted the evaluation questionnaire to be a collaborative effort, they acknowledged Betty's fear that their workload would cause delays in finding time to work together. Her suggestion of them member checking the content was accepted.

Particularly after reflecting on a conflict with staff nurse Nadine (see p.176-9), Loes became more proficient at moving between different levels of engagement and showing vulnerability without taking on board/trying to solve another's problem for them. In her new role as a CN, Fleur learnt to engage differently with colleagues. She grew to believe in herself, her vision and values, applying these in her leadership. She felt herself become more relaxed, less controlling and even when her own thoughts were formed, to trust the process of remaining open to others.

"Fleur: ... I've learnt to go with the flow more, to lean back a little, and trust, even when I don't fully understand it all ...

Betty: Your opening sentence is often, "OK, how are we going to do this?" even when you've thought it all through beforehand." (Annual reflection, July 2010)

Positive leadership change

We all learnt to become more other-centred, suppressing our own interpretations and solutions until after the whole narrative had been surfaced and a reflective dialogue started. The leadership evaluation workshop of action spiral 2 revealed how staff now perceived a leader team of five individuals who led from within the whole team, rather than from above or outside. Like themselves, the leaders were pawns on the chessboard, but their decisions were thought through and strategic. Whilst associates experienced freedom to experiment and develop, they also felt supervised and supported by leaders who knew when to take hold of the reins. The workshop participants felt that CNs were the basis for the warm feeling and atmosphere being experienced on the ward, supporting all through change and back to calmer waters. Betty was likened to the owl, fox, dog, elk and salmon, representing qualities of cleverness, creativity, persistence, vision, positivity, pioneering and exuberance. Loes to a bear, ant, butterfly and jaguar, with qualities of being a hard worker, extremely quick, happy, positive, exuberant, blossoming, present, friendly, approachable, down to earth, explicit, seeing people in need, goal-directed, pioneering and powerful. Fleur was like a deer, swan, squirrel, racoon and eagle, representing hard work, sharp observation, steadfastness, softness, warmth, empathy, tact, being non-judgemental, peace, openness and person-centeredness. All CNs showed elements of what associates felt a person-centred leader should be: the butterfly able to flit from one situation to the next, wings large enough to embrace team members, attentive and intuitive, soft, but with a distinctive colour. Also the jaguar who is steadfast, prepared to bite into something and hang on, and the spider who weaves a strong web holding the whole together. The participant leaders were pleased with these honest descriptions, so different to the images portrayed in the orientation phase data.

"Loes: It gives me a good feeling.

Fleur: ... the first piece [about the leader team] is just as touching as the bit about me, how they see us as one leader team ... it's what we've been striving for, how we'd like to be seen, isn't it?

Loes: It appeals to me because it's perpendicular to how they saw us a few years ago, and it's awesome that we come across like this."

(CN reactions staff descriptions of unit leadership, May 2010)

From managing to leading

Initially, the leaders were parental managers, protective towards associates, directing and deciding what was best for them and ensuring 'things were done right'. In time, they learnt to 'lead' and 'do the right thing'.

"Anne: I had a great job and was very busy on the ward caring for patients and colleagues, making sure everything was well organised ... the focus was on working hard to get everything done, maintain oversight of everything that was happening, be there for everyone so that they could fall back on me if need be, and although the aim was to work together, it was not necessarily concentrating on maximising the potential of others. I wasn't that concerned with how it happened. I didn't spend that much time thinking about strategy, tactics or being systematic. I worked intuitively."

(Annual reflection, January 2009)

As the leaders embodied person-centred leadership they felt more relaxed, experiencing greater self-worth and work satisfaction.

"Loes ... I've become stronger ... improving things, exploring things, more considerately. I see the solution and take my time now ... it's no longer a battle, like a few years ago, I seek profundity ... I notice that it's [leadership] come to a certain level that it happens almost naturally, that your busy with it all day long, that it is goal-directed. I think about the things I do, and I know why I do things. I've learnt to let go, really let go, leave things with others and not try to keep everything under my control, which is working well."

(Annual Reflection, July 2010)

Changing the nursing system was a catalyst to the CNs becoming more inclusive and participatory on a daily basis as they worked more closely alongside associates. In order to meet the needs and demands of the CN and PN role, they had to share responsibilities with others. Coaching associates at the bedside became more the domain of the PNs, whilst coaching associates in their general wellbeing and development remained the domain of the CNs. Initially, the PNs had strongly participated in designing and implementing the new system. However, as the daily routine started to stabilise there were occasions where they did not feel as involved. For instance, when the CNs decided to alternate a week bedside with a week in the office. After voicing their concern, shared decision-making and responsibility grew again and focus moved from implementing primary nursing bedside onto non-bedside activities such as the week planning that Tess took responsibility for.

"Later we became more involved again ... the other non-patient care activities such as interviews etcetera ... it's more collaboration than clear leadership ... We now work more 'with' each other, not 'separated' from each other ... we feel that there is more equality."(PN description of CN leadership, August 2010)

The PNs experienced greater work satisfaction and although they saw themselves as the 'constant factor' in patient care, they did not 'feel' like leaders. However, my observations of their practice and reflection on their narratives revealed that they were leading. It was just different to how they had labelled leadership in the past. Whilst the CNs were enjoying no longer being the first port of call for all questions, instructions and advice, there was a danger that this role would be taken over by the PNs.

"This system is better and the work better than before ... As PN you're not so much the leader as 'constant factor' for six patients ... sometimes there is a danger that people lean on us too much."

(PN description of CN leadership, August 2010)

The CNs and PNs did learn to let go and lead. Realising that nursing and patient contexts constantly change and that no two individuals are identical, they came to appreciate continuously negotiating ways of working together with associates. This enhanced associate negotiated-autonomy and prevented reline into traditional/automated ways of being, as PN Chloé pointed out.

"Chloé: It [negotiating ways of working together] keeps you alert. and hopefully my colleague too. That you take a look at what is practical. You shouldn't just automatically fall into something. That I automatically do the large ward round, or divide [patients] three each ... I try to look at who I know well, and then on my days off I try to hand over to my colleague, "Look at who you are working with and then what is handy.""

(PN evaluation session, January 2010)

"Fleur: ... so, you have to work more collaboratively, and think, "At what level is the other? What can the other do, and what can I? How are we going to divide all this?"

(Preparing for a meeting with hospital UMs, July 2010)

As the administrative backlog declined, the CNs started structuring and sharing organisational responsibilities with the PNs. They found time to leave the office and relieve associates on the floor to attend other activities. Although breaking traditional ways of being was not always easy, the new openness in communication enabled others to give feedback to hierarchical leaders.

"Loes: Recently there was a sick student, who was mentored by Tess. We [the CNs] talked to the student, whilst Tess should really have done it ... Tess came with it [raised the issue] herself and we said, "Of course that belongs to you, it's not our responsibility." It's a trap we still fall into ..."

(Preparing for a meeting with hospital UMs, July 2010)

Relational reciprocity and equity

Becoming and continuing to be more person-centred created a sense of satisfaction at being able to give and receive, be of equal value to others.

"Betty: At first you [Shaun] were always my companion, and somewhere I became your companion, and I could do something for you and mean something for you ... and that is something I felt with you [Loes and Fleur] too ... we're doing it together, I don't feel like your boss or something ... at a certain point you learn from each other ... because you don't have to spend any energy on the differences in ranking, so to speak." (Annual reflection, July 2010)

The CNs experienced relational reciprocity with associates too. Having searched for ways that associates could learn about the CN role, such as taking them to the morning meetings where all hospital CNs met to share bed status and workload issues, they started to experience associate sympathetic understanding and support.

"Fleur: The more we lead like this, the more we get back. The more person-centred we are the more person-centred they are to us ... I notice that they want the workload and pressure to be more evenly shared ... Like today when Nora said, "Yes, I am alone a lot today, but it's OK ... Go. I know that it's important for you. I'll be OK.""

(Preparing for a meeting with hospital UMs, July 2010)

Using the same strategies and processes

I started to observe the participant leaders using the communications skills learnt during the CCRI sessions, such as attentive listening. They also started to use the same principles (criticality and creativity) and processes/structures (such as claims, concerns and issues) when working with associates, as demonstrated by Betty and Fleur when they facilitated a critical and creative culture workshop during the evaluation of action spiral 2. Loes involved 'home-makers'⁸ in examining and restructuring their workload and helped them resolve a conflict with a support worker themselves.

"Loes: I'm becoming more aware [of changes], but also of using this way [of working] and seeing results. It does something to the other and the other can actually do something with it ... I would have avoided this conflict before because I don't like conflicts. I would sooner have thought, "How can I get past this?" ... I'm better able to leave it with them now because I am better able to stand above the problem, see through it and understand what it's about ... I used post-its and they

8 The literal translation of 'hostess' does not accurately depict this new role, so I have chosen the term 'home-maker' to describe staff who assist nurses in light basic care, tend to the immediate bedside environment and accompany patients to other departments etc.

documented all their tasks, then divided them into the shifts. I already had a plan, but I let them puzzle with it and now something that they weren't happy about has changed. I said, "Fine, let's try this and have a look again in six weeks."

Fleur: The same as Betty does with us."

(Halfway evaluation, March 2010)

The weekly storytelling sessions had created a new critical communicative space that was effective in drawing attention to person-centred care and effective team work, more so than the previous, traditional daily evaluation meetings.

"I felt that it was good that we eventually came to the conclusion that she should have asked for help, or should have made time for it [attending to a patient's emotional needs]. It gave her insight into how she works ... we still closed it well by looking at where they could find the person-centeredness."

(Post-storytelling interview with CN Loes, 15/3/'10)

"I found it useful ... I think that the team got something out of it ... at last they're going to do something about it. They came with that [solution] themselves ... "

(Post-storytelling interview with CN Fleur, 22/3/'10)

"Loes: I had to laugh at the naivety of them. Brent and Colin just did their own thing and didn't consider consulting others ... and I was so surprised that Nora and Michelle just let it happen ...

Shaun: What was your intention?

Loes: To get them to talk and make sure that they did it [gave feedback] with respect and not attack Brent ... and [explore with him], "How do you come to such a decision?"

(Post-storytelling interview with CN Loes, 29/3/'10)

Workplace culture change

Whilst Betty initially saw workplace culture as an abstract phenomenon that she had no influence over, she now started to see opportunity.

"Betty: I'm noticing a change in the unit culture. Where, in the past, I saw culture as an abstract concept which I had no control over, because it's so big and abstract, now I'm starting to see possibilities for contributing to cultural change."

(Annual reflection, January 2009)

Working at 'grass root level' and building inductively, Loes noticed greater collaboration, inquiry and less resistance to proposed changes. Associates were prepared to take on more responsibility and/or become involved in decision-making. Both CNs and associates felt that they were taken seriously.

"Loes: What have we achieved on the ward? You notice that it's easier to announce things in the team, easier to discuss things. They are more open to the things we want to change ... we evaluate what we've thought about ... the call for 'ambassadors' [of specific areas of care], people feel responsible for them ... when we ask something we get an answer. That we are taken seriously and that we take them seriously ... we're working from the grass roots upwards, instead of imposing things, and you notice that there's acceptance and people continue to do it. There's still a lot wrong, but the things we're feeding ... gain acceptance ... people also notice that if they don't agree with us, that they can discuss it with us, and that we listen ... everyone is accepted in what they can and can't do ... more clinical lessons are being given [by associates] ... I notice in myself that I ask more, like, "What do you think? What would you do?" and I noticed that because you do that every time, there are more discussions about it ... And now I hear qualified staff asking students, "What do you think about it? How could it have been done differently?"

(Halfway evaluation, March 2010)

We all were noticing a greater sense of tranquillity on the ward. There seemed to be less call bells ringing and shorter periods before pump alarms or patient calls were attended to. The evaluation questionnaire of action spiral 2 showed a tendency for staff respondents to agree there was a better atmosphere on the ward, better continuity and coordination of care, as well as better mentoring of students. As there was a tendency for respondents to agree that nurse work satisfaction had improved, but no tendency to agree or disagree that 'nurse workload/pressure had improved', or that work satisfaction was now 'good', or that staffing levels were consistent and now 'good', associates analysing the data in the workshop of action spiral 2 felt that workload fluctuations were now more readily accepted. Respondents tended not to agree that CN workload had improved and was now 'good', although they did tend to agree that (specialist) nursing knowledge had improved, the primary nurse role was now clear and that the atmosphere on the ward was now 'good'.

The leader's goal of decentralising and sharing responsibility was obtained, alongside positive cultural changes such as a willingness to be open to critique by others and critical of self. These changes were reflected in the photos taken and interpretations shared during the evaluation culture workshop.

"In the past we were very protective, maybe too protective, and it was said that this was sometimes suffocating. Now we're more caring towards each other ... and in the future we'd like to be able to horse around with each other more and bang a fist on the table now and then. Team spirit in the past was often about placing problems at the feet of another, usually the CNs, and that may have been with the best intentions because they knew what they wanted. People hardly ever took responsibility ... Now we dare to look more critically at ourselves, both as a team and individually, and we let others look [critically] at us ... In the past we often spoke about wanting

to be more transparent, but if you look properly [shows photo] you can't see anything ... we couldn't see the tree for the woods ... We've become more transparent, but there is still a screen in front. You can see through it, but it isn't completely transparent. In the future we want to be able to see all corners and for others to be able to see all our corners too."

(UM Betty's account of culture workshop, March 2010)

The PNs felt that the CNs knew them both as a professional and as a person. Working collaboratively with their colleagues, they were also noticing the power of positive feedback and felt like clinical leaders.

"Of course, there are people who don't dare step forward by themselves, who are unsure of themselves and who you need to approach personally. They may find something interesting, but don't dare [put themselves forward] ... we notice this when we give people positive feedback. They're surprised. A lot of people have a need to hear that they have done something good ... they [CNs] know us as a professional and person. They know what type of person we are, where our sensitivities lie, strengths and weaknesses, desires, needs and ambitions."

(PN description of CN leadership, August 2010)

The positives of the work undertaken and changes taking place did not go unnoticed by others. Betty noticed in her meetings with the physician manager that there was interest in the concept of person-centeredness, if only from a care perspective. He was using the term more frequently and made claims that person-centeredness and 'empowerment of patients' was inherent to his speciality and evident in the strong multidisciplinary approach they had to patient care. Recognition from higher management came in the form of approximately a 2,0 full-time-equivalent increase in staffing levels, higher than most other wards had received. The primary nursing system was also gaining interest and a vacancy arose on the hospital intranet for two PNs on another ward. Changes in the nursing system did not clash with hospital policy or vision, in fact, the dual PN/CN role actually helped participant CNs fulfil the hospital policy of CNs being expected to spend approximately 50% of their time in direct patient care. Many CNs within the hospital were finding it extremely hard to fulfil this criterion, including the participant CNs before they started implementing primary nursing and critically reflecting on and developing their new role and approach to leadership.

Leader reflectivity

Whilst appreciating the value of intuition, the leaders started to combine this with cognition.

"Fleur: I don't just act from gut instinct now ... sometimes I have that gut feeling and think about it first ... 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)

Participant leaders were learning to connect their thinking with their doing, articulating the 'why' behind their actions. They were becoming more self-reflective, as Betty shared when considering her views on freedom, structure and workload.

"Betty: I was always the one who said, 'I'm curious to what my limits are? I must have them, but I don't know where they are.' Of course, that's an empty phrase because you could say, 'Are you looking carefully enough?' Instead of continuously saying that you have no limits, that you can take on this and that, [I should be] asking, 'Is that the case?' While I always thought that I dared to look at myself closely, I'm now thinking, 'Is that so? Is it something I need to survive? To say that I can do everything, or that for me there is no 'stop'? Why do I handle in this way?' Why don't I say, 'This is my limit.' ... that you think about it means that you approach it in a different way ..." (Annual reflection, July 2010)

5

Support and freedom to practise person-centred leadership

As personal, experiential/practice knowledge of person-centred leadership grew, participant leaders became more critical of other leadership models.

"Fleur: I'm aware of being person-centred when leading, without having to think, 'Is it person-centred what I'm doing now?' I really know what I'm doing ... and I'm starting to voice I ... It's becoming clearer." (Annual reflection, July 2010)

"Fleur: We've got a symposium evening coming up for charge nurses ... on coaching ... team-building and ... 'lean management' ... it all sounded the same as what we're doing, but, I wasn't very happy with the reasoning behind it." (Evaluation, October 2010)

Thinking about and planning the future was a weakness. Four months after my departure from the ward I returned for one last evaluation. Whilst the CNs could clearly articulate their vision of person-centred leadership and how to enact it, they were still exploring how to facilitate person-centred nursing. Storytelling sessions had not taken place during the summer months and developing person-centred nursing was seen as a whole new project. With the imminent departure of Loes and myself, Fleur lacked the confidence to lead this alone and the hope of external facilitation by Betty or me was not feasible as long as Clive was in post.

Betty and Loes were confident about continuing to be(come) person-centred leaders in their new contexts and roles. Betty was already experiencing positive reactions from the home-maker team she was leading, and Loes intended to be a person-centred employer.

"It's starting to come with the 'home-makers,' and you see that people are pleasantly surprised at the way they are approached [by me] ... I'm starting to hear things that I didn't know, like, "Oh, you really make me happy."" (Betty's annual reflection, July 2010)

Loes: "I want to be person-centred, try to meet the needs of clients, hear what they really need and see where I can offer that. And with the staff I employ ... I hope to be so person-centred that we can run a good business together." (Evaluation, October 2010)

Summary

Changes were reported and observed at the personal, team and cultural level. Associates reported experiencing strong, warm and embracing leadership, more focused on leading than managing. Ways of working together were negotiated and there was a ward climate where feedback could be offered and received without fear of reprimand. Relational reciprocity and equity grew as participant leaders started to employ the same developmental structures and processes used for their own development. Receptiveness towards shared responsibility and change improved. Whilst workload remained unchanged, associate resilience to it improved and a calmer atmosphere was noticeable.

CONCLUSION

To thematically analyse the data from an annual reflection with the CNs, Betty and myself, I asked the question: What does person-centred leadership mean to us? We found it to be a natural and logical phenomenon, not like the dominant western autocratic, hierarchical style of leadership which is unnatural and leads to problems. Developing person-centred leadership is a facilitated process with no beginning or end, a constant cycle of leaders critically and creatively connecting their thinking with their doing in order to affect their future being. A state of negotiated autonomy is achieved as leaders and associates reclaim/maintain self-determination whilst connecting with each other and their context.

Developing person-centred leadership took several years. Time was needed to get to know participants, their history, values and beliefs, as well as the context and the team they were leading. Knowing participant leaders I was able to sense which levels of challenge and support were needed at each moment in time so as to enable effective learning through action. Constantly responding to associate needs, preferences, abilities and capacity felt like a dance, alternating between leading from the front, the side-line, alongside and behind. Being inclusive, collaborative and participatory as well as 'there'

for them fostered relational reciprocity, trust and self-efficacy. I used every opportunity I could to create safe, critical and creative communicative spaces to help connect their thinking with their doing in order to affect future being. This was further aided by feeding back observations of them in practice and facilitating reflection-on-action. I tried to role model (alternative) ways of being (person-centred) and whilst I needed to have a theoretical understanding of person-centeredness, I needed to respect and work with their need to start by experiencing what it was. The effectiveness of this strategy is shown in the palpable difference between the beginning and end of the action research, in how the CNs and PNs talked about their leadership and how others observed and experienced it.

Contexts influenced and were influenced by the developmental process. Participant history, ability, values and beliefs influenced their developmental journey, as did workplace cultural norms and traditions. Nurses have historically been subservient to physicians and management, and this was still prevalent in the research context. As the nurse leaders empowered themselves, the physician (team) and higher management used hierarchical power to reclaim control over the nursing team and context, such as the displacement of the unit manager. Such crises created both barriers to, and opportunities for, participant growth and development. Being able to compare their personal development with that of colleague charge nurses enhanced participant self-efficacy and commitment to continuing their development.

As participant leaders became more reflective and reflexive, embracing and embodying person-centred leadership, they started to employ the same development strategies and processes they had experienced in their own leadership development. Participants and associates saw positive changes in leadership and culture. There was a move from a predominantly parental style of management, ensuring that things were done right, to a reflexive, participatory style of leadership with a focus on doing the right things, in collaboration with those involved. Even though the workload did not decrease, calmness emerged on the ward.

Although they had not managed to develop person-centred nursing, they did transform their own vision of good leadership and develop a style that felt right for themselves and the nursing team. A vision and framework had been created to guide their future leadership, wherever they practised.

**Person-Centred
Leadership: a conceptual
framework**

Chapter 9



INTRODUCTION

Having thematically analysed the data from the critical participatory action research (presented in Chapters 4 and 5), relationships between themes were sought, blended and melded to form constructs for a conceptual framework. Conceptual frameworks are a graphic and/or narrative representation of an approximated/specific view of reality (Fawcett, 1984; Miles & Huberman, 1994). They hold concepts logically ordered and supported by propositions describing the relationship(s) between them and can be inductively or deductively created (Fawcett, 1984). They offer practitioners and researchers meaning, values and essential components to consider (Rogers, 1989), “what to look at and to speculate about” (Fawcett, 1984, p. 3). The frameworks presented in this chapter were created inductively and are discussed in light of existing research, theories and philosophies in order to place them within the current body of knowledge and highlight their contribution.

Person-centred leadership is a complex social phenomenon and whilst the graphic representation (see Figure 25 p.188) offers a visualisation to accompany the narrative and support reflection-in/on-action (Schön, 1987), I have found that introducing ‘the whole’ using a metaphor of argentine tango with an image of two dancers on a beach (see Figure 24 p.186) aids initial understanding of the parts in relation to the whole. Person-centred leadership is therefore introduced as a dance before continuing to explain: the leader attributes of being in relation; processes enabling relational connectedness; stancing of the leader in relation to the associate, aimed at enabling empowerment and wellbeing (coming into own); and how multi-stakeholder needs, evaluation systems, safe critical and creative learning spaces and organisational culture influence and are influenced by the leader-associate relationship(s) (mutual influencing). The development of person-centred leadership is represented by a framework (see Figure 26 p.221) describing adult, active, experiential and transformative workplace learning where learners are facilitated in connecting their thinking with their doing in order to influence their future being.

THE LEADERSHIP DANCE

Human relationships are formed by two or more people interacting. Consider for a moment any one of the many relationships you engage in. They are constantly evolving, in a state of ‘being’ and ‘becoming’, fed and influenced by how you perceive the other(s) and the relationship itself, as well as what is happening around you. When relationships are functioning well, you feel safe, energised, as if you belong and are connected to those with whom you are in relation, even when they are not physically present. It feels right. When the relationship is weak, you feel the opposite. Every relationship constantly moves



Figure 24: The leadership dance

along a continuum between strong and weak and in healthy relationships we focus our efforts on working towards a common good. When no effort or energy is spent on the relationship it starts to stagnate and become weaker.

The argentine tango, like relationships, is in a constant state of flow and movement. It has many styles and is danced in an embrace that continuously moves between 'open' or 'closed' (Jensen, 2006). In a closed embrace the dancers seem to move as one. When in an open embrace, individual uniqueness is visible. Take a quick glance at the photo in Figure 24. Does your gaze fall on the female dancer first, with her unique stance? She looks elegant, competent, exhilarated and free. You may ask yourself, "How can she hold that pose?" Look again and see the role her partner is playing. He 'enables' her to achieve this pose, not by pushing or pulling her into position, but positioning himself, using his foot, arm and body weight to balance the challenge of her leaning outwards. Creating this image, the male dancer must have been attuned to her 'being', knowing her ability and capacity as a dancer at that moment in time. It must have required mutual trust too, that they were willing to risk her falling.

A second glance reveals the uniqueness and mastery of both, and how together they create something more than the sum of the parts. The photo portrays a feeling of safety, energy, empowerment and connectedness. Although there is no-one else around, their dance is still influenced by the context. Dancing on a beach with sand under their feet, a moving shoreline and weather that could change, requires a different kind of wisdom than dancing within a studio, with its solid floor and constant air-conditioning. Even if the

stance was the same, the appearance would be different. Similarly, if they were to change partners but keep the movement, a new image would emerge.

The argentine tango has several 'movements' typical of its style, but no set routine of steps that are continuously repeated. Couples respond to each other and the music, using different gradations of each movement and sequences to create a unique performance. Imagine a collection of individual dancers and one lead. Some are performing to the best of their ability, others are not. The lead dancer moves between the individuals, partnering for varying lengths of time with individuals, sometimes enabling complex moves and at other times the refinement of basics, or helping to regain balance. As the whole group moves around the dance floor, spaces are continuously opening and closing, offering opportunities for experimentation and learning. Sometimes the lead moves self and partner into such a space, at other times the opportunity is passed and a solo dancer moves in to occupy it. It is as if the lead is mindful, not only of the needs of the present partner, but also those of the others. As the whole group moves around the floor, each dancer is influenced by the movements of those around them, as well as structures such as tables and chairs. These 'obstacles' may be (re)moved or even used to enhance the dance.

Similarly, person-centred leadership is a dance of movement, constant attuning and seeking of connectedness between the leader and associate. Each relationship is unique, as is each interaction which influences and is influenced by context and so results in unique performances.

A CONCEPTUAL FRAMEWORK

If we view organisations as living/constantly evolving systems created through human agency, leader-associate relationships will contribute to that system as well as be influenced by it. As with all relationships, leader-associate relationships constantly evolve and interactions are never identical as they move along a continuum between strong and weak. Just as it takes two to tango, so too do two people need to invest effort and energy to create a relationship where they dance 'in sync'.

A person-centred leader's primary focus is to enable associate *coming into own* where they feel empowered and experience wellbeing within the workplace. The assumption being that when people feel they are coming into their own, they will then engage wholly in their work, develop mastery and contribute optimally to overall team performance. Certain leader attributes aid being in relation. Being *authentically other-centred and caring* is important as associates can sense whether or not they are attributed personhood by their leader. Emotional authenticity fosters relational connectedness when people are able to express themselves emotionally (appropriate to their role) and respond adequately to the emotions expressed by the other (Parker, 2002). Emotional intelligence, knowledge

of self (*intra-personal intelligence*) and how best to relate to others in their current state of being (*inter-personal intelligence*) help the leader choose a stance that enables associate coming into own. However, humans are fallible, change and development often slow and sometimes threatening. By being *patient, optimistic and open*, as well as *willing to show vulnerability*, a leader can remain supportive during transformational journeys.

Despite their imperfections, leader *reflexivity* can aid doing the ‘right’ thing(s). Relational connectedness is characterised by a sense of equity and partnership. To achieve this, the leader is constantly assessing where each associate ‘is at’, seeing, hearing and feeling their current state of being (*sensing*). Recognising the embeddedness of humans in context, the leader tries to understand an associate’s being within the context of past history, future plans and the present social environment(s) they inhabit (*contextualising*). Appreciating the interdependency of existence, the leader often finds themselves *balancing* (potentially competing) needs of self, associate and other stakeholders before deciding how best to respond and position self in relation to the associate (*stancing*). Relational connectedness can be further supported by a leader not ‘doing’. Whilst an active process, sometimes just ‘being with’/‘thinking with’/‘staying with’ them in their being

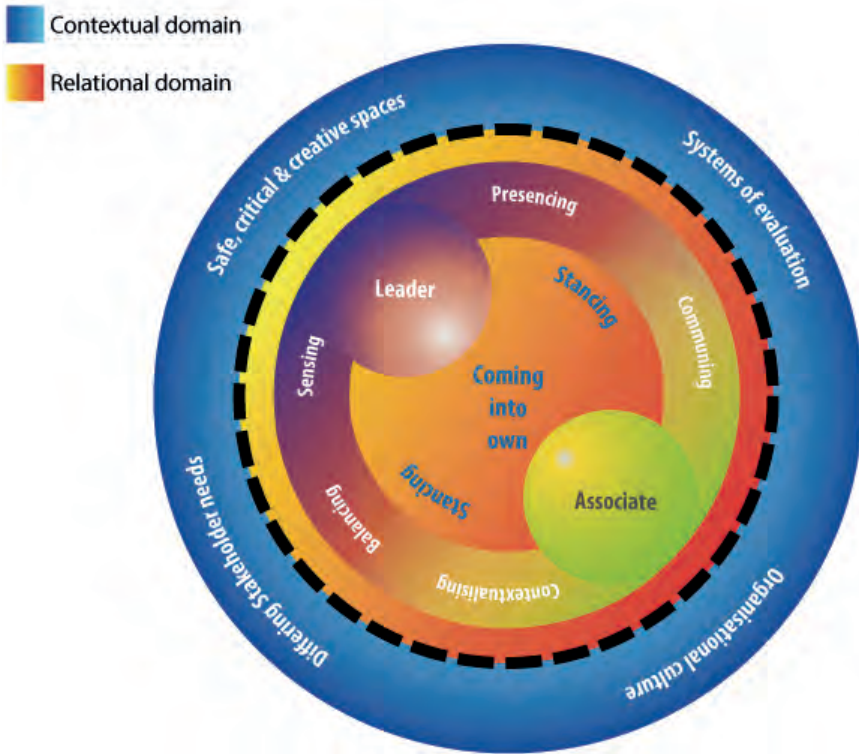


Figure 25: Framework for developing person-centred leadership

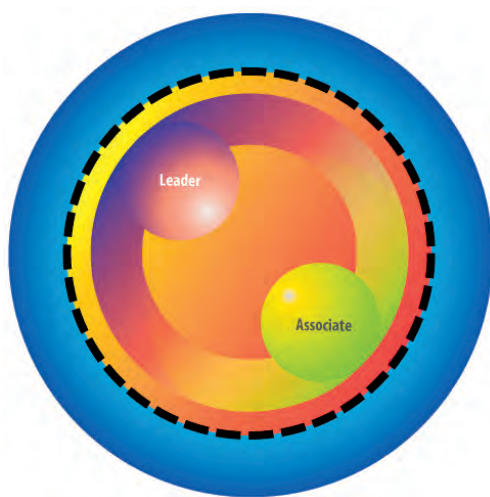
(*presencing*) is more appropriate. At other times *communing* with associates will aid the creation of shared visions and decisions, strengthening the relational connectedness and relationship.

The leader-associate relationship is itself embedded within a workplace and *organisational culture*, influencing as well as being influenced by *differing stakeholder needs* and the outcomes of *evaluation systems*. Creating *safe, critical and creative spaces* for experiential and transformative workplace learning will also influence and be influenced by the leader-associate relationships.

Figure 25 shows the conceptual framework for person-centred leadership. The dotted line separating the inner relational domain from the contextual domain represents the mutual influencing that takes place. Sensing, contextualising, balancing, presencing and communing are positioned to show relational connectedness between the leader and associate within the relational domain. Stancing is placed between the leader and associate, representing leader positioning of self in relation to the associate, and coming into own (whether this be associate or leader) forms the centre and primary goal. The differing (potentially competing) needs of others, evaluation systems, organisational culture and safe, critical and creative spaces are placed in the outer contextual domain, as they represent structures, conventions and practices that influence and are influenced by the processes within the relational domain. The key processes and the framework propositions (*being in relation, relational connectedness, stancing to enable coming into own, mutual influencing of the relational and contextual domain, and experiential workplace learning*) are discussed in more detail below and contrasted with existent literature.

6

Being in relation



Contemporary nurse leaders find themselves in a world of competing values. Service users want improved practices, management want improved efficiency and many nurses are leaving the profession. Flexible leaders and workforces are being called for, able to respond, often quickly, to changing contexts and needs (Drach-Zahavy & Dagan, 2002). With little prospect of this situation improving, leadership research is showing the importance of relational leadership approaches to reducing nurses' intent to leave (Cowden et al., 2011).

We found that person-centred leaders are: authentically other-centred and caring; have good knowledge of self and other; patient, optimistic and open; prepared to show their vulnerability, and are reflexive. These attributes show congruency with other studies exploring what nurses look for in good clinical leaders. Stanley's (2006a) survey of UK nurses found that the top ten attributes of good clinical leaders to include: being approachable; clinically competent; motivational; supportive; confidence inspiring; coping with change; flexible; setting direction; helpful and integral. Wieck et al (2002) also found that both younger and mature nurses particularly want honest leaders. Their study also suggests that leaders need to be aware of differing needs as the 'emerging workforce' of Generation X (20-30 yrs.) look for nurturing leaders who will motivate, be supportive, optimistic, approachable and receptive towards others, as well as show interpersonal intelligence. The 'entrenched workforce' of Baby Boomers (born between 1946-62) has a greater need for empowering leaders who show integrity and fairness.

Despite positive outcomes of relational leadership studies and that people today "want to be led – not managed" (Shelton & Darling, 2001, p. 264), an ultimately counter-productive, traditional, hierarchical and bureaucratic style of leadership (Cummings et al., 2010) is still alive within many healthcare organisations. Modern day nurses want strong relationships with their leaders, but CNs do not always know how to meet these needs. In Israeli healthcare, which is strongly influenced by the British and Dutch healthcare systems, an observational study found that CNs were more focused on caring directly for patients than "operating and facilitating the caring of their staff" (Drach-Zahavy & Dagan, 2002, p. 24). On average only 10% of their time was spent 'leading' associates individually and collectively (Drach-Zahavy & Dragan, 2002).

Participant leaders in this AR study felt that although anyone could learn to become more person-centred, they would first have to want to change. This brings into view the importance of values. Cultural values can influence the development of person-centred leader traits. Plas (1996) highlights the danger of trying to implement models and frameworks focused on collectivism, such as leadership styles focused on whole team performance at the expense of the individual, in cultures that value individualism. She calls for related individualism in leadership, which recognises human interdependency and how enabling the coming into own of each individual can enhance performance of the whole team. Leaders are advised to lead associate-by-associate, rather than problem-by-problem (Plas & Lewis, 2001).

Leader attributes associated with person-centred leadership demonstrate the characteristics of nurturing yet empowering leadership (see Box 9 p.191). Living humanistic values, person-centred leaders add a moral dimension to leadership, such as seeing the individual within a greater context, creating space and being patient for people to adjust to new ideas and circumstances, and being prepared to show one's own vulnerability and reflexivity. Such characteristics are found in other leadership styles such as transfor-

mational, servant and authentic leadership and person-centred leadership can be seen as meeting Hurley & Linsley's (2007) call for more hybrid forms of leadership that can cope with competing values.

Person-centred leadership pulls on existential humanism beliefs that humans exist in relation and should be valued for who they are rather than as a means to an end. Existential humanists are committed to what is positive and possible through human relating (Buber, 1958) and being in relation is central to person-centeredness (Slater, 2006) person-centred nursing (McCormack & McCance, 2010) and person-centred leadership. Buber (1958) describes two modes of relating with others. The 'I-It' relationship gives rise to perception without connection, where the 'Other' (whether that be another person or thing) is viewed objectively and a possible means to an end. The 'I-Thou' relationship is characterised by connectedness, where the 'Other' is valued as a unique individual and relating becomes meaningful. Although another human being can never be an 'It', as they too have freedom of will (Ashman & Lawler, 2008), when one person treats another as an object they dehumanise them by failing to bestow personhood (Kitwood, 1997; Macmurray, 1961). In 'I-Thou' relationships mutuality and reciprocity grow as each person attributes personhood to the other, co-creating and giving meaning to the world they inhabit and forming a living connection. The relationship can become a vehicle for self-actualisation for both, when conditions of unconditional positive regard, authenticity and sympathetic understanding are present (Rogers, 1980).

Leader attributes:

- Authentically other-centred and caring
- Intrapersonal intelligence (knowing self)
- Interpersonal intelligence (knowing other)
- Patience, optimistic and openness
- Showing vulnerability
- Reflexivity

Box 9: Attributes of the person-centred leader

Being *authentically other-centred, caring and open* helps create the conditions for self-actualisation. Responding in a manner that is appropriate for the unique individual, at that moment in time, without losing sight of the surrounding contextual influences, brings the person-centred value of individualisation to life. In the research findings of this study, being person-centred did not always result in an associate obtaining what they initially wanted. Macmurray (1961) offers an explanation on how/why seemingly 'I-It' relating may in fact still be underpinned by a positive moral intention. Our attitude towards others can be viewed on a continuum between the 'personal' and 'impersonal'. As we move towards the impersonal, emotional distancing occurs and the other is viewed with

less empathy, but not necessarily as an 'It'. Such a change in attitude is only justifiable if the intent is to enable empowerment. Macmurray (1961) refers to a 'rhythm of withdrawal and return' to denote these shifts in attitude, similar to McCormack & McCance's (2010) description of moving through different levels of engagement. Essential here is that the primary mode for relating is positive, i.e. authentic, other-centred, caring and aimed at connectedness. As an example, Macmurray (1961) describes the psychologist who, when conversing with a friend, notices signs of hysteria and moves from a personal friendship to an impersonal professional attitude. An example from my fieldwork was when CN Loes did not prevent staff nurse Nadine from taking on more physical care activities than she could physically cope with (due to limitations caused by physical trauma). Loes' intention was not to ignore Nadine's individual circumstances, or to use her as a means to ensuring that patient care was carried out with minimal reconfiguration of staff. The intent was to enable Nadine to self-discover her limits and learn to take self-protective action. When Nadine failed to do this she suffered pain and accused Loes of being uncaring. Whilst the conflict was resolved, Loes learnt the importance of being open and transparent about intentions, sharing the 'why' of her reluctance to 'decide for' Nadine.

Effective being in relation requires *intra-* and *interpersonal intelligence* (Gardner, 1993), the ability to read and understand one's own and another's state of being and respond (non)verbally in a manner that maintains relational equity and connectedness. It requires knowing one's self as an emotional being with values and beliefs and the affect this may have on others. For Senge et al (2005) leadership is a process of human becoming that begins with knowing self, however, successful relating also requires knowing the other too. Working with the values and beliefs of others is also a key process in person-centred nursing (McCormack & McCance, 2010). Getting to know the other should not be clouded by judgement and prejudices. Rogers (1961) describes unconditional positive regard as a non-possessive form of caring, non-judgementally accepting the other person for whom they are and trying to understand them embedded within their context(s). It is considered a condition for enabling human development and growth (Rogers, 1961), helping to release positive energy and human potential which may benefit the individual as well as others and organisational effectiveness (Shelton & Darling, 2001). Being non-judgemental is currently promoted in the field of patient safety too. After investigations into hospital practices in the UK and Netherlands (Berwick, 2013; Danner et al., 2013), leaders are being called to quash cultures of blame. Using emotional intelligence, listening to associates and patients, viewing adverse events at a systems rather than individual level, is claimed to encourage sharing and learning so that lessons learnt can then be used for continuous quality improvement (Berwick, 2013; Smith et al., 2009).

Whilst shared decision-making is valued, a person-centred leader may use interpersonal intelligence and contextual knowledge to make decisions for others. Canadian nurses have expressed how they value leaders who can be decisive in times of crisis, using

their expertise and moral compass to make the right decisions (Anonson et al., 2013). Emotional intelligence plays a major role in intra- and inter-personal intelligence, and has gained significant attention in leadership research. It involves becoming attuned to, trying to understand and work appropriately with the emotional being of self and other(s). Akerjordet & Severinsson's (2010) review of theoretical and empirical literature states that emotionally intelligent leaders build resilience among associates, infuse energy into the workplace, connect with associates at an emotional level making work more meaningful and enabling coming into own. Leaders also need to be aware of any parental like tendencies where they may want to protect others. Caring involves showing sympathetic presence, but as the participant leaders in this study stated, it also includes "leaving the problem where it belongs". Interaction becomes effective in enabling coming into own when connectedness is sought at the rational and affective level, and when both leader and associate recognise and accept differentness and responsiveness. Although there is a lack of consensus on what emotional intelligence is in leadership literature, and measurement tools are usually an amalgamation of other tools, Akerjordet & Severinsson (2010) see grounds for promoting its development. However, they also caution that emotionally intelligent leaders are not necessarily morally driven. Bass & Riggio (2006) also warn of 'pseudotransformational' leaders who work "primarily toward personal gains as opposed to focusing on the outcomes of followers" (Bass & Riggio, 2006, p. 13).

I prefer to use the term 'associate' when referring to those being led, as I feel the term 'follower' conjures up images of having power-over another and does not portray the interdependency of leadership-associate relationships. Leadership would not exist if associates were not willing to be led by or relate with a leader. A large amount of literature explores how leaders can make themselves attractive to followers in order to exert leader influence (Popper, 2011). This implies that leadership agency causes outcome changes, although, follower research is challenging this assumption (Bligh & Kohles, 2012). Popper (2004) describes three types of leader-associate relationships influenced by both associate and leader behaviour. In 'regressive relationships' associates appear to seek direction and protection, which can potentially lower their autonomy (Popper, 2004). During the orientation phase I observed associate dependency on leaders. Sharing my findings enlightened participant leaders to the phenomenon and the burden of responsibility this was placing on their shoulders. They were frustrated by associate lack of independence, but were not aware of how their own values and behaviour were contributing to this situation. 'Symbolic relationships' develop when associates feel attracted to what the leader represents (Popper, 2004). Being open about my values, vision on person-centred leadership and showing my own vulnerability was appreciated by participant leaders, was conducive to building relational connectedness and to maintaining commitment throughout the study. Authenticity, as congruency between my espoused and lived values (Schein, 2010), is vital to believability (Stanley, 2006a). In 'developmental relationships'

associates are attracted to the potential of growth by being in relation with the leader (Popper, 2004). This type of relationships is plausible for person-centred leadership which focus' on enabling associate coming into own, and as participant leader narratives and feedback demonstrated, they grew through being in relation with leaders authentically trying to become more person-centred.

Add leader *reflexivity* to the mutuality of leader-associate relationships and the moral dimension is deepened. I found posing moral/phronetic questions helpful, for instance: "What does this person need in order to come into their own? (How) Can I offer them what they need? What would be possible consequences of my/our actions? Is this the right thing to do, and for who?" Posing such questions the leader does not lose sight of the person immediately in front of them nor stakeholders within the surrounding context. Similarly, considering staff nurse Jane's position within the ward, the participant CNs found themselves with a moral dilemma. Was her failure to develop the level of competency needed to function within the team due to her personal inability to grow to that level? Was it due to a lack of capacity at that moment due to troubles at home? Or was it a combination? Communing honestly and openly with Jane, among themselves and with the human resource officer, neither Jane's needs nor those of the team/patients were automatically prioritised. Strategies were explored to create space for Jane to work on her private problems without becoming disconnected from her workplace or negatively affecting associates and patients.

An *optimistic* leader is able to support and guide others through crises and chaos. I had long admired Betty's positive attitude and none-more so than during the period she was displaced from her post. Despite her initial grief, she continued to support the charge nurses through a difficult time, sharing her conviction that they had passed the point of no-return on their journey to becoming person-centred leaders. She was also optimistic that the journey towards cultural transformation was still feasible. Leader passion for nursing and optimism towards associate ability to cope with difficult circumstances have been identified as attributes of exemplary leaders (Anonson et al, 2013).

An essential attribute Betty learnt was *patience*. Patience is an active process, requiring intra- and inter-personal intelligence. Many organisations still hold mechanistic, deterministic and reductionist views of organisation and leadership (Shelton & Darling, 2001; Wheatley, 2006) and that by objectively studying parts the whole can be understood and controlled. In a culture of 'quick fixes' and rapid change in order to respond to changing climates, many leaders revert to bureaucracy, hierarchy and coercive power to gain a sense of control, but by doing so, they create negative energy and dehumanise the workplace (Hurley & Linsley, 2007). Critical social science and critical realistic explanations of how history and embeddedness within cultures and traditions influencing our thinking and doing (Fay, 1987) can help explain why personal and organisational transformations can take so long. Initially, the charge nurses struggled with the concept of person-

centeredness. They found it strange to focus on enabling people to come into their own, rather than what the organisation wanted. Uniformity was valued, but as the meaning of person-centeredness was explored, the value of individualisation and the effect of social structures, conventions and practices on leader and associate being became clearer.

Even though these leader attributes have been identified, they are not seen as a set of stable traits inherent to the leader as a person. Person-centred leadership is a complex integration of behavioural, cognitive and social skills that can be developed through active learning and become part of the self-identity (Lord & Hall, 2005). In her personal annual reflection, Betty shared how she was learning to be more patient, using her intra-personal intelligence to control her tendency to drive forward decision-making and action. Creating space for others to think and determine appropriate action was proving effective in developing self-determination, lowering dependency and enhancing collaboration. Similarly, I had learnt to be more other-centred and patient as I took ownership of my own frustrations, continuing to support and wait until the CNs reached a level of self-efficacy where they wanted to start facilitating storytelling sessions. Whilst optimism is motivational, an invitational stance and patience show respect for individuality. Combined with continued challenge and balanced by support, transformation becomes self-determined, rather than imposed, and thereby sustainable.

Being authentically other-centred, caring and reflexive implies moral consciousness and a distinct ethical orientation. Gilligan (1993) states that relationships can be viewed hierarchically (masculine perspective) or as a web of connections (feminine perspective), and that the perspective held influences ethical and moral reasoning. A masculine approach, aligned to the ethics of justice, is based on a belief that all people are equal and that emotional 'separation' of self from dilemmas is needed in order to judge objectively, guided by a set of universal principles. The feminine approach, more aligned to existential humanism, focuses on preserving relational connectedness and trying to find win-win outcomes. Equity, which recognises, values and works with difference, rather than equality, becomes the key principle alongside emotional engagement and consideration of contextual factors (Edwards, 2009). Although an ethics of care is not gender specific (Jaffee & Hyde, 2000), considering the high percentage of females and nature of nursing as a caring profession, its popularity in nursing is not surprising. Reflecting on research and ethics literature, Storch et al (2013) feel that ethical nurse leadership at the micro-level, where person-centred leadership is enacted, should entail role modelling and engaging in ethical behaviour to build moral communities that meet nurse and service user needs. It should be based on principles of caring, connectedness and shared decision-making within a safe environment. Nurse leadership becomes "caring for others, or taking responsibility for them ... attention to what is going on in the world and emotional concern about the wellbeing of others ..." (Ciulla, 2009, p. 3). Nurses also consider morality an essential leader trait, with exemplary moral leaders holding the whole together in times

of stress, encouraging reciprocity, respect, advocacy and integrity, and demonstrating these values in their behaviour (Anonson et al., 2013). Ethics then becomes practice, not a task (Tronto, 1993), a continuous search for answers to the question: "How can I (we) best meet my (our) caring responsibilities" (Tronto, 1993, p. 137).

Whilst Gilligan (1993) does not reject Kohlberg's (1969, 1976) masculine ethics of justice, neither does she offer suggestions on how these two voices of ethics can be integrated. Tronto's (1993) work introduced a political perspective into the ethics of care, stating that "a theory of justice is necessary to distinguish among more and less urgent needs" (Tronto, 1993, p. 138). She defines an ethics of care as "a species activity that includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible". This definition acknowledges the existence of potentially competing needs and possible win-lose scenarios. Stakeholder needs may compete with those of the associate and as Bowden (2000) states, relying solely on an ethic of care may prove disempowering in current masculine socio-political healthcare climates. Nurses and nursing have been criticised for being too second person orientated, at the expense of the first and third person. Botes (2000) advises integrating the ethics of care with the ethics of justice, maintaining the principles of fairness and equity whilst considering multiple perspectives (of first, second and third persons), contextual influences and consequences. Such integration would be compatible with a person-centred approach to leadership.

Trying to be authentically caring towards an associate within the context of a hierarchical organisational culture and other stakeholder needs is challenging for person-centred leaders. However, focusing on 'enabling' empowerment rather than 'giving' empowerment and/or resolving issues for others, can help leaders make ethical decisions from a care perspective. For instance, when staff nurse Angela announced that she could not attend the unit education programme as organising childcare was too expensive, the charge nurses did not disregard her personal problem, nor concede to her not attending the programme. Instead, they communed with her to find a solution. In doing so, her particular circumstances were acknowledged, but she was still encouraged to attend the programme the same as everyone else. Thinking with Angela rather than organising a solution for her, demonstrated enabling empowerment, rather than giving empowerment.

Cross-sectional and self-report tools may not be the best option for capturing a leader's ethical orientation. Simola et al (2010) found that leaders perceived by associates as highly transformational, were orientated towards Gilligan's (1993) ethic of care. Those perceived as highly transactional were significantly orientated towards Kohlberg's (1969, 1976) ethic of justice (Simola et al., 2010). However, Howell and Avolio (1992) showed that transformational leadership did not guarantee intent to enable associate empowerment. This questions the value of cross-sectional studies and leader self-reports to 'measure' leadership. Longitudinal studies with diverse participant perspectives and participant observation, such as were used in this study, offer more detailed data and produce a

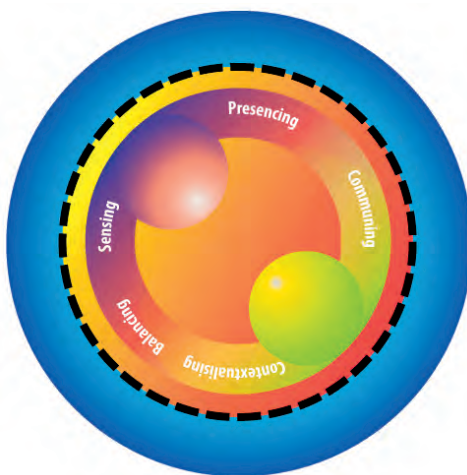
more robust picture of leadership. Associate perception is a good indicator of congruency between espoused and lived values and participant observation adds an outsider perspective to the data mix. Longitudinal designs such as AR would reveal patterns and few inauthentic leaders would be able to maintain consistent person-centred behaviour over time.

Summary

In these times of scarcity there is a proven need for more relational and morally oriented leadership styles. Person-centred leadership offers an existential humanistic approach to being in relation where the focus is on forming relationships through *authentic other-centeredness and caring* intended to enable associate empowerment and wellbeing. Personhood is attributed, the leader is transparent about intent and congruent in action. *Inter- and intrapersonal intelligence* is required to know self and other non-judgementally, and *showing vulnerability* helps retain a sense of equity. Using their emotional intelligence, the person-centred leader knows how to influence others, sensing when to do for others or when to be with/think with them. Whilst leader and associate being determines the nature of their relationship, leader *reflexivity* enables review and balancing of multiple/competing needs before shared decisions are made. Showing *optimism and patience* supports associates in making self-determined and sustainable transformations. Integrating an ethic of care with justice and enacting individualisation, fosters relational connectedness and raises consciousness of all to meet their care responsibilities towards self and each other.

6

Relational connectedness



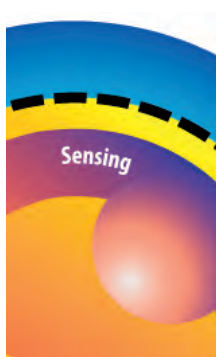
Organisational change and design has mainly been considered from an entity perspective and how individual leader and associate attributes and behaviour influence change, but this ignores the social/relational processes involved (Uhl-Bien, 2006). Feeling connected to leaders is a sign of exemplary leadership (Anonson et al., 2013) and coming from an existential humanist stance, Ashman & Lawler (2008) feel that how associates and leaders choose to relate will influence outcomes. In everyday discourse connectedness means 'linking', 'joining' or 'uniting'. In

a socio-relational context it means feeling recognised, safe and belonging, all of which are

fundamental human needs (Maslow, 1943). Edward Hallowell, a psychiatrist, offers an appealing definition of connectedness:

“... a sense of being a part of something larger than oneself. It is a sense of belonging, or a sense of accompaniment. It is that feeling in your bones that you are not alone. It is a sense that, no matter how scary things may become, there is a hand for you in the dark. While ambition drives us to achieve, connectedness is my word for the force that urges us to ally, to affiliate, to enter into mutual relationships, to take strength and to grow through cooperative behaviour” (Hallowell & Thompson, 1993, p. 196).

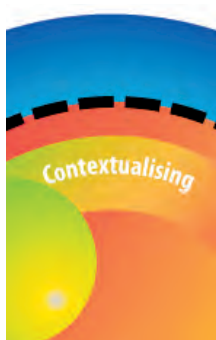
Gilligan (1993) sees working towards, achieving and sustaining connectedness as a feminine approach to relationships and catalyst to personal growth and happiness. Like Macmurray (1961), her ontological assumption is that people exist in relation, not separation. Relational connectedness does not have to start by focusing on self, or the other, but can develop by focusing simultaneously on both. Kegan (1982) explains related individualism as seeking both inclusion (welcomed into, held, connected with, part of a greater whole) and distinctness (demonstrating self-determination and directing own agency), which enables survival and thriving. Plas (1996) considers related individualism to be key to person-centred leadership as individual needs and team goals are merged and the individual becomes part of the whole team without losing their individuality. Neuro-physiologists recommend leaders seek connectedness because “when we feel connected and safe, the cerebral cortex of our brain responds by becoming involved, which leads to peak performance. When we work in a culture of constant fear, the deeper levels of our brain are activated to respond to the fear and our cerebral cortex is disabled” (Kerfoot, 2011, p. 94). The person-centred leadership framework derived from my study offers five processes for a leader to employ in building relational connectedness: Sensing; Contextualising; Balancing; Presencing; Communing.



All nurses are taught that the nursing process begins with assessment of a service user's needs, but the approach taken depends on personal and workplace values and beliefs. In a reductionist approach, the nurse often uses a set framework to assess the service user's being, and then reduces findings to key areas/problems/needs for resolving by specific interventions/tasks. The danger of such an approach is that care becomes task-orientated. A holistic approach, whilst often supported by an assessment framework such as Roper, Logan and Tierney's (1980) activities of daily living, or Gordon's (1994) functional health patterns, does not reduce the service user's experience to a set of problems to be solved by task execution. It recognises

the interdependency between different aspects of human being. As humanistic nursing theorists such as Paterson & Zderad's (1976), Parse (1981) and Peplau (1952) propose, the nurse-patient relationship is important in facilitating patient wellbeing. The assessment process often begins by inviting service users to share their narrative of events leading up to the meeting of nurse and patient, offering the nurse insight into the patient's lived experience. As well as actively listening to the patient's narrative, the nurse (pre)consciously uses other senses to gather information. Although *sensing* patient needs and wellbeing is poorly researched (Morse et al., 1994), narratives of nurses working in acute care situations (Bundgaard et al., 2012), dementia care (Sellevold et al., 2013) and learning disabilities (Martin et al., 2012) describe how they see, hear and smell, as well as physically and spiritually feel, in order to understand the service user's perspective and needs.

The same process was observed and narrated in this study on person-centred leadership, but I have found no publications describing sensing in a leadership context. In situational leadership, Hersey et al (2001) speak of diagnosing the environment and associate readiness/development. Whilst one may presume that the diagnosis is based on sensory information, the language used by Hersey et al (2001) is more reminiscent of a reductionist approach and assessment restricted to task performance ability. This is in contrast to the person-centred leader who is not primarily concerned about ability to perform a task as about associate wellbeing. Poor wellbeing will certainly not enhance task performance. Aware that what we see is not necessarily all that there is, the person-centred leader often supplements sensory information with data gathered via other resources, such as personnel files or observations made by others. Rogers (1980) warns that our interpretations of another's being may be inaccurate and I found feeding back observations/interpretations for verification lowers the chance of inappropriate response.



Active listening is a trait frequently referred to in leadership literature and the most important skill in narrative interviewing (Riessman, 2008). Inviting associates to share their narrative offers the leader insight into associate identity, perceptions, values and beliefs (Holloway & Freshwater, 2007; Riessman, 2008) and so see beyond the observable. Blending knowledges from different sources offers a more robust and holistic view of an associate in context. Acknowledging a critical and holistic paradigm, person-centred leaders view an associate as embedded within context. Contextualising is the process of seeing and understanding the associate

within the context of their whole being, not restricted by the here and now, but including their multiple social roles, personal history and future plans. As with sensing, the term is not found in nursing leadership literature, although, participant leaders and I discovered how contextualising aids understanding of how different forces/factors within the

various contexts an associate is embedded in influence their being. The leader uses this understanding to ascertain how best to respond whilst simultaneously considering the needs of the associate, the organisation and other stakeholders.



The person-centred leader is often balancing needs, taking into account reason, emotion, practice, social context and may engage in critical dialogue with others before making decisions and/or undertaking action. Balancing becomes a moral activity in a post-modern world full of diversity and leaders cannot rely on one set of rigidly applied principles (Thompson, 2004). Our attention was first brought to the morality of balancing when a consultant physician promised a patient that he would be discharged to the same long term residential care as his wife, even though he did not meet the criteria for residential care.

The narrative raised questions around scope of focus and differing stakeholder needs: "To whom should we be person-centred? The person we see before us, and/or those whose face we have not yet seen?" Whilst there are no straight forward answers to these questions, they do enable leader reflexivity and considering the consequences of decisions before action. Meeting the needs and/or enabling one person to come into their own may have negative consequences for the wellbeing of others, especially in times of scarce resources. Communing becomes an important process where shared visions and decisions can be created as associates become aware of their interrelatedness.

Where descriptions and definitions of dialogue often end with 'understanding', communing is the process of communicating at an intimate level, showing support, seeking understanding, finding a common ground, creating a shared vision and/or making shared decisions, and is more action orientated than dialogue. MacPhee et al (2010) showed how leader trust, shared visioning and shared decision-making reduce conflict and enable project progress. Literature often emphasises the importance of leader communication competency. However, this is usually portrayed as a unidirectional process with leaders sharing information with others for organisational visioning, change implementation and structural empowerment as associates are considered unable "to comprehend their role in the organizational scheme of things" (Ashman & Lawler, 2008, p. 254). In contrast, Groysberg & Slind (2012) conclude that "smart leaders ... engage with employees in a way that resembles an ordinary person-to-person conversation more than it does a series of commands from on high ... [T]alking with employees, rather than simply issuing orders, leaders can retain or recapture ... operational flexibility, high levels of employee engagement, [and] tight strategic alignment" (Groysberg & Slind, 2012, p. 78). They acknowledge the relationality of communication and identify four essential elements to engaging staff in developing and living a shared vision: intimacy as in mental/emotional proximity achieved through trust, listening to and acknowledging the person; interactiv-

ity by conversing with, rather than talking to associates; inclusivity enhancing a sense of shared ownership; and intentionality to prevent divergence and rambling (Groysberg & Slind, 2012). Communicating then becomes mutually beneficial as people learn about/validate self and place self within a larger whole (Belenky et al., 1997).



Whilst effective communication has been shown to influence patient safety, job satisfaction, nurse retention and healthy work environments, there is also evidence to show that nurses dare not speak up for themselves (Garon, 2012). Perceived power differences can negatively affect authenticity within communing (Grill et al., 2011). Whether or not nurses feel that they are heard and relevant action is undertaken, is influenced by how leaders respond to their often passionate and emotionally expressed concerns (Garon, 2012). Listening is the most important leader skill (Ashman & Lawler, 2008) and person-centred leaders also create safe communicative spaces for associates to share their narratives. These spaces may be incident-

tal private conversations or regular structured meetings, such as the storytelling sessions we used in this study. The primary nursing system also created spaces for the PNs to regularly commune with associates, a pattern front-line nurse managers also feel is imperative to good communication and interpersonal relationships (Marx, 2013).

Communing with a team has been shown to have a positive influence on conflict resolution, team identity, collaboration and development (MacPhee et al., 2010; Young-Ritchie et al., 2009). Communing here is not just an exchange of information but a relational meeting (Ashman & Lawler, 2008). Mutuality grows and empowerment and psychological wellbeing are enabled as people become moved by the feelings, thoughts and perceptions of the other. They come to see and know the other whilst being authentic (Covington & Surey, 1997). Structural and psychological empowerment is enabled as the leader listens, shares information and thinks with associates. The sharing of information, personal values and beliefs may be achieved through direct, indirect and/or creative communication. Metaphor, imagery or narrative can be effective ways of conveying a message, although, how the associate receives and interprets the messages conveyed is personal to them and the leader should respect this (Ashman & Lawler, 2008).

Ashman & Lawler (2008) are critical of leadership styles that propose using communication to manipulate or persuade associates to move in leader specified directions. Reitz (2011) also emphasises the importance of leaders being mindful of their connectedness and advise dialogue to improve ethical decision-making, creativity and organisational learning. However, Grill et al (2011) found that dialogue means different things to different front-line leaders and that espoused use of dialogue was not always congruent with observed behaviour. Cisna and Anderson (1998) suggest that as associates may perceive

power differences within the leader-associate relationship that may hinder their authenticity, leaders should take the initiative to create the conditions for dialogue. However, creating the conditions for dialogue (see below) can be very difficult in everyday practice, which has led me to use the term *communing* rather than *dialoguing*. *Communing* acknowledges attempting to create the conditions for dialogue, but even if all the conditions are not met, relational connectedness is still achievable.

Buber (1958) describes dialogue as *praxis*, so there are no fixed rules, only conditions: acknowledging individuality; receptiveness towards an other's perspective and; sympathetic imagination and allowing the emergence of new shared understanding, rather than imposing it. Freire (1970) names similar conditions, but includes critical thinking. Reitz (2011) feels that moments of dialogue between leader and associate are possible when leadership is seen as an emergent process, not restricted to formal roles and, like Ashman & Lawler (2008), possible when leaders are prepared to see self and others as persons rather than a number with a human mask. However, how an associate perceives role and status power within the relationship will also influence the degree of genuine dialogue (Reitz, 2011). This was evident when staff nurse Carl kept silent about his objection to Fleur's plan on how they would work together. He simply replied, "You're the chief".

In 1957, Buber and Rogers dialogued the possibility of mutuality within unequal role relationships. Whilst many report that no conclusion was drawn, Cisna and Anderson's (1998) analysis of the conversation concluded that it was acknowledged as possible, if only momentarily. Ashman & Lawler (2008) state that genuine dialogue can be challenging for leaders who, despite their desire for relational connectedness, may feel a need to retain psychological distance in order to protect their image and/or disguise their own shortcomings. MacPhee et al (2010) found that past history can also play a role too. Such leader reservation would not be characteristic of person-centred leadership where leaders are willing to acknowledge their fallibility, show their vulnerability and do not value role status or power-over others.



Presencing, or showing sympathetic presence as it is labelled in the Person-Centred Nursing framework, is "an engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the recognition of important agendas in daily life" (McCormack & McCance, 2010, p. 100). Working with pastoral workers Baart (2001) developed a theory of presence, which has since been applied to nursing (Baart & Grypdonck, 2008). For Baart (2001), presence begins with unconditional openness and beneficent attentiveness (attentiveness for the sake of attentiveness and not as a means to an end) towards the other, with the sole aim of understanding the other's narrative and achieving relational connectedness

from which both can decide if and how the professional can help (Klaver & Baart, 2011). The term 'being with the other' is often used to describe presencing and whilst the professional may not employ technical skills, the offering of spiritual and emotional support is an active process requiring intra- and interpersonal intelligence. Doona et al (1999) used data from three studies exploring nursing judgement and identified six elements of nursing presence. 'Uniqueness' describes the fundamental humanistic value of respecting individuality. Their descriptions of 'connecting with the patient's experience', 'sensing' and 'going beyond the scientific data' resonates with the person-centred leadership processes of sensing, contextualising and balancing. 'Knowing' describes use of professional experiential knowledge, and 'being with the patient' describes supportive companionship by remaining open to the subjective experience of the patient and simultaneously showing hope and encouraging self-efficacy. As well as being there with and for the other person, I found that presencing also included thinking with the associate and/or doing for them. For instance, when PN Chloé became emotional and voiced her concerns and frustrations about the need to evaluate the primary nursing system, her leader colleagues showed sympathetic presence by listening attentively, sharing how they imagined she was feeling, offering hope and alternative perspectives to the situation, raising her awareness to the shared responsibility they had and offering concrete solutions.

McCormack and McCance (2010) argue for using the term 'sympathetic' rather than 'empathetic' presence, as our perceptions of experience are unique, influenced by history, values, beliefs and emotion. Not having experienced a situation with the same history, values, beliefs and emotions as another person, it is questionable whether we can be truly empathic. At best, we can use sympathetic imagination (Kontos & Naglie, 2007), which resonates with Rogers thinking when he defined empathy as "an act of engaged imagination, an attempt to imagine another's experience as if it were one's own, but without losing the 'as if'" (Cisna & Anderson, 1998, p. 85).

Whilst empathy has been shown to significantly correlate with associate job satisfaction, extra effort and effectiveness (Skinner & Spurgeon, 2005) and is named in servant, situational, authentic, person-centred and congruent leadership models, the term presencing tends to be used with reference to Senge et al's (2004) theory and Scharmer's (2009) U theory of leading change. 'Having presence' here is more in relation to context and personal being, rather than in relation with associates. It entails suspending preconceptions and redirecting focus to view situations from a 'whole' perspective, letting go of traditional solutions and ways of being so as to let the new emerge, which is then crystallised in a vision, prototyped and if effective, institutionalised (Senge et al, 2004). Presencing is claimed by some to require leader authenticity, attentiveness and responsiveness 'in the moment' to what is happening within the context (Kouzes & Posner, 2007; Scouller, 2011). Whilst this was observed in this study, reflected in the

processes of sensing, contextualising and balancing needs in order to respond appropriately, the depth of meditation and mindfulness Senge et al (2004) refer to was not observed. However, the journey of tailoring primary nursing to fit the context did entail letting go of traditional solutions and ways of being to let the new emerge and so is reminiscent of presencing. Personally, I also feel that, in time, the safe, critical and creative communicative spaces could have developed into spaces for presencing as described by Senge et al (2004), but then within the workplace.

Whilst the cascading effect of person-centred leadership influencing person-centred care was not the primary aim of this study, Binnie and Titchen's (1999) emancipatory action research study did show how structural and leadership change can empower nursing teams to practise humanistic nursing. The nurse leader (Binnie) showed presence in the context and sympathetic presence to her associates and transformation of practice was achieved. Sympathetic presence by nurses was observed in the use of (non)verbal communication, slowing down to convey a sense of having time for patients, and being available for them. The same behavioural pattern was observed by person-centred leaders as they related with associates.

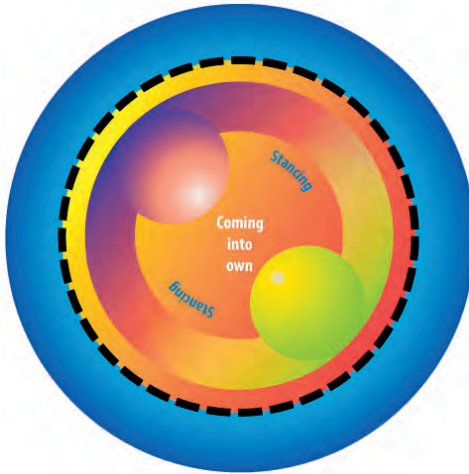
As just mentioned, the focus of this study was not the transformation of nurses and nursing care, although early signs of cultural change were captured in evaluations, such as calmness on the ward despite sustained high patient dependency and workload. Outcomes such as Binnie & Titchen's (1999) and our own observations, encourage me to propose that person-centred leadership is an enabling factor for person-centred nursing (McCormack & McCance, 2010) and effective workplace cultures, where all flourish (Manley et al, 2011). However, further research in this field is needed.

Summary

Relational connectedness is a process of creating a sense of safety, recognition and belonging, so as to enhance associate wellbeing. Similar to nurses, person-centred leaders engage in sensing, using multiple senses, to assess the current wellbeing and needs of the other. Gathering information from various sources and seeking validation enables the leader to see beyond the observable and gain a more holistic view of the person in context. The associate is considered to inhabit various contexts besides the present, all of which may be influencing current being. The leader engages in balancing needs within the current and future workplace context so that an appropriate response can be determined. Communing as conversations oriented towards connection and action in an atmosphere of psychological safety are characterised by intimacy, acknowledgement, interactivity, inclusivity and intentionality. Presencing is less about conversing and more about being in relation and connected to self, other and context. Whilst an active process, it does not necessarily imply doing as being and thinking with oth-

ers, uninhibited by tradition and judgement, can help new insights and solutions to emerge.

Stancing to enable coming into own



The primary aim of person-centred leadership is to enable associates coming into their own, based on the assumption that when people feel good at work, performance and commitment are more likely to follow. Most leadership models, especially traditional ones, are primarily concerned with improving associate performance and/or implementing practice change. Definitions usually refer to the social influencing of 'followers' to achieve organisational/leader goals, which may explain why associate empowerment as a means to improving performance and

achieving organisational goals has been given much attention in the literature.

Situational leadership (Hersey et al., 2001) is concerned with leaders influencing associate task performance. Transformational leaders aim to "stimulate and inspire followers to both achieve extraordinary outcomes and, in the process, develop their own leadership capacity" (Bass & Riggio, 2006, p. 3), although, Kouzes & Posner (2007, p. xi) only refer to getting "extraordinary things done in organizations." Authentic leadership does place performance secondary to work satisfaction as leaders "are able to enhance the engagement, motivation, commitment, satisfaction, and involvement required from followers to constantly improve their work and performance outcomes" (Avolio et al., 2004, p. 804). Discussing person-centred leadership, Plas & Lewis (2001) make specific reference to employee burnout and place professional and personal development on equal par with service user satisfaction and product quality. Servant leadership begins "with caring for individual persons, in ways that requires dedication and skill and help them grow and become healthier, stronger, and more autonomous" (Greenleaf, 2003, p. 37). Assuming intent is closely linked to values, the leader intent described in the different leadership styles would also explain why person-centered, authentic and servant leadership showed the strongest congruency with the person-centred values framework generated through the literature study presented in Chapter 2.



Stancing is the process of positioning self in relation to another, based on understanding derived through sensing, contextualising, balancing, presencing and communing. The engagement is invitational rather than imposed and four basic stances were identified: leading from the front; side line; alongside and; behind. Once embodied, and as expertise develops, leader movement between the four stances is fluid, like a dance. To move effortlessly and appropriately between all four stances could be considered beautiful leadership.

Ladkin (2008) states that beautiful leadership requires mastery (understanding self, context and domain, with attentiveness to possibilities within the here-and-now), congruency (between what is (non)verbally said and done) and ethical purpose. All three of these attributes are described in the person-centred leadership framework.

At first sight, the four stances of person-centred leadership seem to reflect Hersey et al's (2001) four modes of situational leadership (S1-S4). However, unlike situational leaders who make a diagnosis based on associate readiness/maturity/level of development for task performance, person-centred leaders are more holistic in their diagnosis of what an associate needs in order to come into their own, experiencing wellbeing and empowerment.

Leading from the front, the person-centred leader 'offers' directive support such as role modelling or doing for the associate, whether it be a technical skill or how to respond to a situation. For instance, when CN Loes observed a student struggling to coordinate and provide patient care, she offered to attend to the hygiene needs of several patients as she knew the student's learning objectives were centred on co-ordination of care. Situational leadership style 1 (S1) is comparable to leading from the front in terms of giving direction, but Hersey et al (2001) use the term 'telling', rather than 'offering', to denote leader behaviour. CN Loes 'offered' to do for the student and did not 'tell' her. This in effect preserves the student's sense of self-determination. Other terms used by Hersey et al (2001) for S1, such as guiding, directing and structuring, are more comparable to a person-centred intent.

The critique of discourse issue is again applicable in Hersey et al's (2001) S2 mode, where leaders are said to 'sell' and /or 'persuade' associates to psychologically 'buy in' to what the leader wants (Hersey et al., 2001). A person-centred leader leading from the side line would offer instruction. Recognising their own fallibility, they would not 'sell' their perceived way of being, preferring instead to commune and/or negotiate with the associate. Alternative descriptions of S2 offered by Hersey et al (2001) are more congruent with a person-centred paradigm; for instance, encouraging, questioning,

discussing details, providing the 'what, when, how and where' information an associate may need and checking associate understanding. Communicating clearly and honestly the options available to an associate, as well as offering rationale for the options presented in a way/discourse that the associate can understand, also demonstrates other-centeredness.

Leading from alongside and leading from behind are less directive as spaces are created for associates to experiment and/or take, what for them may feel like, risks. The person-centred leader is focused on enabling associates to dare find their own way and enhance self-efficacy. Hersey et al's (2001) S3 style of leadership, 'participating', also focuses on supporting associate confidence and involvement in problem-solving. The leader actively listens, supports risk-taking and encourages the associate by using praise and compliments (Hersey et al., 2001), although, why giving praise and compliments should be limited to S3 is unclear. This mode of situational leadership shows the strongest discursive congruency with person-centeredness. Person-centred leaders actively listen to associates' narratives and perceptions of where they are at that moment, how they came to be there, where they want to move to and how they feel that can be achieved. Communing is prominent in this stance as the leader combines high challenge with high support to enable action. Having agreed that their meetings required more structure, Betty asked the CNs to think about how they could restructure the meetings, leaving them to contemplate this before asking about their ideas.

Sometimes, Betty consciously chose not to intervene with a CN's plan of action, even if she felt the CN's decision was not the right course. By doing so, Betty took a step back and observed; i.e., she led from behind. Unlike Hersey et al's (2001) S4 mode, this choice is not necessarily based on the leader's conviction that the associate can be or do without leader intervention. The S4 mode of situational leadership entails delegation of tasks (Hersey et al., 2001). Unlike situational leaders, person-centred leaders do not consider associate ability and willingness to perform adequately and independently prerequisites to delegation. Inviting an associate to take on an activity is sometimes viewed as a learning opportunity and the person-centred leader uses knowledge of the associate and context to calculate the risks involved. By following up and/or observing progress, the leader is at hand to intervene and offer support if and when need be. Calculated/Considered risk-taking is characteristic of empowering care environments (McCormack & McCance, 2010) and viewed by Crenshaw & Yoder-Wise (2013) as an essential competency for contemporary nurse leaders as the benefits include: associate self-awareness; self-empowerment; self-confidence; job satisfaction; professional development and; organisational innovation.



Coming into own is, as already stated, the primary aim of person-centred leadership. It encompasses moments when individuals feel good and things feel right. The concepts of wellbeing, empowerment and self-actualisation are relevant here. When people are reaching their potential they shine, demonstrate greater self-determination and authenticity and experience a sense of equity within the workplace and between themselves and leaders. A focus on wellbeing and empowerment is relevant in modern healthcare leadership, especially since

an NHS Health and Wellbeing Review (Boorman, 2009) found that many staff did not feel leaders took their health and wellbeing seriously. Greater focus on wellbeing and empowerment is recommended as it has been linked to quality of patient care, and a subsequent NHS NICE guideline recommends that front-line leaders encourage participation, delegate, give constructive feedback, mentor and coach staff (NICE, 2009). The other-centeredness and caring attitude implied here should be authentic if it is to be considered an attribute of person-centred leadership and the leader should have adequate self-knowledge. Linked to self-respect and self-determination (Ménard & Brunet, 2011) authenticity becomes stronger and more evident as leaders acquire self-knowledge and demonstrate behaviour congruent with their values and identity (Avolio et al., 2004; Knoll & van Dick, 2013). We also found that genuine person-centred leadership fosters leader coming into own too.

Ménard & Brunet (2011) found that authenticity was positively related to subjective wellbeing within the workplace among public sector managers, although it was partially mediated by the leader's perceived meaning of their work. Participant leaders in this study expressed that becoming more person-centred felt right and that their work was becoming more meaningful and enjoyable as they noticed associates responding positively to the new leadership style and showing interest in leader wellbeing too. Ménard & Brunet (2011) define wellbeing as having two components: the subjective wellbeing of happiness and satisfaction, and the psychological wellbeing of reaching our potential and thriving. They conclude by stating that "authenticity leads to meaning which, in turn, leads to happiness" (Ménard & Brunet, 2011, p. 342).

The phrase 'coming into own' was frequently used by participant leaders in this study to describe what they were experiencing and aiming for in their leadership. Whilst their descriptions were suggestive of the concept of human flourishing, only moments of coming into own were observed or referenced. There was no distinct pattern. Although human flourishing may not have been observed, I feel that it could potentially be an outcome of person-centred leadership and my rationale is based on the following authors' work. Despite some philosophers' views that human flourishing can never be obtained via

work, Hincliffe (2004) argues that it is possible when work is seen as a practice with both technical and ethical dimensions and does not necessarily have to produce something external to the process itself. Healthcare is given as an example of work that can enable human flourishing (Hincliffe, 2004). McCormack, McCance, et al (2013) argue that nurses need to experience a similar sense of caring and support in their work environment if they are to enable the flourishing of service users, and in their concept analysis of effective workplace cultures in healthcare, Manley et al (2011) identified human flourishing as an outcome and person-centeredness as a core value. It seems feasible then to suggest that person-centred clinical nurse leadership could potentially enable human flourishing.

To feel acknowledged and accepted within the workplace, possess more self-determination and influence over one's own being and reach one's potential, requires self-efficacy and an ability to work with contextual influences. Empowerment is the term most frequently used in leadership literature to describe the process of coming into own, although, there are differing conceptualisation of empowerment and underlying assumptions. In this study, contextual forces limited the empowerment experienced by participant leaders. Studying nurse perceptions of moral dilemmas, van der Arend & Remmers-van den Hurk (1999) found that Dutch nurses most frequently experienced problems with their organisation when they felt they had very little influence. Two thirds of those surveyed in 91 care institutions felt that leadership was strongly hierarchical, non-communicative, and becoming increasingly 'business-like' (van der Arend & Remmers-van den Hurk, 1999), a scenario not conducive to empowerment. Trying to explore and develop person-centeredness within a context similar to that described by van der Arend & Remmers-van den Hurk (1999) was challenging. However, as the enactment of individualisation was explored and strategies of inclusivity, participation and collaboration in everyday leader practice utilised, empowered associate behaviour did started to emerge. For example, there was less consultation of CNs about what to do, with associates resolving more problems among themselves, rather than depositing them with the CNs. Plas & Lewis (2001) regard empowerment as a basic principle of person-centred leadership, based on the belief that associates know the primary process best and should therefore be included in decision-making, co-creating visions, taking considered risks and being creative. Whilst the leaders valued this, they were selective in who participated in what and under which conditions. As Argyris (1998) states, empowerment also needs to be individualised and particularised as not everyone wants the same level of responsibility and self-determination, or all the time. CN Fleur recognised this when she stated, "A lot of people are not that far yet ... and they don't want to carry that [responsibility] yet, not think about that yet, and can't handle that as well yet ... you look at who you're working with."

Empowerment within the workplace is a concept gaining increasing attention in leadership literature and two types have been identified: psychological and structural empowerment. Structural empowerment is based on the belief that leaders can give power

to associates by delegating authority and changing social structures so as to increase access to organisational information, resources, support and opportunities (MacPhee et al., 2014). This paternalistic view of power and empowerment seems particularly prevalent in healthcare organisations. Koberg et al (1999) found that employees of an American hospital perceived empowerment as related to hierarchical position and/or when feeling that one's personal values and beliefs matched those of the organisation, and/or when leaders encouraged self-worth and facilitated effectiveness. In The Netherlands, a similar paternalistic view of structural empowerment is evident among researchers such as Hakimi et al (2010) who define leader empowering behaviour as when "employees are given greater authority and responsibility for their work" (Hakimi et al., 2010, p. 702) and conclude that leaders need "to find the right way to empower their followers without losing control over their followers' actions" (Hakimi et al., 2010, p. 711).

When power is interpreted as the ability to influence others and get things done from a hierarchical position with control of access to resources, it can be difficult to separate power from empowerment. However, power is often associated with coercion and domination in a nursing context (Kuokkanen & Leino-Kilpi, 2000). Nursing's history as female work of low social status, relatively late development as an academic subject and a reluctance/failure of nurses to acknowledge and use their own power to assert their position within healthcare contexts, has not helped them move from an oppressed position (Manojlovich, 2007). In the Netherlands, higher management roles such as a director of nursing are non-existent. The majority of board directors have an economic, business and/or physician background. Nursing advisory councils are often present in larger institutions, although few are active or strong enough to exercise much political influence.

Traditional, Kantian views of power and empowerment focus more on increasing associate productivity than wellbeing and fail to acknowledge the influence of the person's self or the relationships they engage in. Wagner et al (2010) propose that structural empowerment is an antecedent to psychological empowerment, although this again implies dependency on leader facilitated access to power/resources. Psychological empowerment goes a step further to focus on self-determination, agency and interdependency. Spreitzer (2008) describes psychological empowerment within the workplace as having an active-orientation to one's work with a sense of 'fit' between personal values and role demands, self-efficacy in task performance, self-determination in deciding what one does and influencing outcomes of one's work.

Post-modernists argue that if power needs to be delegated in order to empower others, the so-called 'empowered' will never reach a status of equity as they remain dependant on those delegating authority and access to resources (Spreitzer, 2008). Consequently, goals such as self-determination and interdependency are not considered relevant or remain unachievable. Whilst I acknowledge that leader delegation, shared decision-making and opening access to information and resources will enable nurses to experience a sense of

control over their own work environment, without sufficient levels of self-efficacy they are less likely to continue to make use of the opportunities created. This phenomenon was observed in the person-centred leadership study when participant leaders hung up a list of 'interest groups' for associates to voluntarily assign themselves to lead, rather than approach individuals and/or delegate responsibility, as was the traditional approach. Whilst associates voluntarily added their names to the list, and enthusiasm was noticeable, subsequent action by the group leaders was lacking. This could be an indication that something more than simply offering choice in delegation of responsibility is necessary if associates are going to be able to empower themselves.

From a critical theory perspective, psychological empowerment has been defined as "a process of enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information" (Conger & Kanungo, 1988, p. 474). The assumption is that when associates believe and feel confident in what they are doing, and when conditions inducing powerlessness have been removed, they will experience a greater sense of wellbeing and are better able to demonstrate mastery of their working lives. Empowered associates will then rise to a position of equity within the context and come into their own. The problem I have with this definition is the lack of an appreciative approach, focusing as it does only on removing barriers, rather than simultaneously seeking enabling factors at the group and individual level to support and build self-determination and agency. There were no recognised formal organisational or informational barriers to the staff nurses on the research ward leading the interest group of their choice, yet still it failed to materialise. A more active, supportive and encouraging stance from the participant leaders may have resulted in a different outcome.

I used the term 'mastery' rather than 'performance' in the previous paragraph as it is linked to the humanistic value of equity and Ladkin's (2008) description of expertise in leadership. A person may demonstrate mastery in a professional field and/or a particular skill, and mastery is not determined by amount of performance, but their ability to judge the degree of action, gesture or communication needed (Ladkin, 2008). As unique individuals, each of us has strengths and weaknesses, and to expect each member of a team to perform equally well in all areas/tasks is unrealistic and incongruent with the person-centred value of individualisation. Mastery, on the other hand, is concerned with being the best one can be at something. Where performance is often measured by comparing one's competency to that of others, inciting a sense of competition, mastery focuses on individual or group achievement without comparison with others (Johnson & Johnson, 2005).

In their description of person-centred leadership, Plas & Lewis (2001) place a strong emphasis on effective teams that enact the principle of equity. Individual strengths are supported and developed and there is a willingness to compensate for the weak-

nesses of others. This was evident when the charge nurses were faced with staff nurse Jo who, whilst having worked on the ward for many years and was renowned for her caring attitude towards patients and family, lacked the technical competencies to care for increasingly complex acute cases and was, thereby, unable to supervise junior staff. Jo was initially resistant to attending the internal education programme, but the CN's felt that attendance was of particular relevance to her in light of her shortcomings and they made a conscious effort to encourage and support her in doing so. Whilst following the programme alone could never resolve the issue of her technical skills, the CN's felt that Jo could now still make a positive contribution to the ward and team. The decision was made to no longer laden Jo with the same expectations as other experienced staff nurses, i.e. be able to take charge of the ward and lead a team of associates for that shift. In doing so, her strengths were appreciated and made use of, and her weakness were compensated by others taking charge of the ward.

Conger & Kanungo (1988) also propose that empowerment can be enabled by examining contextual factors creating powerlessness, such as organisational structures and conditions, style of supervision, systems of reward and job design. Low status can feed low self-efficacy and underestimation of a person's contribution to outcomes, foster a withholding of valid information, deferring decision-making to those higher in the hierarchy, low organisational commitment and reluctance to voice concerns (Nembhard & Edmondson, 2006). Psychologically empowering interventions can include: the recruitment of staff with, or the development of, competences needed for practice; structures and processes that enable participation, collaboration and inclusion; leader expressions of confidence in staff ability and praise of achievements; networking opportunities and; matching personal qualities with jobs/tasks (Conger & Kanungo, 1988). Foster-Fishman et al (1998) identified six pathways to empowerment experienced by staff in a disabilities service organisation. These included: opportunities for self-determination; freedom to be creative; gaining job relevant knowledge; feeling trusted and respected; job satisfaction; and shared decision-making. Person-centred leaders also use relational processes such as communing and creating safe, critical and creative learning spaces to enable psychological and structural empowerment; i.e. enabling associates to come into own. They are aware of power perceptions and presence within relationships, but, holding humanistic values and being reflexive, they are sooner inclined to seek 'power-with' and 'coactive power' rather than 'power over' or 'coercive power' (Follett, 1940).

However, empowerment is complex, as can be seen above, and can mean different things to different people, can change over time and/or as the context changes (Foster-Fishman et al., 1998). Whilst front-line leaders have an important role to play in enabling empowerment, we must also remember that they too are led by others and so are also subjected to empowering and/or disempowering processes. Regan & Rodriguez (2011) state that leaders must feel empowered if they are to empower others, which implies

that empowering leadership should be evident throughout the organisational hierarchy. Wagner et al's (2010) conclusion, after reviewing empowerment literature, was that structural and psychological empowerment within the workplace increase nurse (manager) job satisfaction, feelings of being respected, increased commitment and innovation, better effort-reward balance and reduced burnout. However, US and Canadian research is showing that middle level nurse managers are not experiencing sufficient organisational support and structural empowerment (Patrick et al., 2011; Regan & Rodriguez, 2011). In this study, whilst becoming and being person-centred leaders to the associates they led was enhancing participant leader wellbeing and psychological empowerment, their relationship with higher management became disempowering.

Summary

Stancing is the process where a person-centred leader invites engagement and positions self in relation to an associate in order to enable them to come into their own. Whilst there are four basic positions, the expert person-centred leader shows mastery, congruency and (ethical) purpose as they dance between all four positions, continuously responding to changes in associate being and the context. Leading from the front/side-line, direction and instruction are offered, rather than imposed. Leading from alongside/behind, leaders offer high challenge/high support and/or create spaces to exercise greater self-determination and learn.

Feeling confident and authentic, doing something meaningful and right/good, are signs of a person coming into their own. Focusing on wellbeing and mastery, rather than performance, individual strengths are nurtured and weaknesses compensated. As relational reciprocity grows, the leader may also experience a greater sense of wellbeing, psychological empowerment and self-actualisation too. Sustained coming into own could lead to human flourishing in person-centred cultures, especially when individualised empowerment strategies are used to enable the individual to come into their own, rather than delegate power/tasks to them. Associates need to feel supported in feeling confident if they are to thrive in taking on more responsibility. As well as appreciating and enhancing ability, social structures, conventions and practices creating feelings of powerlessness may simultaneously need to be removed. When person-centeredness becomes a lived cultural value, team members need to be willing to acknowledge individual strengths and compensate for weaknesses, and leaders seek 'power with' associates. However, it should be remembered that person-centred leaders are themselves led by others, and so the extent to which person-centred leadership is practised within the context can positively or negatively influence the local/idio-culture.

Mutual influencing between the relational and contextual domains



Whilst person-centred leadership acknowledges the mutual influencing between the contextual and relational domain, research has tended to stay clear of studying situatedness and contextual influences on day-to-day leadership interactions (Ashman & Lawler, 2008). Transcending dualist thinking of A causing B, the critical realist approach used in this study helped highlight the spiral influencing between social structures within the research setting and leader activity. Although some

social structures such as the evaluation systems set up by the participant leaders enabled them to become more person-centred in their leadership, others such as the cultural values and beliefs of higher management and the physician team proved to be constraining. Habermas (1984) draws attention to mutual influencing in the everyday, taken for granted lifeworld where social values and norms are reinforced and learnt through socialisation. He differentiates the lifeworld from the systems world of “powerful administrative and economic components which affect the way we think, act and live” (Stewart, 2012, p. 224) and warns of ‘technicization’ where the technical/rational systems world colonises and takes control of the lifeworld (Rammert, 1999). Communication then becomes technical and strategic rather than sincere and authentic (Stewart, 2004), resulting in relational distancing between people rather than connectedness.



In their Model of Competing Values, Cameron & Quinn (1999) describe four types of organisational culture: family, hierarchy, adhocracy and market. Although I do not want to attribute person-centred leadership to any one of Cameron & Quinn’s culture types, the research setting did show characteristics of a hierarchical culture, which had a strong influence on leader development. A hierarchical culture is characterised by managerial beliefs that control improves efficiency and leaders should coordinate, monitor and organise

staff and work processes (Cameron & Quinn, 1999). Managerialistic leaders, such as the physician manager and sector manager in this study, believe in stability, control and rationalism. They try to achieve this by exerting ‘power over’ others and/or empower others through delegation. They influence others by creating and/or draw on social structures, conventions and practices to maintain hierarchy that is unconducive to the psychological empowerment of associates. Use of traditional physician power over nursing and nurses was clearly evident in the research setting, and the sector manager offered no resistance,

openly admitting to Betty that she felt unable to oppose the physician manager's call for Betty's displacement. Regardless of whether I consider the physician and sector managers' actions as being right or wrong, I can appreciate that they too have been socialised in the past by cultural norms and/or their behaviour influenced by social structures. From an interpersonal/intergroup perspective, Freire's (1970) study of dehumanisation and oppression also helps explain how both oppressor and oppressed can contribute to psychological constructs and social structures that maintain a status quo of inequity. It was with this theory in mind that I created and facilitated the workshop with the CNs to help them acknowledge and respond to the emotions they were feeling after hearing about Betty's displacement.



Praxis as "reflection and action upon the world in order to transform it" (Freire 1970, p. 33) is needed if humanising and anti-oppression ideas and social structures are to become embodied in leaders and embedded within contexts. I also found that as leaders start to seek relational connectedness with associates and are reflexive in their being, social structures start to emerge, such as safe, critical and creative communicative/learning spaces and evaluation systems.

These structures then create conditions that are conducive

to person-centred practices, such as person-centred leadership processes within the relational domain. However, whilst effort was made to be inclusive of other stakeholder needs within the context, intergroup conflict arose when the nurse leaders' vision on how to lead the nursing team clashed with the division and physician managers' beliefs. Suddenly, whilst there was apparent progress along the path to empowerment within the nursing team, in which "a disorganised and unfocused group acquires an identity and a resolve to act in light of its new-founded sense of purpose" (Fay, 1987, p. 130), a powerful negative influence arose from the external hierarchical organisational culture and, to varying extents, de-railed the empowerment of team members.

Positive mutual influencing between the relational and contextual domain was also evident during the implementation of the new nursing system. Originally nurses were individually assigned patients at the beginning of each shift by the person 'in charge' (usually the CN). Observations of this practice revealed a pattern of associate dependency on CN directive leadership, even for decisions/actions that one would expect a qualified nurse to execute independently. The new nursing system created not only a structure that decentralised coordination of care to PN/associate dyads, but also spaces where CNs could work in close proximity with associates for substantial periods of time. However, early narratives indicated that assumptions around role responsibility and division of labour were not changing. Associates were assuming that the dyad six patient caseload

would be divided 3:3, and that the PN would take responsibility for coordinating care and resolving issues. Critically and creatively reflecting on these narratives, the CNs became enlightened to their misconception that structural change alone was sufficient to enable associate empowerment. Psychological empowerment also needed attention. As the CNs and PNs empowered themselves to transform role convention, a more collaborative, inclusive and participatory relating developed within the dyads, characterised by mutuality and reciprocity. They communed at the start of each shift how to work together, learning spaces were created and/or space for one of the pair to attend non-bedside activities, such as meetings. The PNs also started to demonstrate empowered behaviour, suggesting and initiating structural changes. What was emerging was a transformation of perceptions of relational power and empowerment. Whilst empowerment strategies were still often leader initiated, action orientated communing (Habermasian communicative action) was enabling structural and psychological empowerment without hegemony or 'bestowed' empowerment. Consequently, associate feelings of empowerment were not an illusion (c.f. Boje & Rosile, 2001) or 'false-consciousness' (c.f. Fay, 1987).

Empowering through 'sharing' rather than 'delegating' power was also evident when Betty invited two staff nurses to investigate and contemplate opening an extra bed. The challenge was increased by inviting them to relay their decision to the evening staff. In doing so she exercised 'power with' the two associates, creating space for them to exercise power over a phenomenon that would strongly influence the practice of their colleagues that evening. Sharing her narrative in a CCRI, Betty was challenged as to whether her intent was genuine enablement of empowerment, or delegated power with a reserved right to retract this if the associate's decision did not coincide with her personal assessment of the situation. However, her argumentation was plausible. Her intent was not just to help the associates 'feel' the power, but also to 'feel' the responsibility accompanying such decisions. She also returned to the staff nurses to verify that they had experienced a safe learning environment and freedom to make their own decision, confident that it would be respected and honoured. Betty also shared that whilst she would not simply have accepted a decision in opposition to her own, she would have communed with the staff nurses to discover their argumentation, which could then have dispelled her own. As such, she was willing to seek what Follett (1940) calls 'power with' associates, rather than use legitimate power (French & Raven, 1959) or 'power over' them. Follett (1940) was also a strong advocate of collaborative leadership and working with the values and beliefs of others without disregard for one's own values and beliefs. She states that in the leadership relationships there should be "willingness to search for the real values involved on both sides and the ability to bring about an interpenetration of these values" (Follett, 1940, p. 181). She claimed that by trying to understand the other's perspective and blend this with one's own, new situations could be created through a coactive rather than coercive use of power (Boje & Rosile, 2011). The value of this and applicability to person-centred leader-

ships was evident in the conflict resolution between CN Loes and staff nurse Nadine. This research study confirms Follett's (1940) work that demonstrated the relational nature of power, rejecting the notion that power is a thing to be possessed, instead circulating as people exercise their ability to influence others, whether that be leaders influencing associates or vice versa. Foucault's (1980) later description of power as a dynamic relational energy resonates with this, where attempts to exercise influence (power) can be met by resistance or have no impact at all on the others 'field of action'.

Clegg's (1989) theory examines power circulating at three levels: the micro/interpersonal, group and contextual level. Power circulating at each level can influence agency on other levels. For instance, (meso) contextual structures, conventions and practices can positively or negatively influence individual/group agency, i.e. (dis)empower them. Betty's displacement is an example of this. Influencing between levels occurs through 'obligatory passage points' where circuits interconnect. Using a case study of hospital doctors, Clegg (1989) describes how being in control of obligatory passage points, physicians determine whether and what influential power passes from one level into another. The physician and sector managers' control of obligatory passage points in this study enabled them to use existent contextual structures and conventions of a hierarchical organisational culture at the meso-level to remove Betty from her post. Once Betty was removed from her post there was no nurse leader at a strategic/hierarchical position to influence the meso-level, and so the work on person-centeredness within the ward failed to progress at the same rate of development. Leadership by the physician and sector manager also suggested a desire to regain 'power over' the nursing team. For instance, not only did they demand that Betty write an announcement of her departure that they would screen before its dissemination, they also did not include the CNs in any of the decision-making surrounding Betty's displacement. Considering that the hospital organogram positions the UM post on equal par with the physician manager, this highlights how status and traditional hierarchy can influence the use of power. Studying status in professional hierarchies and psychological safety, Nembhard & Edmondson (2006) found that professional status and experienced psychological safety were negatively related, which offers a plausible explanation as to why the traditional power of physicians was still evident in the research setting despite structural changes in the hospital organogram. Higher attributed professional status can increase self-efficacy and free voicing of opinion, but also failure to recognise or include the voices of those of lower status (Nembhard & Edmondson, 2006).

The difference between physician and nurse status has always been large, and whilst nursing as a profession is slowly coming into its own, there is sufficient anecdotal and research evidence to show the continued dominance of nurses and nursing by physicians (McMahan et al., 1994). For instance, a repeated national survey of American staff nurses showed a fall of only 57% to 46% between 1991 and 2008 of nurses who felt that they were subordinate to physicians (Sirota, 2008). Experiencing collegial relationships

only rose from 29% to 38% (Sirota, 2008). When conflicts arise, nurses play the 'doctor-nurse game', using indirect communication to voice their concerns, for fear of further jeopardising the relationship (McMahan et al., 1994). This is observed within the research setting in how the participant leaders and associates communicated with physicians and the physician manager in particular. Considering that nurses tend only to use direct communication in conflict with physicians when they feel a strong compulsion to act and indirect communication has already failed (McMahan et al., 1994), a nurse who immediately uses direct communication could be seen as psychologically empowered. This did emerge among the participant CNs who directly refused to adhere to the physician manager's demand that they not meet with me for a final evaluation interview. They also decided to cancel the last evaluation evening with the whole team as the physician and sector manager would only give 'permission' if they saw the programme beforehand. The CNs shared how participating in the action research project, and working with Betty, had raised awareness to the oppressive forces within the context. The support experienced helped reinforce their belief in self and build confidence to resist such power.

Whilst psychological empowerment within the nursing team idio-culture was increasing, the development of structural empowerment was meeting resistance from an outside/adjacent idio-culture. Idio-culture here is used in line with Bolon & Bolon's (1994) definition of it being a group of individuals with shared values and beliefs and a common problem/goal. They are not structured by hierarchical or physical boundaries, and an interaction between idio-cultures creates the organisational culture. Based on my philosophical framework, I would also argue that the interactions between idio-cultures are also influenced by the social structures, conventions and practices (organisational culture) they are producing. This would be a plausible explanation for Betty's displacement. Existent assumptions, found in the wider Dutch culture and indicated in international literature, enabled the physician manager and sector manager to displace a unit manager of equal/lower hierarchical position without fear of reprimand or need to justify their initial decision with evidence of incompetence. Not even later, when evidence of competence had been gathered and judged.



Some structural changes within the idio-cultural/contextual domain enabled associates to participate in decisions influencing their practice, a key element of practice development (Manley, Titchen, et al., 2013). Safe, critical, and sometimes creative communicative spaces were created for shared visioning, structure/system design and evaluation, for instance, the co-creation of a creative workload inventory during the orientation phase, and the 'think group' who designed a basic structure for the new nursing system. Participant leaders contributed

to gathering evaluation data from multiple disciplines using various techniques and at various intervals during the early implementation phase of the new nursing system, which sometimes contributed to more structure, convention and practice changes within the relational and contextual domains. For instance, based on their own and associate evaluations, the CNs decided to alternate their PN and CN roles weekly in order to reduce fragmented presence in either role, an issue also discussed by Binnie & Titchen (1999). The CNs and PNs also collected multi-stakeholder perspectives and expectations of the PN role and blended these with results from their own critical and creative role analysis before writing a role description. During the biweekly CCRI's and annual reflective inquiries, narrative analysis led to both structural changes as well as more conscious use of relational processes and leader attribute development. Finally, to evaluate leadership and workplace-/idio-culture changes, data was collected from nursing team members using mixed methods to increase rigour, as advised for practice development evaluation (Hardy et al, 2013; Wilson et al, 2008).

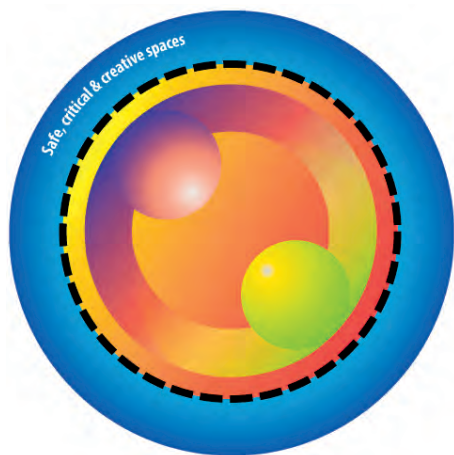
Awareness of social interdependency (Johnson & Johnson, 2005) grew in time. Leaders could not lead without associates, and effective teamwork (positive interdependence) would involve substitutability (using one's own strengths to compensate for the shortcomings of another), cathexis (psychological energy investment in things outside oneself) and inducibility (openness to influencing and being influenced) (c.f. Johnson & Johnson, 2005). Self-interest became joint-interest with a seeking of win-win scenarios, exemplified when PN Chloé created space for a temporary enrolled nurse to learn how to administer medications using the computerised system. The investment of Chloé's time and energy was considered worthwhile as it met the nurse's learning need and, as a frequent visitor to the ward, she would be less dependent on permanent staff for administering medications to her patients in the future. Leader initiated events such as the above strengthened a sense of community with reflected and structured action.

Summary

Being in relation and seeking relational connectedness requires leaders and associates to create a shared vision on how to enable the coming into own of all and which social structures, conventions and practices need to be reproduced or transformed in order to create conditions conducive to person-centred cultures. Whilst structural empowerment alone is usually insufficient to enable sustained growth, wellbeing and mastery, the person-centred leader will also need to consider strategies for enabling psychological empowerment too. Leader-associate relationships based on 'power with' rather than 'power over' the other are needed and evaluation systems using mixed-methods multi-stakeholder evaluations will create a feedback mechanism to enhance and/or continue the realisation of person-centeredness within the idio-culture. However, the idio-culture created also interacts with other idio-cultures, embedded as it is within an organisational

culture. Intergroup/idio-culture conflict and traditions may negatively influence the development of person-centred leadership and should therefore be given explicit attention from the beginning.

Experiential and workplace learning



The development of person-centred leadership is approached with an intent of enabling potential changes in participant leader perception and behaviour through workplace adult, active, social, experiential and transformative learning. Analysing data of the learning journey, a framework for workplace learning emerged, showing that orientation, motivation, planning and action for learning requires facilitation. The role of the facilitator is to enable learners to connect their thinking with their doing in order to influence their future being. The

learning process is influenced by and influences the context in which it takes place (see Figure 26 p.221). I propose that the developmental framework is also suitable for developing person-centred nursing, where the facilitator uses the Person-Centred Nursing framework (instead of the person-centred leadership framework) in safe, critical and creative learning spaces (McCormack & McCance, 2010). The findings of this action research study suggest that the creation of communicative spaces raise participant awareness to current leadership and nursing practices. As well as communing in a common language/discourse, metaphors, analogies and imagery can help participants become acquainted with what could otherwise feel like alien concepts found in the conceptual frameworks. McCormack et al (2013) also state that critical and creative processes enable energising of the human spirit and the potential to see new possibilities of growth and development. The use of creative expression within learning spaces certainly aided communication and understanding of participant leaders in this study.

As there was no official practice developer/educator role within the ward, the participant leaders, like Binnie (Binnie & Titchen, 1999), often found themselves facilitating learning activities at the bedside as well as in structured meetings such as storytelling sessions. This is not strange if one considers sensing and highlighting areas of patient care for critical reflection, enabling perspective transformation and supporting others through change, are considered attributes of effective clinical leaders (Cook & Leathard, 2004). Whilst nurses appreciate leader interest in facilitating their professional growth and development (Anonson et al., 2013), the participant leaders were also concerned with

enabling personal development. Facilitated workplace learning can be both professionally and personally empowering (Merriam, 1996) and knowledge of learner needs and context were used to employ appropriate learning strategies and activities in advance, or as opportunities arose for leader development. Opportunistic facilitation of learning is extremely valuable within workplaces, as Snoeren et al (2013) discovered in an action research study on workplace learning. Coming from an enactivist stance, they argue that people continuously re-orientate themselves to the dynamics of the context in which they find themselves (learning), rearranging cognitive, body and experiential frameworks with which they interpret the situation. Learning becomes more conscious when actions instigating intra- and/or interpersonal unrest cannot be dealt with from existing personal knowledge, and actualised when a facilitator posing challenging questions creates such unrest. This unrest triggers reflective processes that can be enhanced when narratives are shared in critical and creative communicative spaces, producing new insights, understandings and theories to interpret similar situations in the future.

Knowles (1968), influenced by humanistic psychology and group dynamics (Imel, 1999), identified five principles of andragogy (adult learning), evident in our study. Given that I had no formal organisational role, it was less easy for me to work alongside the leaders to help them to learn experientially, in and from their work, in a way they were able to facilitate the bedside learning of associates. Instead, I tried to create safe, critical and creative learning spaces for us to explore the concept and practice of person-centred leadership. The content of the learning spaces was influenced by expressed desires to explore something (problem-focused). Although I usually prepared a structure, this was always offered, never imposed, thereby creating opportunity to participate in its design (self-directedness) as group learning should be a shared responsibility (Imel, 1999). Open to learning and change (readiness), orientated and motivated to applying new knowl-

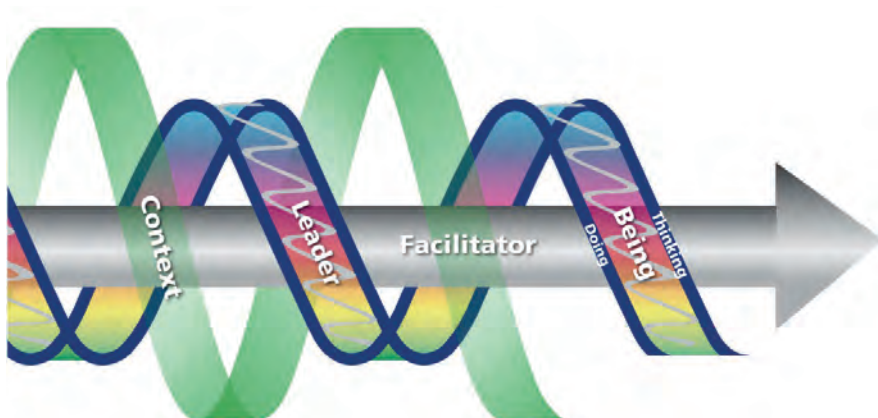


Figure 26 framework for developing person-centred leadership

edge to our practice (internal motivation), we used our own experiences to understand and learn experientially.

The four C's of transformative learning described by Story & Butts (2010) were also evident. **C**aring about and for each other during our learning journey became natural as we learnt more about person-centeredness. **C**omedy diffused tensions and/or re-awoke motivation and energy to continue the, at times, challenging journey. **C**hallenging our own and each other's assumptions was part of being critical, but also effective as we consciously balanced levels of challenge with support to maintain psychological safety for learning. As a facilitator I had to find and use my **c**reativity to not only deal with unexpected challenges such as reduced timeframes and/or participants giving priority to other pressing issues, but also to find alternative means of creative expression that participants felt comfortable with.

Imel (1999) states that adult educator researchers and theorists have tended to concentrate on group dynamics and individual learning rather than the group learning as an entity. Based on Habermas' (1971) description of instrumental, communicative and emancipatory knowledge, Cranton (1996) describes 3 types of group adult learning: cooperative learning where individual qualities contribute to group learning; collaborative learning where communicative knowledge is sought through the exchange of ideas, feelings and personal information; and transformative learning where critical reflection creates emancipatory knowledge. In our critical and creative reflective inquiry sessions, cooperative, collaborative and transformative learning was present as we used individual and, at times, collective experiences to enable individual and collective knowledge development and transformation of being. As the integration of divergent perspectives continued to create its own knowledge (c.f. Imel, 1999), leaders' individual and group identities seemed to be in a constant state of emergence (c.f. Lord & Hall, 2005) and consequently the framework for workplace learning has no beginning or end. This is congruent with a belief that leadership is "an emergent property of social systems, rather than something that is added to existing systems" (Day, 2001, p. 605). I also conclude that developing person-centred practices, whether they are leadership or care practices, is a continuous journey and reflects the core value of life-long learning characteristic of effective workplace cultures (c.f. Manley et al., 2012). Our focus on and benefit of focusing on relationships reflects research findings that adult learning within the workplace is social and that high-quality relationships are significantly correlated to team learning and performance (Brueller & Carmeli, 2011; Edmondson, 1999).

Ortega et al's (2013) survey of Spanish hospital nurses showed that team learning mediates the relationship between team beliefs about the interpersonal context (psychological safety, task interdependence and group potency) and performance, and that psychological safety is the strongest influencing factor. Learning is effective when authenticity and criticality are present, and feminist theorists also advise an environment

of (psychological) safety with reduced power differences. Going beyond interpersonal trust, psychological safety within a group is “a sense of confidence that the team will not embarrass, reject, or punish someone for speaking up... [and] stems from mutual respect and trust among team members” (Edmondson, 1999, p. 354). Facilitating the critical and creative communicative/learning spaces I was conscious of creating conditions for so that participants could feel safe to share and explore their lived experiences, thoughts and ideologies. The depth of sharing, sensitivity of some narratives and evaluations demonstrated that this was achieved and was greatly appreciated. Learning is not always fun and can even feel threatening as critical learning requires a willingness to suspend disbelief, confront held values and beliefs and possibly unlearn old ways in order to accept alternative perceptions (Macdonald, 2002; Mezirow, 1981; Schön, 1987). CN Loes’ exploration of showing vulnerability was just one example of how challenging transformations were at times. Safe learning spaces are characterised by openness towards, and generation of new influences and ideas without fear of negative interpersonal consequences, and behaviours detrimental to the process are deflected (Brueller & Carmeli, 2011; Edmondson, 1999). Not only was such safety achieved in the learning spaces I facilitated, the CNs were also able to achieve sufficient levels of safety in the spaces they created for associate learning too, such as the storytelling sessions.

Inviting people to participate, rather than telling or selling, is a primary principle of person-centred leadership, as shown in this study, and we applied it to workplace learning too. We were always explicit in stating/facilitating that respect should be demonstrated for each person’s contribution so that people could feel safe enough to be authentic. In terms of the physical environment, we chose separate rooms and were attentive towards each other if there was a danger of passers-by hearing part of the conversation and possibly drawing wrong conclusions. However, we also found that the nature of the experience used to enable learning and sensitivity of participants to others will influence what an effective learning space looks like. For instance, the storytelling sessions took place in the staff room on the ward. Although there were many disruptions with others entering the room, evaluations and observations did not reveal that this inhibited and/or disturbed the flow of honest conversations.

Psychological safety is also relevant with regards to using creative expression as high-challenge and low-support can foster learner aversion and quash the potential effectiveness of creativity for experiential learning (Fowler & Rigby, 1994). Aware of this I was always explicit that creative expressions were a means of non-verbally conveying often embodied messages. As Condon (2009) states, they are not intended to be works of art and so should be viewed with respect. Three small sentences helped us live this value when commenting on each other’s work: “I see ...”; “I feel ...”; “This makes me think of”. To support working with creative expression, I was always prepared to offer individuals and/or the group an alternative method to the one planned, and if at any time

I sensed hesitancy, I would share my observations for verification. Seel (2003) states that leaders creating command and control environments tend to hinder creativity, whether it be artistic expression or an ability to 'think outside the box'; and that whilst creativity cannot be created in individuals, the creative potential can be released when a supportive environment is created (Lowry-O'Neill, 2011). Loes' reaction to, and enthusiasm for, working with tableau vivant during the CCRI's was an example of how a person who does not initially see themselves as creative, can suddenly discover a whole new being when they find a method that suits them personally. Leading and facilitating using the relational processes of sensing, contextualising, balancing, communing and presencing, certainly helped me create conditions for participant creativity to emerge and be effective.

Workbased learning is popular in adult educational settings as it encourages experiential learning. The majority of examples found in the leadership literature are programmes developed by educational institutions/departments and based on activities such as assignments and portfolio evidence of learning. The current economic crisis affecting healthcare organisations has encouraged workbased learning programmes, with their 'self-directed' and 'self-paced' philosophy. Decreasing numbers of nursing staff, who form the largest workforce, are being released from the workplace to attend off-site education programmes. Although the self-direction and self-pacing principles of workbased learning may initially appear to enable learner empowerment, the activities involved in such programmes can be more time consuming than traditional educational courses. This can create new problems, as Williams (2010, p. 628) states, "it is unrealistic to expect nurses to undertake work-based learning with less or in some cases no study time". It is participant leaders' frequent referral to "the three years of learning" that has swayed me to propose that detaching learning from academic accreditation and embedding it in workplace learning could be a viable alternative to workbased learning for leader development, as long as it is accompanied by skilled facilitation.

Learning outside educational institutions is characterised by interactions taking place in a social system, use of tools and objects found within the context and developing situation-specific competences (Resnick, 1987). It can be formal or informal, regular or incidental, and is a social, action oriented and experience based activity, most effective when supported by the organisation and leader, but also influenced by intra/interpersonal factors (Allan & Smith, 2010; Andresen et al., 2001). It involves (re)constructing and (re)contextualising knowledge, based on the belief that effective practice, or praxis, cannot be learnt from literature alone (Cathcart et al., 2010; Snoeren et al., 2013), nor outside the context, as phronetic understanding (practical wisdom) requires immersion in experience (Cathcart et al., 2010; Dewing, 2010). The findings of this study support this view as participant leader learning and development took place by applying principles of adult learning within the practice context.

Whilst educational materials and activities that rely on passive forms of learning have been shown to have little or no effect on changing professional behaviour, interactive educational meetings do (Bero et al., 1998). Learning within practice settings usually involves team and/or groups, with team/group learning defined as “an on-going process of reflection and action, characterized by asking questions, seeking feedback, experimenting, reflecting on results, and discussing errors or unexpected outcomes of actions” (Edmondson, 1999, p. 353). Based on this definition, the CCRI’s used in this study can be considered an effective means of enabling group learning. Allan & Smith (2010) propose that nurses can potentially improve their practice (environment) by reflexively working with experience, and in particular, exploring issues of power and ideology. Whilst this was clearly evident in the CCRI sessions we held, my observations revealed that this was less evident in the storytelling session facilitated by the participant leader. This may be related to the relatively short period of time available each sessions (on average 15 mins), facilitator inexperience and/or changing membership each session. Andersen et al. (2001) and Dewing (2010) feel that experiential learning should be collective and active, bringing personal work experiences together through the creative use of various learning methods and techniques. Where Kolb (1984) suggests combining experience, perception, and cognition with action, Dewing (2008) suggests dialoguing with self and others, observing and doing. These were elements missing in the storytelling sessions but present in the CCRI’s.

Working with action research participants on one ward enabled the development of leader (human capital) and leadership (social capital) capacity as “individual and collective adaptability across a wide range of situations” (Day, 2001, p. 582). Day (2001) defines human capital development as intrapersonal growth, such as self-awareness, self-regulation and self-motivation. Social capital development is interpersonal/relational growth and involves the enactment of social awareness and skills (Day, 2001). The growth of the leaders and their leadership was not only evident in their evaluations, but also in associate evaluative descriptions of the participant leaders individually and as a team. Associates felt that the leaders had been successful in creating unity whilst retaining individuality among themselves. They complemented each other well in their joint leadership and led from within the team, as opposed to outside/alongside. The leaders were experienced as making conscious and strategic choices, creating a warm ‘nest’ for associates to work in, were pillars of support to them when needed and enabled supervised freedom to practise whilst showing equity.

Leader participants became better equipped to deal with the demands of their roles, indicating that transformative learning was taking place. they attributed this learning to their role as co-inquirers into their own individual and collective practices, therefore, this study is supported by theorists such as Mezirow (1981) and Freire (1970) who show how transformative learning, thinking about doing and the (re)formation of meaning

attached to experience, changes personal and social frames of reference (c.f. Thomas, 2012). According to Lord & Hall's (2005) theory of leader development, leadership skills and knowledge are inextricably integrated with self-identity. As they develop across time and develop expertise, shifts also occur from the individual to the collective mind-set (Lord & Hall, 2005). By the end of the fieldwork, not only did the participant leaders feel that they could not lead in any other way except what they now believed to be person-centred leadership, that it had become so embodied that it was a part of them and a way of being, associates observed the collective mind-set as shown in their evaluations described above. Another example includes the shift in leader perspective on whether or not associates wanted to be directed/managed, and told what, when and how to practise. Whilst challenging them, the collective, critical and creative exploration of assumptions led to enlightenment of the morality of surrounding issues such as associate dependency and their own role in this.

Although reflective group learning is used abundantly in nurse education, in both academic and practice settings, I am often surprised by the lack of structure and/or theoretical underpinnings. Platzner et al's (2000) evaluation study of post-registration group reflective learning among nurses found other hindrances such as workplace/educational socialisation reducing self-directedness and a reluctance to voice opinions for fear of showing vulnerability. The CCRI method (Cardiff, 2012) resolved such concerns. Founded on ideas from action science, critical theory and reflective practice, the method is structured in three phases and creates a psychologically safe space for collective critical and creative learning. Alongside extensive experiential knowledge from facilitating action learning sets in various contexts, I consciously used propositional knowledge from authors such as McGill & Brockbank (2004), Heron (1999) and Shaw et al (2008) to guide my practice, and consistently evaluated this with participants at the end of each session. Alongside experienced facilitation, participants felt that working with personal narratives of leadership practice and the use of creative expression were strong enabling factors (Cardiff, 2012). The questioning of values, beliefs and assumptions embedded within everyday yet complex scenarios was not limited to CCRI's and became standard practice, e.g. during post-observation interviews. Trying to facilitate participant leaders to connect their thinking with their doing by posing critical questions, helped them suspend their expert understanding of situations (c.f. Lord & Hall, 2005), reconsider surface structures (what they and other people were doing) as well as reconsider the deeper structures of emotions and assumptions (what they themselves and others were feeling and thinking).

Whilst the use of creative expression helped participant leaders articulate expert/experiential knowledge and implicit theories guiding their practice (c.f. Argyris & Schön, 1974), they had a preference to converse, rather than read. As reading was not a preferred learning strategy, I needed to find alternative strategies for introducing theoretical knowledge into participant learning. That nurses experience difficulty retrieving, read-

ing and understanding research literature is well documented in the evidence-based practice literature (Munten, 2012). Like Spouse (2001), I feel that workplace learning requires the use of knowledge gained from formal education, personal reading of professional literature and experiential knowledge if nurses are to critically reflect on current practice and propose alternative ways of being. The paucity of relevant literature in the Dutch language only added to the expressed hindrances of time and lack of interest in reading scholarly literature. Unable to find researched strategies for enabling reading, I found myself frequently reflecting on how I could encourage them to read more, until I questioned whether this was in fact being person-centred. I found myself balancing our differing values and needs, i.e. my perception that they needed to read more in order to develop faster, and their perception that they had insufficient time, ability (to read English with ease) and interest. My conclusion was that despite my view on the necessity and benefits of personal reading, by using alternative methods to introduce participants to propositional knowledge I would be working with their needs and values, and demonstrate sympathetic presence. Sensing was the key facilitative leadership process. Sensing when I could offer articles on a subject that they had expressed an interest in, and which I had sourced and considered relevant. Also, sensing when I could introduce research findings and theories I had been reading and considered of relevance. For instance, when I introduced CN Loes to Macmurray's (1961) theory of being in relation. As I explained Macmurray's theory (1961), she came to understand how she was approaching her relationship with staff nurse Nadine from a negative modus, distancing herself rather than seeking connectedness. Exploring what approaching the relationship from a positive modus would require and mean, helped Loes 'be' different the next time they met. Although not an ideal situation of 'self-directed' learning, it was effective at that moment in time, in that context.

Despite positive participant feedback on my sharing of propositional knowledge I knew and/or had sought, I remained convinced that reading would be of greater influence for participant self-efficacy. For instance, the CNs delayed starting the storytelling sessions and often expressed that they were finding working with the Person-Centred Nursing framework challenging. In my view, this was because they had relied only on me offering verbal explanations and imagery, alongside naming examples I heard in their narratives. Reading the original literature may have had a greater impact on their understanding and thereby self-efficacy. It is from this personal experience that I remain convinced that experiential workplace learning can be more effective in transforming personal and group being if learning methods include participant collective and/or personal reading and discussion of propositional knowledge, and then using it to make sense of their own current and future practice. This would enable the enactment of the person-centred values of blending different knowledges (see Chapter 2). Although discussing the teaching of ethics and virtue, Begley (2006) makes an interesting point,

that expertise requires theoretical (cleverness) and practical (maturity) wisdom, i.e. working with experiential and propositional knowledge. One might assume that combining person-centred leadership development with academic study would be a suitable option as it would motivate reading. However, Jasper et al (2010) report that academic skills needed to create a portfolio may have been too challenging for some participants on their All-Wales professional development programme for ward managers. Unfortunately, there have been no studies comparing workbased academic learning with workplace learning on leader competency development, so drawing a conclusion on this matter is difficult.

On the other hand, facilitating learning in and from practice has been demonstrated to be effective. Whilst one-on-one coaching within the workplace has been shown to be extremely effective in achieving specified metric targets, such as falls reduction and improved patient satisfaction scores (Johnson et al., 2010), Binnie & Titchen's (1999) study showed how critical companionship (Titchen, 2000) enabled a unit leader/manager to develop characteristics synonymous with our description of person-centred leadership and effectively facilitate nurses in providing person-centred care. Moreover, the PNs and staff nurses in this study did search and read literature when they were encouraged to inquire into something that interested them and then do something with their new understandings, like prepare a poster on some aspect of care. Perhaps more significantly, they started to read when they personally felt visible and exposed as PNs responsible for their patients' care, and were prepared to be held to account for and justify their practice to their patients, families and colleagues (Binnie & Titchen, 1999). This links back to Snoreen et al's (2013) assumption that feeling cognitive/body disequilibrium can instigate conscious learning actions. This initially left me puzzled. Was a strategy of fostering accountability the only way to facilitate learner engagement with propositional knowledge within a workplace learning context, especially where reading is not a personal/cultural preference and/or valued? A recent conversation with Angie Titchen herself has helped shift the focus of my thinking on this issue. Maybe thinking and looking for strategies to motivate reading is diverging focus away from the more important area of creating conditions that make reading attractive, part of being a professional and feasible within working hours, with the hope that this may then be extended beyond then as people become hooked. Celebrating reading goals and achievements should not be forgotten, and it would seem wise to approach the issue with an appreciative attitude of seeking claims as well as a critical attitude of removing barriers.

Summary

Based on the findings of this action research study, a framework for developing person-centred leadership has been created, based on the principles of adult, active, social, experiential and transformative learning. Creating safe, critical and creative learning spaces

within the workplace, and using everyday practice events, local tools and resources, learners are facilitated in connecting their thinking with their doing in order to influence future being. This study also found that workplace learning could be a viable, if not preferable, alternative to workbased learning in the current resource challenged healthcare context, as it retains the positives of self-direction and self-pacing, but takes place within the workplace and does not necessarily require time-consuming activities for academic recognition, such as compiling a portfolio of learning. However, skilled facilitation is required for effectiveness.

In line with the person-centeredness values identified in Chapter 2, the skilled facilitator combines propositional knowledge from facilitation and education theory, with personal experiential knowledge and knowledge of the learner, to create spaces and conditions for individuals and/or the group to learn regularly and opportunistically in and from practice. Considering the close proximity with which clinical leaders work with practitioners, the framework could potentially be of benefit to those wishing to enable person-centred practice, whereby a person-centred care framework could be used in place of the person-centred leadership framework to guide and support learning.

CONGRUENCY BETWEEN THREE FRAMEWORKS

Chapter 2 of this thesis entailed the creation of a values framework for person-centeredness based on a literature study. In Chapter 3 the choice to use McCormack & McCance's (2010) Person-Centred Nursing framework as a theoretical framework supporting the study was argued in terms of core conceptual and contextual relevance, as well as congruency with the person-centred values framework. Theorisation of the findings of this study, presented in this chapter, has resulted in a conceptual framework for person-centred leadership. As values are strong influencers of behaviour, it seems appropriate and pertinent to explore the person-centred leadership framework further so that leaders using it can feel assured that the values embedded within it are congruent with person-centred values.

The first person-centred value of *individualism* is reflected in person-centred nursing through McCormack & McCance's (2010) conceptualisation of personhood, persons being in place and caring as a moral imperative. These concepts combined with the nurse attributes of knowing the service user as a person and working with their values and beliefs enable a nurse to enact individualism through respecting uniqueness and diversity, understanding the person in context and being flexible in individualising interventions. Similarly, person-centred leaders uphold existential humanism, leading person-by-person (Plas & Lewis, 2001) and being reflexive and other-centred. They use sensing and contextualising to understand the other in context and balance needs before choosing a stance appropriate for the individual associate.

Relational connectedness is the second person-centred value. As well as their conceptualisations of caring, negotiated autonomy and therapeutic relationships/cultures, McCormack and McCance (2010) describe nurses using interpersonal skills and processes of shared decision-making, sympathetic presence and levels of engagement, to enable the empowerment of service users. Upholding the idea of related individualism (Plas & Lewis, 2001), person-centred leaders also use their attributes of being authentically caring and other-centred, and interpersonal intelligence, whilst engaging in presencing and communing aimed at enabling achieving relational connectedness.

Being in relation with another person so that individualisation and relational connectedness are maintained, entails the *blending of personal and professional knowledge*. Person-centred nurses use knowledge of self and the other, alongside professional competency to enact individualisation and achieve relational connectedness. Examples of the person-centred nursing framework being used in practice, published in McCormack & McCance's (2010) book, describe how people are blending different forms of knowledge critically and creatively in order to enable learning, culture development and service user

Person-Centred Values	Person-Centred Nursing	Person-Centred Leadership
<i>Value:</i> Individualisation <i>Descriptors:</i> respecting uniqueness and diversity; understanding the person in context; flexible individualised interventions	<i>Concepts:</i> personhood; person being in place; caring as a moral imperative <i>Attribute:</i> Knowing the other <i>Processes:</i> Working with service user values and beliefs; holistic care	<i>Concepts:</i> existential humanism; leading person-by-person <i>Attributes:</i> Other-centred; reflexivity <i>Processes:</i> Sensing; contextualising; balancing; stancing
<i>Value:</i> Relational connectedness <i>Descriptors:</i> interpersonal skills and trust; altruistic caring; presencing and communing; empowerment	<i>Concepts:</i> caring; negotiated autonomy; therapeutic relationships/cultures <i>Attributes:</i> Interpersonal skills <i>Processes:</i> shared decision-making; sympathetic presence; levels of engagement <i>Outcome:</i> feeling involved; wellbeing	<i>Concepts:</i> related individualism <i>Attributes:</i> authentically caring and other-centred; interpersonal intelligence <i>Processes:</i> presencing; communing <i>Outcome:</i> coming into own
<i>Value:</i> Blending knowledges <i>Descriptors:</i> Know self, other; professional knowledge; blending	<i>Attributes:</i> Knowing self, other; professional competency. Critical and creative use of knowledges to implement person-centred nursing.	<i>Attributes:</i> intra- & interpersonal intelligences; <i>Processes:</i> safe critical and creative communing/learning
<i>Value:</i> Supportive culture <i>Descriptor:</i> warm, welcome environment; accessible staff; person-centred management	<i>Context:</i> workplace culture, shared decision-making & power; physical environment; leadership	<i>Context:</i> organisational culture; stakeholder needs; safe critical & creative spaces, evaluation systems

Table 2: Aligning person-centred values, nursing and leadership

empowerment. This study adds to these examples from a leadership perspective. The person-centred leadership framework also promotes the use of intra- and interpersonal intelligence whilst being in relation, and the creation of safe critical and creative communicative spaces for adult, active, social, experiential and transformative learning.

The materialisation of person-centeredness within relationships is positively influenced by the presence of *supportive cultures* where environments are warm and welcoming, people are accessible and management is also person-centred. McCormack & McCance (2010) also describe the influence of leadership on the empowerment of nurses and development of person-centred cultures, as well as the influence of the physical environment on service user being. This study and the person-centred leadership framework demonstrate how context can positively (and negatively) influence leader-associate relationships. Whilst the organisational culture and needs of other stakeholders can positively or negatively influence leader-associate relating, influencing is not unidirectional. Using their attributes, relational processes, safe critical and creative communicative/learning spaces and evaluation systems, person-centred leaders and associates can be active in influencing others and the surrounding context so that they/it become more supportive.

In this section I have attempted to demonstrate how the person-centred nursing and leadership frameworks share the same values as those described in the person-centred values framework. Whilst there may be slight differences in how each value manifests itself in each framework, the congruency between all three frameworks has been demonstrated See Table 2 p.230).

CONCLUSION

This chapter presents a conceptualisation of person-centred leadership based on the thematic findings of the action research study. Person-centred leadership is presented as a relational approach to clinical leadership and does show similarities with other styles found in the nursing literature, such as authentic, transformational, situational, servant, and congruent leadership. However, where others primarily focus on associate performance and achieving leader/organisational vision and goals, the person-centred leader is primarily concerned with enabling associate wellbeing, empowerment and self-actualisation (coming into own). The arrival of a new conceptual framework for clinical nurse leadership is also timely as relational approaches to leadership are being called for in the wake of major reports on patient safety, both in the UK and The Netherlands. Daily conversations among practitioners are filled with narratives about the (Habermasian) systems world seemingly overtaking and suffocating the lifeworld. There is often talk of caring fading in healthcare and concerns of increased technology and mechanistic organisation systems dehumanising healthcare.

I propose that a person-centred leader uses traits and processes to be in relation and achieve relational connectedness with associates. Although building strong leader-associate relationships is not new, the detailed description of 'how' to achieve this is unique to the framework. Such connectedness fosters coming into own of both associate and leader, the rationale for this being that individual mastery can be developed whereby the individual can make a positive and optimal contribution to the performance of the whole team. This explains why moving the associate as an individual person to the foreground of a leaders field of attention, does not equate to losing sight of whole team performance.

We found that person-centred leaders are authentically other-centred and caring, using their intra- and interpersonal intelligence to build leader-associate relationships that feel morally right and foster the developing of one and all. As development and transformation can be a challenging and slow process, patience, optimism and openness become enabling traits. Leader reflexivity and willingness to show their vulnerability demonstrate leader humanness, which also fosters relational connectedness. Such traits are in line with practitioner descriptions of good/exemplary clinical leadership found in several studies.

Valuing related individualism and believing in existential humanism, we found that person-centred leaders want to connect with associates in a way that demonstrates equity and partnership. The processes involved include: sensing; contextualising; presencing; communing; and balancing. Whilst *sensing* where the other is at (their state of being) is not a strange concept to nurses or nursing literature, it is not described or discussed in the leadership literature. The same is true for contextualising, presencing and communing. Coming from a holistic approach, associate state of being is seen as influencing and influenced by the different spheres of being and the social roles they inhabit. Understanding these influences help a leader decide how best to interact/relate with the associate (*contextualising*). *Presencing*, as in being with/thinking with the other, it is not used with the same interpretation in the leadership literature either. Most of the leadership styles referred to in the nursing literature speak of leaders sharing and disseminating their personal and/or organisational vision. We found *communing* to be action-orientated dialogical conversations where the person-centred leader engages with associates with an aim of finding a common ground. Whilst shared visions may emerge, the leader is primarily aware of potential power differences and, wanting to maintain a sense of 'power with' rather than 'power-over' the associate, invites the sharing of associate values, beliefs and narratives, listening attentively, before responding. *Balancing* needs is a process familiar to all leaders, but in person-centred leadership principles of an ethic of care are integrated with an ethic of justice to help maintain a moral attitude where individual and differing stakeholder needs are seen in conjunction, neither is immediately prioritised, and consequences for the greater whole considered. We found that using these five processes, a leader determines how best to position self in relation to the associate (*stancing*),

and four basic stances were identified. At first glance, the four stances show similarity with those of situational leadership, however, when the discourse/terminology used is taken into consideration, fundamental differences are discovered as to leader intent.

Enabling associates to come into their own is the primary focus of the person-centred leader as experiencing wellbeing within the workplace and empowerment to have greater influence over one's work, were considered important to developing mastery (becoming the best a person can be). Individualised leader action was found to enhance associate strengths and remove barriers. Coming from a critical paradigm, genuine empowerment is not considered achievable through the delegation or giving of power often referred to in leadership literature. We also found that both structural and psychological empowerment needs to be attended to simultaneously, which supports the view that a leader should enable empowerment rather than delegate power.

Safety is an important element of psychological empowerment and learning. Creating *safe, critical and creative learning spaces* is one of the four factors found to influence and be influenced by events in the relational domain. Based on principles and theories of adult, social, experiential, active and transformative learning, a development framework for workplace learning was created. The use of creativity is unique as most leadership theories and development models only refer to cognition and rationale, leaving creative imagination and embodied/preconscious knowing unrecognised. Skilled facilitation regularly and/or opportunistically created safe, critical and creative learning spaces for individuals and/or groups to learn from lived experiences using a variety of methods, local artefacts and resources. Participant leaders were helped to critically and creatively connect their thinking with their doing in order to influence their future being. Whilst the framework was inductively created from the facilitation of participant leader development, the development framework could help person-centred leaders become facilitator rather than manager of associate learning within the workplace, and so meet the description of clinical leadership. Given that humans in relation evolve constantly, creating and changing the contexts that influence their being, the development framework has no beginning or end and so congruent with the value of life-long learning identified in effective workplace cultures. The framework could also support leaders facilitating associates in providing more person-centred care, where reflection using the person-centred leadership framework would be replaced by the Person-Centred Nursing framework.

Various new *evaluation systems* were created within the research context and the feedback mechanism created helped the continuous development of person-centred leader being and development, as well as contextual structures to support person-centred cultures and practices. *Organisational culture* and in particular the physician team idio-culture, created an opposing force to leader development and being. This finding supports other research and views that a hierarchical organisational culture and power attributed through traditional beliefs around the status of physicians can become a major

barrier to nurse leader development and empowerment. It is further support for growing evidence in the practice development literature that attendance to contextual factors and forces should start from the very beginning of development and empowerment orientated projects.

Person-centred leadership is a new approach to relational leadership developed in and for clinical nurse leadership practice. The conceptual framework of relational processes and contextual influences, as well as the development framework, offer practitioners, researchers and educationalists two tools for developing person-centred practices.

Discussing worthiness

Chapter 7



INTRODUCTION

It is standard practice, indeed a necessity that researchers reflect on the quality of their work and its contribution to scientific, education and practice communities, i.e. its worthiness. Assessing and/or discussing the rigour of the research implies using a set of criteria. However, longstanding and unresolvable differences in what constitutes good research, between positivist and non-positivist research scholars, has failed to produce a universal set of criteria (Guba & Lincoln, 2005). Whilst many paradigms and research methodologies have developed criteria, there is a lack of universal criteria for action research (AR). Reason (2006) argues that a fixed set of quality criteria for AR is not feasible as many ways of knowing are used and the value of actions and outcomes are determined by participants in their particular circumstances, so no objective account of validity as 'getting it right' can be used. For him,

"Quality in action research [rests] internally on our ability to see the choices we are making and understand their consequences; and externally on whether we articulate our standpoint and the choices we have made transparently to a wider public. (Reason, 2006, p. 190)

Designing a framework to review the study was therefore challenging and I have decided to use the person-centred leadership framework and my philosophical framework to demonstrate the study's worthiness. I interpret worthiness here to mean that a significant contribution has been made to the existent body of knowledge on clinical nurse leadership and practice development, and that methodological rigour was sought as choices made were in line with the philosophical framework and key principles of AR. Contribution of the person-centred leadership conceptual framework is presented first before moving on to discuss the influence of my philosophical framework. A discussion on the research journey then follows, exploring the using concepts from the relational domain of person-centred leadership. Contextual influences are discussed before closing the chapter with implications and recommendations for practice, education and research.

THE CONTRIBUTION

The concept of person-centred leadership is new to nurse leadership and has been inductively derived by studying nurse leaders in practice. Nurse leaders have, until now, had to rely largely on models and frameworks generated within other contexts and professions, which may not include core values and characteristics of the nursing context. The literature review of Chapter 2 identified four core values of person-centeredness. The resulting values framework is new and influenced the development of the person-

centred leadership framework presented in Chapter 6. This framework offers plausible explanations of how and why leader attributes, processes and contextual elements contribute to leadership practice that incorporates person-centred values.

Leadership theory and research often focuses on leader traits and behaviours, neglecting the role of context and the leader-associate relationship (Küpers & Weibler, 2008). This study approached leadership as a relational concept and contributes to relational leadership theory, of which little is known (Uhl-Bien, 2006). It explores the role of aesthetics in leadership and how processes of relational connectedness, as well as contextual forces, influence leader cognition, action and connection with the other and context. Several of the relational processes described have not been discussed in the leadership literature before, for example, sensing and contextualising. Based on existential humanistic values as well as critical and creative theories, person-centred leadership proposes that the primary focus of the leader should be associate coming into own (wellbeing and empowerment). Workplace rather than workbased learning was the approach used to enable its development. It offers an alternative to traditional production-oriented approaches, which are currently being questioned in light of reports such as the Staffordshire inquiry, as the praxiological approach considers the ultimate goal of leadership practice to be for the good of all. This is achieved through relational connectedness and enabling wellbeing and empowerment, rather than relational distancing and ensuring the 'production' of things external to self. The person-centred leadership framework and development framework will therefore be of significant interest to national and local policy makers reviewing desired changes to leadership and its development in healthcare.

Most leadership models portray an image of the leader as one who knows what is 'right' and how to achieve leader/organisational goals. In contrast, the person-centred leadership framework developed in this study reminds us of human fallibility and emphasises the importance of shared visions/decision-making, validating interpretations and showing one's own vulnerability. Valuing equity, rather than equality, partnership is sought rather than hierarchy. Development of the framework included my own experience as an action researcher with no formal hierarchical position within the organisation yet still leading others in an action research study. Action researchers are normally referred to as facilitators of others, not leaders, so this study could raise further dialogue of the similarities and differences between leadership and facilitation, as well as offer action researchers a new perspective on how to lead action research projects.

Practice development theory has tended to discuss facilitation separately from leadership. Practice developer and clinical educator roles tend to be the primary roles referred to when discussing/researching practice development. In the absence of practice developer and clinical educator roles in the research setting, the formal leaders in this study demonstrated how they too can play a major role in developing practice and associate learning within the workplace. This raises questions for future discussion on the level of

active involvement and primary responsibility of formal leaders, such as charge nurses and unit managers, in practice development. Describing facilitators as people (in)formally appointed to enable empowerment in experiential group learning, Heron (1999) also feels that effective managers can facilitate personal development within the workplace. The attributes and skills associated with effective facilitation (Harvey et al., 2002) show great similarity with those of the person-centred leader, which supports a need for the nursing community to engage in dialogue on this area.

Action research is not a popular methodology for studying (clinical) nurse leadership and most leadership development studies use development 'programmes' and/or work-based learning. I approached leader development as workplace learning, enabling individual and collective connection of thinking with doing in order to influence being. Given that this approach appears successful and did not encounter the problems identified by development programmes, the study supports the proposal that leader development may best be undertaken within the workplace, rather than classroom.

Although the use of creativity is not new to practice development, it is new to leadership research. Most leadership theories, models and research only refer to/work with cognition and rationale, leaving creative imagination and embodied/pre-conscious knowing unrecognised. The critical participatory action research methodology and use of creativity was positively evaluated by the participant leaders as they felt supported in exploring new ways of working and pushing boundaries with nothing ever 'imposed'.

WORKING WITH THE PHILOSOPHICAL AND THEORETICAL FRAMEWORKS

7

Defined in three easy to remember statements and visualised as a spiral (see Figure 6 p.58) I found my philosophical framework a practical tool keeping me focused on observing and inquiring into how: leaders and associates relate; relating reproduced/transformed context and; context created conditions that influenced leader relationships. Consideration was thereby given to internal and external influences on leadership such as personal and cultural values and beliefs, structures and conventions. Consequently, the person-centred leadership framework describes leader attributes and processes involved in leader-associate relating, as well as contextual factors.

The philosophical framework also describes how creating critical and creative communicative spaces enables collective inquiry into 'lived experiences' for the generation of transformative knowledge. This influenced my thinking about and design of research activities. The principle of collectivism meant that I needed to be participatory and conduct research 'with' rather than 'on' participants. Previous experience conducting a quasi-experimental quantitative study for my master's thesis had taught me how aiming

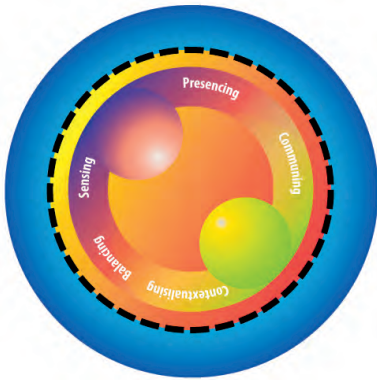
for objectivity and relational distancing between researcher and participant can actually leave the unobserved and unspoken hidden. In quantitative and interpretative inquiry, whilst a change process can be studied and represented, the researcher has no active role in facilitation (Reason, 2006). Critical participatory action research methodology was congruent with my philosophical framework and I was able to facilitate participant individual and collective reflective inquiry into leader relationships, contextual influences and their transformation. In the communicative spaces, lived experiences and observations were analysed collectively, theories-in-use critiqued and propositions from theoretical frameworks considered for relevancy before these/new propositions were tested in practice. The mix of personal perspectives as data increased the robustness of findings. As Winter and Munn-Giddings (2001) state, it is the care and rigour taken to continuously negotiate between different perspectives that gives AR its validity.

As there was no person-centred leadership framework developed in and for nursing to guide our inquiry questions, thinking and doing, there was a risk that we would end up wandering and/or getting lost in side-tracks. McCormack and McCance's (2010) framework on person-centred nursing proved to be a useful tool in the early phases. Whilst we realised that this was the product of studies in nurse-service user relationships, it did offer relevant concepts for us to consider in leader-associate relationships, such as: knowing self, power, working with the values and beliefs of others, levels of engagement, shared decision-making and having sympathetic presence. As the values framework emerged from the literature review, this introduced new thinking about how individualisation and relational connectedness were/could be enacted in leadership relationships. Combined, these frameworks were supportive and not restrictive to inquiry. For instance, moving from creative expression into verbal dialogue, the concepts and descriptors offered a vocabulary to articulate the embedded and embodied in, and meaning of, what we were seeing, feeling and hearing. At the same time, we were conscious of not limiting ourselves to these concepts, so the sensing, contextualising, and communing not mentioned in other frameworks was given space to emerge.

Having discussed the role of my philosophical framework on the study design and process, I now move on to use the new person-centred leadership framework to further demonstrate the worthiness of this study.

The relational domain

The relational domain of the person-centred leadership framework in this study describes leader attributes and processes that foster relational connectedness to enable the associates and leaders to come into their own. As an action researcher, I was in relation with research participants and focused on building partnerships with them. I found that working towards partnership fostered participation, authenticity and required reflexivity. Participation helped me conduct ethical research and generate knowledge that partici-



pants and I considered adequate. In other words, our shared understandings led us to claim that the framework not only has practical and theoretical adequacy, but also demonstrates mutual adequacy. Relational connectedness in our partnership was demonstrated throughout the study with participants and I feeling safe enough to share lived experiences and reflections authentically with each other. Moreover, the trustworthiness of the findings was assured as data were collected from multiple sources, initially critiqued and analysed

collectively in communicative spaces and these dialogues then used in post fieldwork analysis with member checking by participant leaders. Being reflexive included being caring and other-centred in facilitating empowerment, so participants could become the kind of leader they felt was right and good. My experience supports views that the action researcher-participant relationship can be compared to a partnership (Boog, 2008; Bradbury Huang, 2010; Reason, 2006) and is pivotal to validity (Boog, 2008; Coenen & Khonraad, 2003; Waterman et al., 2001) as reciprocal relationships are based on authenticity and mutuality (Boog, 2008).

Achieving relational connectedness entailed continuously sensing where participants were at, contextualising them as unique individuals embedded within multiple social roles and contexts and balancing potentially competing needs. Whilst communing fostered the sharing of lived experiences and reflections and enabled shared visioning and consensus on how to act, sometimes, only presencing was needed to support participants through difficult times and change. I found myself responding to individuals and the context using various stances, constantly reflecting on how my stance could enhance participant empowerment and wellbeing.

Sensing

Continuously sensing where participants, stakeholders and the context were at required gathering information from them personally through communing and/or observing, as well as from other sources. I collected research data overtly and verified interpretations wherever possible. Research activities were created to invite participant and stakeholder sharing of personal narratives, offering me and each other insight into that which could not be seen, felt or heard. Participant observation enabled me to sense what was going on inwardly and outwardly as leaders engaged in their work and the research, and post-observation interviewing gave me the opportunity to inquire after the thinking behind their doing and in doing so support their reflection-on-action.

Being in relation over a period of 3 years, engaging with participants before, during and after daily practice, enabled me to get to know them individually, their history, values, beliefs, preferences and behavioural patterns. As relational connectedness and knowing the other grew, my sensing became more specific and accurate, enabling me to respond 'just-in-time' and/or adequately. It also led me to diverge occasionally from agreed action plans, in response to issues sensed and needs that required action and so prevent potential hindrances to the research process. Examples include the development of a patient dependency and workload inventory tool, or the workshops for Betty and the CNs to work through their emotions after hearing of Betty's displacement. As well as clearing distractions to focus on the meaning and development of person-centred leadership, such activities also offered insight, through reflexivity, into participant being and interpretations of good leadership. My focus was not restricted to sensing and removing obstacles. Blending an appreciative with critical stance, I also sensed and built upon what was working well. For example, the structure and process of the CCRI's worked well for the participant leaders and so we kept the basic pattern and principles but downsized them in a short guideline to support their facilitation of storytelling sessions. Sensing claims and concerns positively influenced commitment and participation. A short-term example was when I sensed withdrawal and/or someone appearing over-challenged during reflective sessions or workshops. I openly shared my observation and started (re) negotiations on how to proceed. By acknowledgement of individuals in this way, a sense of equity needed for partnerships was fostered.

Sensing began immediately and was not restricted to the participant leaders. After introducing myself and the research aims to the whole team, I invited team members to share their hopes, fears and expectations about the project. After verifying interpretations, I was able to rectify misunderstandings, relieve concerns and verify shared hopes before gaining consent to continue with the study. All team members consented, but data gathering was never implicit or covert. My data recording materials (notebook and/or voice recorder) were always clearly visible and verbal consent was obtained each time at the beginning of each session to prevent reliance on tacit consent. Verifying interpretations through member checking and participation in data analyses enhanced shared understanding and authentic conceptualisations of person-centred leadership. Re-presented narratives, such as in the orientation phase, were member checked before being used. In addition, during the action spirals, I fed my interpretations back immediately and leader participants and/or team members were included in data analyses. Participation in data analysis introduced multiple perspectives and helped develop shared understandings. Inclusion of participant leaders in the development of the framework helped achieve mutual adequacy and authentic conceptualisation of person-centred leadership (c.f. Winter, 1998).

Sensing was not just about observation and use of interpersonal intelligence. It involved being authentically other-centred and caring. As a nurse and person, I feel being caring towards others is a valuable attribute and moral obligation. Reading action researcher accounts on the importance of/how to build relational trust, I am often struck by the detached, technical and almost formal perspective taken, for example, drawing up ground rules, establishing written informed consent and participation in research design and action choices. I found that a deeper level of trust is obtained when the researcher is authentically other-centred and caring. Participants will sense and notice researcher intent and whether they are genuinely valued as a person or whether they are just seen as a means to an end, for example, gathering authentic data. It is in this respect that I feel my relational focused reflection in this chapter can contribute to the existent body of action research literature.

I agree with Grant et al (2008) that some researchers may need to unlearn 'distancing for objectivity'. This was true for me in that I had to unlearn this distancing role acquired during my previous research experience, and I had to learn to accept that my natural tendency to be caring was of value in the researcher role. Being authentic, caring and other-centred created an interpersonal space for participant leaders and I to feel safe, enhancing our willingness to share intimate and emotionally laden narratives. We were prepared to show our vulnerability, which added depth and scope to the data. The caring I felt towards them was not parental or protective, more a presence.

I further justify my caring research role by referring to the work of others. Caring as a value and activity is not unique to nursing (McCance, 2003) and is often viewed as intentional and authentic interaction nurturing growth in the other (Freshwater & Cahill, 2010). Leslie & McAllister's (2002) encourage critical social nurse scientists to make good use of their 'nursedness' (competences particular to nursing practice) to enhance researcher-participant relationships. However, my own experience suggests that guided reflection to maintain awareness of possible over-relating is necessary to avoid compromising the critical stance. Documenting my thoughts, emotions and actions in a research journal, as well as sharing them with supervisors and/or my action learning set, created conditions for me to remain reflexive throughout the study.

Contextualising

Being in relation and building relational connectedness also involved getting to know participant leaders as individuals with a unique history, a particular set of values and various roles and contexts influencing their being. Knowing the particularity of each individual helped me understand each person better and so individualise my facilitation. For instance, I observed a discrepancy between how CN Loes related with and talked about associates. She was perceived by associates as a strong and decisive leader, but one who showed limited emotions which gave people the impression that she was less

caring than her colleague CN. This was in contrast to the person I saw and heard, who worried about staff and did her utmost to make things easier for them. However, there was a history attached to her appointment within the ward that explained her distancing. Seeing and understanding her in context, I was able to draw out events and expressions for reflection, supporting her in what was, at times, a painful journey of self-critique and discovery.

At a group level, contextualising helped me to see and understand the pressures placed on participant leaders by contextual structures and expectations. My own contextuality as a nurse and educator helped me use personal and professional knowledge that I blended and melded with social science theory to make methodological choices, build relational connectedness and grow as an action researcher. Nurses' reluctance to read English language literature and use of theory in practice was a phenomenon I had experienced before as a clinical educator and university lecturer in both the bachelor and master programmes. I was therefore not surprised to encounter this again within the research setting. However, drawing on experiences of working with creativity and non-conventional methods of data collection, as well as theories on adult and active learning, I was able to be responsive to participant abilities, capacity and needs. I knew that reflective journaling would probably not be welcomed with enthusiasm, but I also knew that nurses like to talk. I decided to create safe, critical and creative spaces for communing and storytelling as a means to collective inquiry. These were welcomed as working flexibly and creatively with what they did know, were interested in and capable of doing, fostered shared ownership, relational connectedness and commitment. Support such as short guidelines, role modelling and verbally explaining things also helped participants develop research and cognitive skills that they used in leadership practice. Creating evaluation systems also provided participant leaders with information that triggered inquiry questions, and so the interdependent relationship between contextualisation and relational connectedness, set out in the person-centred leadership framework and elsewhere in the literature, was mirrored in my relationships with participants.

Balancing

Being reflexive often entails balancing potentially competing needs and is intricately entwined with sensing and contextualising. I found myself constantly balancing participant leader and/or local stakeholder needs with my own, and that of research rigour. In the initial meeting with the nurse manager, sector manager and head of education, I sensed a desire for a maximum return of investment in terms of profiting the whole organisation. However, I was concerned as a novice action researcher that if the scope of the research setting was not bounded I would have less time and space for personal learning and the depth of data would be compromised. Negotiating a global plan, we managed to balance needs by agreeing to conduct the study on one ward. However, all activity designs

such as processes used and workshops guidelines, and knowledge generated would be made freely available for other wards within the organisation. We also agreed that sharing with other organisational members/wards would be an 'insider' responsibility as this would both foster embodiment of what was being learnt and probably be better received if participants themselves did the sharing. Betty was very active in sharing with her colleague nurse managers what we had done and learnt. The CNs used the knowledge and skills they had acquired and shared their experiences on an internal management development programme with other CNs from the organisation.

Shared decision-making and being conscious of not 'imposing' my own ideas and interests helped balance needs too. Whilst I would offer suggestions and pose increasingly challenging questions, the activities we undertook were the result of shared decisions. Reflecting before and in-action, I would use personal knowledge and member checked interpretations to consider the needs of myself, research rigour and participants, as well as possible consequences. This resulted in, sometimes, being more persistent in promoting my own ideas and suggestions. At other times, I would take a step back and observe what emerged. Being reflexive, I was working towards the empowerment aim of action research.

Some situations, such as the displacement of Betty, were complex and/or emotionally charged. The use of hierarchical power touched me as a nurse who believed strongly that nursing was a profession independent from, but equally as important as, medicine and management for effective healthcare. It also touched me as a researcher as I was concerned about beneficence. Had my role and/or the study caused harm? My primary thought was to approach the physician and sector managers directly to discover whether and how I and/or the research had contributed to their decision. Whilst this may have met a personal need for clarity and provided valuable research data, I had to consider the possible consequences for those involved. I felt a moral responsibility to share my thoughts and ideas with Betty first as she was already in a vulnerable position. She agreed that pursuing an interview with the managers could offer relevant research data, but she was also convinced that my presence and the research had only exposed, and not created, a troubled relationship. She had no regrets about participating in the study, but neither did she want to actively pursue finding a resolution for this problem. She also feared potentially negative consequences for the study's continuation and the CNs sustained development. We therefore agreed that whilst interviews with management would not be avoided, neither would they be actively sought. My actions and decisions reflect Coenen and Khonraad's (2003) belief that balancing needs, explicitness and negotiation are valuable principles for action research as they foster the relational connectedness needed for ethical research. On the other hand, the absence of the physician and sector manager voice could be a point of critique. Bringing differing views into an open communicative space for contestation and debate strengthens the trustworthiness of

the research findings (Winter & Munn-Giddings, 2001). This study shows how difficult or sometimes impossible this can be, when ethical principles are in conflict with data rigour.

Communing

Communing enabled us to identify common grounds, create shared visions and/or make shared decisions. The trust and equity created through relational connectedness fostered authenticity and depth of data collected. As we were engaging in an action research study, communing tended to be more action orientated than dialogue is usually considered to be. In our communing, individuals were actively listened to with emotional attentiveness and consideration given to any actions deemed adequate.

Communing is most effective when frequent and regular. Weekly meetings with Betty, in which we discussed ways of moving the research forward, had the advantage of combining her local knowledge with my theoretical knowledge. The biweekly CCRIs enabled cumulative development of a shared understanding of person-centred leadership that was not disconnected from practice. Referencing back to previously established mutual understandings, we were able to test them by applying them to new narratives and so refine, discard and/or add to them. Maintaining a critical stance and introducing propositional knowledge also helped reveal false-consciousness at individual and group level, thus raising analyses above a common-sense level.

During post fieldwork data analysis and theorisation I maintained contact with the participant leaders. We would meet so that I could share findings of the thematic analysis (see chapters 4 and 5) and the person-centred leadership framework (see chapter 6). Texts were translated back into Dutch and/or explained in Dutch to minimize misunderstanding, and we would discuss the degree to which the frameworks reflected their experiences and interpretations. As communing was not limited to fieldwork, continued discussion, contestation and debate helped ensure mutual adequacy of the final product.

Presencing

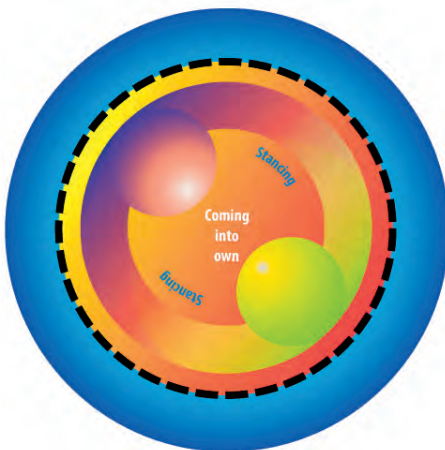
In this study, presencing as other-centeredness was a process of 'active support' rather than action. The simplest way of describing it is being with and/or thinking with the other. I initially had concerns about the proposed internal education programme as I did not see how this would contribute to the exploration and development of person-centred leadership. It arose from a conclusion that specific nursing knowledge among team members was insufficient for the increasing complexity of patient problems. I was also concerned that it would consume a lot of participant leader time and energy that would otherwise have been channelled into the other action spirals. Aware of the egocentricity of my thinking, I made a conscious effort to listen and think with the leaders as they discussed the feasibility of the programme. As I listened, I was struck by their approach to the schooling as a project. There was no consideration of didactical principles or learning theories, and

they seemed to rely on those traditional methods of passive education familiar to them. I knew that such methods were the least effective in changing professional behaviour (c.f. Bero et al., 1998). Balancing needs and reflecting on potential consequences, I decided to be actively present rather than action-oriented. I responded openly and honestly when asked for my opinions and I critically questioned their plans. I was honest in sharing my concern that if I were to become too involved, my enthusiasm would deter me from focusing on the research needs. By critically questioning the status quo, my role in the process and my interpretation of the situation, I was following an advised rule of thumb promoted by others, e.g. Boog (2008) and Coenen & Khonraad (2003). The result was that the internal education programme was not included in the research activities, participant leaders were careful in asking for advice and not help, and they occasionally used the CCRI space to reflect on events in and around the education programme. Presencing in this way fostered reciprocity.

Stancing

Understanding reached through sensing, contextualising, balancing, communing and presencing, helped me decide how to position myself in relation to individuals, the team and context. The educational programme was one example of me changing stance, stepping back without losing connectedness. At other times, I led more from the front, such as drawing up structures and guidelines for the CCRI. Although I used all four stances constantly, and was reflexive in positioning myself, knowing about the four stances as I now do could have improved the efficiency and effectiveness of their usage. At the time, I was learning about being an action researcher and leader and the four stances were not named until the post fieldwork data analysis.

Like all relationships, the action research relationship evolves constantly. During the orientation phase I was relatively silent, creating space for participant voice to take centre



stage. In the beginning, participant leaders were naturally uncertain as to whether they were doing and/or saying the right thing, and when asked, I would remind them that this was all new to me too. As I observed them becoming more confident and assertive, I started to introduce my own voice. To have made my own thoughts and interpretations known too early may have recreated in our relationship the kind of leader dependency being observed in their relationship with associates. Titrating my own input to be in balance with theirs,

'power with' became the norm in our relationship, rather than the 'power over' participants that action researchers such as Boog (2008) and McCabe (2009) warn us about. That leader participants felt on equal par with me could be deduced from their challenging of my interpretations and suggestions, even subtle suggestions I made and which they did not agree with or questioned.

Stancing was individualised to the person and particularised to the situation. In new situations I was often leading from the front, but consciously aware of trying to move through the other stances in order to lead from behind. The person and situation determined the speed at which this could take place, and movement between stances was not linear, often moving back and forth. For instance, I was the constant facilitator of the CCRI sessions of action spiral 1, despite numerous invitations for the participant leaders to facilitate. That the leaders continuously turned down my invitations started to concern me as my intent was to enable them to learn and practise facilitation within the safe environment of our CCRI's so that they would build confidence and start to facilitate the storytelling sessions of action spiral 4. Sensing their reluctance I tried various strategies to encourage and support them, trying to move myself into a stance of leading from the side-line and alongside. Eventually, after openly sharing my concerns, we communed, balanced needs and agreed to prioritise my skilled facilitation of the CCRI's above the development of facilitation skills. Storytelling sessions did begin, later than I had originally hoped, but they started when the CNs felt that they were ready and I was able to move quickly from role modelling the first sessions (leading from the front) to offering feedback and support during post-observation interviews (leading from the side-line and alongside) and onto leading from behind where I was no longer present during the storytelling session and conducted post-observation interviews after listening to the recorded sessions. This demonstrates the importance of relational connectedness in enabling the empowerment of others and how working with the relational processes can achieve shared goals in a person-centred manner.

Recording objective descriptions of observations in a separate column to personal thoughts and interpretations, and reading my notes before entering post-observation interviews, were effective strategies for identifying my own prejudices. They helped me create time to reflect on which questions I could ask and how to phrase them so as not to come across as being judgemental. Meetings with my supervisors and my own action learning set also helped self-reflexivity in this respect. A combination of all these strategies with my willingness to show my own vulnerability and seek authentic feedback from participants, formed a 'technology of self' (c.f. Flaming, 2006) that enhanced my self-awareness and practice as an action researcher.

Coming into own

Coming into own was a term frequently used by participants to describe moments and experiences of feeling good, when things feel right, a greater sense of wellbeing, empowerment and self-actualisation. I experienced these moments too. I had learnt about myself and how not knowing or understanding something creates an inner physical and cognitive turmoil in me that can manifest as appearing withdrawn, impatient and/or negative. This self-awareness helped me use my emotional intelligence. It taught me that if I shared my unrest and frustration, I would be revealing my vulnerability and fallibility, so that others could understand where I was in my being at that moment. Participant leader descriptions and evaluations of my leadership revealed how they appreciated my openness, accepted me for who I was and felt that I was being person-centred.

I felt that I had been successful in enabling participant leaders to overcome barriers and build on strengths to find a style of leadership that they felt was an improvement on their previous styles. The experience of being observed and facilitated in conducting an inquiry into their leadership was new to them, but, they evaluated their experience of me observing and helping them as highly effective. They had been personally and professionally transformed, no longer the same as they were and unable to return to that state of being. They had become more self-aware and reflexive and demonstrated self-determination. I had been successful in becoming an action researcher and achieving the aim of enabling empowerment. In light of the way contextual influences were responded to, I would not be so bold as to claim that emancipation was achieved. 'Power over' was still an intergroup issue. Feeling unable to truly come into their own within the context, all participant leaders have since left the ward, but they have continued their transformative journeys in becoming person-centred leaders elsewhere (see Epilogue).

Neither can I claim that human flourishing took place during the study. Whilst coming into own resonates with the term human flourishing, only moments of coming into own were identified and not a sustained state.

Summary

In this study I found the leader attributes and processes of the relational domain of the person-centred leadership framework supported me as an action researcher in working towards relational connectedness within the researcher-participant relationship. Relational connectedness was conducive to generating knowledge of mutual adequacy because I made a conscious effort to build relationships that lived the value of equity, and to blend knowledges from different sources.

Sensing was not only about gathering information/data, analysing it and member checking interpretations about how the leaders and context were changing, it also involved noticing those moments when a caring and flexible response by me was needed to support individual and group transformation. Building relational connectedness

was aided by understanding the influences on individual and group being, and being reflexive in balancing competing needs. Reflexivity raised my own awareness of my own being in relation and power within the relationship, helping me choose stances that were adequate for that moment and those individuals, groups and/or context involved i.e. fostered moving through different levels of engagement. Communing enhanced openness and trust for the creation of shared visions and decisions, so that the research activities produced practical and theoretical knowledge that were mutually adequate. No one stance for being in relation with participants was used as I responded to the individual and particular values, beliefs, needs and circumstances.

Although discussions on the researcher-participant relationship in action research are not unique, I have not encountered many publications that describe the concept of relational connectedness and/or the attributes and processes for achieving it. This may be because most action researchers consider themselves to be facilitators rather than leaders of the research project.

The contextual domain



In this study we found that the interactions taking place within the relational domain were influencing the elements of the contextual domain and vice versa. This was evident in leader-associate relationships and in the researcher-participant relationships. For instance, leaders took their lived narratives into safe, critical and creative spaces for individual/collective reflection, the outcomes of which influenced their being. Similarly I took my narratives of facilitating an action research into guided reflection with supervisors and my

action learning set, the outcomes of which influenced my own being as an action researcher. The outcomes of evaluation systems influenced the way leaders interacted with associates and I interacted with participants. Transformative learning took place as safe, critical and creative spaces were created regularly and opportunistically, and were at times political as the status quo of practice, policy and culture was challenged. For instance, the PNs were very keen to liaise with the human resource department to formulate a job description, fearful that if they did not act politically now the future of their role

could be weakened. As an action researcher, I needed to be aware of such influencing in order to collect data and consider facilitative responses.

Creating safe, critical and creative communicative spaces

The aim of creating safe, critical and creative spaces was to enable workplace adult, active, social, experiential and transformative learning through enlightenment to and reflection on the values, beliefs and structures enabling or hindering a more person-centred approach to leadership. This generated practice knowledge on person-centred leadership, which was later blended and melded with propositional knowledge to create a conceptual framework of mutual adequacy.

Sometimes the spaces created were regular and structured, such as the CCRIs of action spiral 1. At other times, they were incidental and/or responsive to current events, such as the visioning workshops or those created to support Betty and the CNs work through emotions aroused by Betty's displacement. Working with the principles of criticality and creativity enabled Apollonian and Dionysian inquiry (c.f. Reason, 2006). Apollonian inquiry is characterised by rationality, linearity, being systematic and explicit. Dionysian inquiry is characterised by imaginativeness, expressiveness, spontaneity, spiralling of learning and development and use of tacit knowledge. Combining the two had a positive influence on energy levels and depth of inquiry as embodied, preconscious and cognitive knowing and practitioner theories on leadership was surfaced, shared and critiqued until shared understandings emerged. Collective reflection took place on whether, why and how the leadership described in narratives could be considered person-centred, or what would be needed for it to be considered person-centred leadership. I used my practical knowledge of facilitating guided reflection, facilitation theory and reflection models, to help me structure the spaces, determine my stance and formulate facilitative questions to support the inquiry process and so generate practice knowledge for testing in my own and participant leader practice. This critical and creative cyclical approach to inquiry enhanced the trustworthiness of the data before it underwent post fieldwork analysis.

Inadequacies and/or limitations of espoused theories held by leaders were identified and/or reviewed in the communicative spaces. For instance, participant leaders' explanations for predominantly leading from the front were often attributed to factors external to themselves. Critically questioning assumptions underpinning this explanation, exploring alternative explanations and alternative stances used by the participant leaders in similar situations in the past, fostered enlightenment about factors internal to the participants themselves. As new assumptions were tested for practical adequacy, the realisation came that other forms of stancing can be equally effective when tailored to the individual, situation and leader intent. Lifting our conceptualisation of person-centred leadership out of the local context and comparing it with existing propositional knowledge, a conceptual

framework of person-centred leadership emerged with mutual adequacy, i.e. considered to have practice and theoretical value.

As a researcher I found posing critical questions challenging as it requires not only being attentive to what is said/read and the interpretations being presented/I was making, but also being attentive to the intent of my questioning. Was I remaining open to emergent understanding, or was I directing the communing along a path I felt should be taken? Psychological safety within the communicative spaces was an important condition as it fostered authenticity and criticality. Intragroup relational connectedness and a sense of a common purpose contribute to psychological safety. This demanded more than technical actions such as collectively agreeing ground rules on confidentiality, or working in a closed room so that discussions could not be overheard. Interpersonal skills and a caring attitude towards each other, and balancing challenge with support, enabled participants to trust that they could be their authentic self. However, such intragroup relational connectedness and sense of safety had potential disadvantages. A group boundary was being created which excluded rather than included others. I challenged the group boundary being formed around the CCRIs when I suggested Fleur was included in the group as a participant even though she was initially acting/ad interim CN. I suggested the same when the PNs were appointed. Each time I encouraged the existing group to explore reasons and possible consequences of (not) including these others, and each time a shared decision was made to invite them to participate in the CCRIs. In doing so, the principles of collaboration, inclusion and participation of practice development and CPAR were being considered in the context of particular situations before being enacted. This also contributed to building leader reflexivity and the sense of mutuality characteristic of relational connectedness and partnership.

Caring, facilitated criticality enabled transformation from the inside out as participants explored their thinking and doing. Learning was not just a means of generating practice knowledge of what person-centred leadership was, it was also a journey of self-discovery and empowering. Working with creative expression such as sculpturing a tableau vivant, helped surface pre-cognitive and embodied knowing. Asking people how it 'felt' to be in the sculptured position introduced other sensory information into the dialogues. Reflecting collectively raised awareness to how individuals can perceive the same situation differently, supported the blending and melding of multiple interpretations, and brought themes to the foreground that may otherwise not have been identified if only the written/spoken word had been used. Working with multiple forms of knowledge enhanced the worthiness of the findings, especially as this was continued into the post fieldwork analysis where I continued to use creativity to help surface my preconscious and embodied understanding of the data to then be blended with, and melded onto, my cognitive understanding.

Evaluation systems

Various evaluation methods and sources were used to identify change progress and issues requiring action during the study. Data were collected from participant leaders to evaluate their lived experience of the research process and my facilitation/leadership. Often group interviews were conducted at the end of activities. Other group interviews were organised specifically to evaluate the whole study progress and facilitation. One group interview was facilitated without me being present. A colleague of mine from the university with no ties to the unit, created a critical and creative space for associates to freely and confidentially evaluate participant leader leadership. They agreed for me to have access to the interview transcript, which I transcribed and represented as a narrative text. After member checking the narrative text, they also agreed that the participant leaders could receive this. Such ethical treatment of participant data was consistent throughout the study, further contributing to the study's worthiness.

Guba and Lincoln's (1989) claims, concerns and issues structure was often used to guide evaluation data collection. It created space for any and all claims and concerns to be shared so that identified positives could be continued and/or built upon, and negatives refined and/or removed/discontinued. This could include social structures, conventions and practices, or values and beliefs. The PNs used the claims, concerns and issues structure in their biweekly meetings where they used personal experiences and feedback from other stakeholders to evaluate the implementation of the new nursing system and their role. With an open approach and consideration of both positives and negatives, they were able to tailor and ease implementation of the new nursing system, as well as develop their new role and being within it. This supported their empowerment as they demonstrated self-determined influence of their working environment, did not only include their personal perspective, and so met the aims of CPAR.

Each evaluation strategy was tailored to the purpose and intent of the evaluation (for example, the PN evaluation of the new system and their role described above) and used a method of data collection that was appropriate for the purpose and context. Space was created for collective reflection on data wherever possible, for example, when associates and a CN participated in the interpretation of an evaluation questionnaire. Sharing multiple interpretations and perspectives so close to events, and with people familiar with the context and situations embedded in the data, increased practical adequacy of the initial findings. Taking these initial interpretations into the post fieldwork analysis helped me protect participants' voice. My philosophical framework was not positivistic (seeking absolute truths), so patterns and tendencies were sought. As the participant leaders member checking my final analysis were familiar with most narratives and events referred to in the findings (see Chapters 4 and 5), this cascade of analysis with participant involvement positively influenced the trustworthiness of the final results.

Organisational culture

My philosophical framework drew me to consider the role of context in the exploration and development of person-centred leadership. Deciding to use participant observations in the orientation phase offered me insight into structures and conventions. Working with participant narratives offered me insight into how the idio-cultures within the unit were experienced. Awareness of different idio-cultures helped me be sensitive in my presence and facilitation. For instance, aware that associates were experiencing a high workload and insufficient staff, I was flexible and creative in negotiating when and where research activities took place, so as not to disrupt ward routines and patient care. Longer activities usually took place at the end of a day shift and some shorter activities, such as the story-telling sessions, were integrated into the existing structures, such as the daily evaluation sessions. Being flexible and working with existing structures and conventions helped maintain commitment throughout the three year period as associates experienced the benefits of participation without this interfering with their work.

Aware that the physician manager saw himself as ultimately in charge of and responsible for the whole unit, I was conscious of trying to keep communication channels open. I was explicit in my willingness to inform him and the physician team of, and/or include them in, research activities. However, these offers were seldom taken up and requests to become involved never materialised. As the focus of my study was clinical nurse leadership, I did not feel inclined to push for physician involvement. When we met unfounded accusations and scepticism about changes taking place within the nursing idio-culture from the physician team, and physician manager in particular, it became difficult to try and maintain progress. I was conscious of how I shared my personal views on physician-nurse relationships, wanting to raise awareness to the possibility of this being problematic, without being persuasive. Concerns that I was being persuasive were alleviated as participant leaders did challenge my interpretations at times, and offer alternative interpretations of events. I felt confident that we were reaching shared understandings on the basis of equity. My approach generally was to listen to and acknowledge participant leader interpretations and offer a counter perspective substantiated by examples and quotes. Focusing on forms of power in the relationships did raise participant leader awareness to this in both their relationship with the physician manager and physician team, as well as with associates. Power is an issue that should be addressed when encountered in CPAR in order to achieve the aim of enabling participant empowerment.

Unfortunately, the physician manager and some members of his team started to employ strategies to regain power over the nursing team and idio-culture. The sector manager remained relatively silent and passive. It took courage and reflexivity from the participants and me to work with these power issues and continue data collection and development until the agreed end date. I feel that it was relational connectedness and consciousness raising about power relations that helped maintain participant leader com-

mitment to the project, and enable their resistance to and neutralisation of the physicians' attempts to re-establish their old power over the nursing team. Although a challenging period, the participant leaders were pleased with, and proud of, their empowerment in dealing with the situation.

Other stakeholder needs

Awareness of the interconnectedness between different participants, stakeholders and idio-cultures helped me conduct ethical research, enable transformation and enhance the trustworthiness of findings. How different stakeholder perspectives were included in the data and analysis has already been discussed above. However, this study did not just include other stakeholder perspectives. As other-centeredness and working with the values, beliefs and needs of others is inherent in person-centred leadership, it felt natural to also consider differing stakeholder needs in relation to the research itself, its aims, design and how activities are conducted. Being flexible and creative in planning and conducting research activities have also been described above in relation to organisational culture. Trying to meet the needs of the hospital were discussed in the section on sensing. My own reflections on how I worked with participant leaders demonstrate how I tried to work with their values, beliefs and needs, and I experienced reciprocity from them in this respect. There were times when they too would adjust their agendas to meet my needs. Worthiness is thus demonstrated in terms of living the principles of critical and participatory research.

Reflecting on why and how I/we tried to work with other stakeholder needs, I was reminded of the idiom: You can please some of the people some of the time, but not all of the people all of the time. Various factors influence whether and to what degree the differing needs of others can be met, for example, the factors time and the focus of the research questions. An example would be the participant leaders' initial desire to develop person-centred nursing within the unit. This was not the primary aim of the study and so influenced the degree to which I focused on facilitating and inquiring into its development. The conflict between the participant leaders and physician manager could also be viewed from a needs perspective. Were his needs being met and/or sufficiently attended to? The answer is probably 'no'. The primary reason was the focus of the study: exploration and development of person-centeredness within clinical nurse leadership. Secondly, as the physician manager did not demonstrate a desire to become more involved, time would have been needed to build a collaboration with him. In hindsight, I could have been more active from an early stage in including his perspectives and needs into the study, as well as encouraging and supporting communing between him and the participant leaders. However, the question remains whether or not he would have attempted to take control over the study and actions, how I/we could have worked with such a phenomenon and still made significant progress on other fronts. This study has

made me question whether such a strategy would have prevented the breakdown in relationship between the physician manager and nurse leaders without jeopardising the enablement of their empowerment in such a situation. The event occurred in a specific context with specific individuals, but a plausible explanation was drawn from existing theory and research and many third persons have shared that the account of events has strong believability. I feel that there is a need for more research into how an 'outsider' action researcher can start to work with this sensitive issue early on in the research process. This would preferably be nursing research, in contexts where nurse leaders have become accustomed to higher management/physicians exerting power over them and where the action researcher seeks strategies and/or creates conditions for an attitude of 'power with' replacing 'power over'.

Summary

This action research study demonstrated how events within the researcher-participant relationship influenced and were influenced by contextual factors. Including contextual data and multiple stakeholder perspectives enhanced the trustworthiness of the findings, as did working with multiple forms of knowledge such as experiential, practice, practical, preconscious, embodied, cognitive and propositional knowledge. AR aims to generate knowledge of mutual adequacy through enabling and studying change. Attending to contextual factors helped the facilitation of participant leader transformation. Facilitated safe, critical and creative learning spaces meant that participants could use multiple forms of knowledge and multiple perspectives to generate and test practice knowledge on person-centred leadership. Lifting the findings out of the local context and discussing them in light of existing theories and research, resulted in a framework for person-centred leadership which could be considered to have mutual adequacy.

Psychological safety was an important factor for learning and authentic participation in the inquiry process and both a technical as well as relational approach was taken to develop this. Evaluations of the research process, facilitation and participant leadership, were gathered with care from multiple perspectives and used to help participant leader's exercise control over their working lives (become empowered). Insight into the different idio-cultures and stakeholder needs influenced how I as the action researcher facilitated the process and which issues I brought to the table. The exercising of power over the participant leaders by the physician manager and physician team was a big challenge in terms of how to approach this, and raises questions for future research in developing clinical nurse leadership.

IMPLICATIONS AND RECOMMENDATIONS

This critical participatory action research study has produced a conceptual framework for person-centred leadership and its development. The framework could be a valuable tool for practice, education, policy and research. Inductively developed using lived experiences, existing theory and research enhances its transferability, but I appreciate it was based on the findings from one research setting. The first recommendation, therefore, is that the framework should be implemented and researched by other practitioners in other settings. However, it should also be noted that the framework was constructed on the assumption that social contexts and human agency are dynamic, so they are never identical from one moment to the next or one location to the next. I thereby recommend that further developmental work be facilitated by using participatory action research or practice development methodology. By doing so, the myth that social 'facts' derived from one study can be simply 'applied' by other practitioners and organisations (Susman & Evered, 1978) will be avoided. Action researchers may also consider using the relational processes of the framework to enhance the researcher-participant relationship and inquire into whether and/or how this contributes to depth of authentic data and participant empowerment.

The term 'coming into own' was chosen for leader aim and outcome of person-centred leadership. This was due to only moments of wellbeing and empowerment observed/reported. However, I see a potential that in more supportive contexts, leaders and associates may experience human flourishing. Further research using a critical and creative philosophy and methodology (Titchen & McCormack, 2010) could help explore how creating conditions for flourishing enables person-centred leadership.

This study focused primarily on the exploration and development of person-centred leadership, and nurse leaders were the primary source of data. I recommend future researchers also focus on associates' lived experiences of person-centred leadership and how associates influence leader being. This line of study could use and contribute to relational leadership theory and person-centred practice theory. As the conceptual framework shows greater congruency with the four core values and 12 descriptors of person-centeredness presented in Chapter 2 than other leadership styles, I would also suggest it be tested as an appropriate enabling factor for the development of effective workplace cultures (c.f. Manley et al., 2011) and/or the development of person-centred care (c.f. McCormack & McCance, 2010).

Whilst the primary participants in this study were the UM and CNs, I would not recommend placing a 'managerial' or formal leadership boundary around the framework but introduce it to all those engaged in leading others. Many leaders in practice, like the PNs in this study, do not hold managerial or formal leadership positions within an organisation organogram. Participant Anne also felt that person-centred leadership was relevant

to her role as clinical nurse specialist, and as leadership is a core competency of advanced nursing practice (Hameric et al., 2009) the framework should be of value to advanced practice nurses.

In the wake of incidents such as those in the Francis Report, there are growing concerns that current healthcare leadership has resulted in a situation where (in Habermasian terms) leader focus on the system has overshadowed the lifeworld and led to a dehumanisation of healthcare. The person-centred leadership framework offers a viable practical tool to help healthcare leaders regain balance as they focus primarily on persons without disregarding the context. To develop person-centred leadership I recommend using the principles of workplace learning, as traditional work-based development programmes are failing to be as effective in enabling healthcare cultural changes as initially thought. A workplace learning approach would obviously have implications for practice developers, clinical educators and academic institutions. However, deciding to develop leadership through workplace learning would probably stimulate stronger collaborations between practice and educational organisations, a desire that has repeatedly been voiced by many for many years.

As well as the graphic representation, the photo image and dance metaphor could be useful in introducing leaders to the complex dynamics of person-centred leadership, especially where reading the thick descriptions of each process may be an issue. In this respect the presentation of person-centred leadership has been considered with user (practitioner) friendliness in mind. The elements of the framework can also be readily translated into questions to support leader reflection. For those wishing to facilitate others in becoming person-centred leaders, I would also recommend the use of CCRLs (Cardiff 2012) as an innovative alternative to action learning.

CONCLUSION

In this final chapter I have presented the contribution this study makes to the body of nurse leadership knowledge, reflected on the research process and made recommendations for practice, education, policy and research. In doing so, I hope to have demonstrated the worthiness of the study convincingly.

The study produced a values framework for person-centred practice and a conceptual framework for person-centred leadership with a development framework embedded within it. The new approach to clinical nurse leadership was inductively developed within a nursing context using multiple forms of knowledge and multiple perspectives to enhance trustworthiness. Participant involvement in data analysis during the fieldwork, member checking post fieldwork thematic analyses and reviewing the theorisation of findings, enhanced the mutual adequacy of the resultant conceptual framework.

The detailed description of processes contained in the relational domain make a contribution to current relational leadership theory and have the potential to spark new thinking about the nature of the action researcher-participant relationship. Using the relational processes described in the framework, I found that, as an action researcher, sensing where participants and other stakeholders were at, getting to know them embedded within multiple social contexts and embodying various social roles, as well as balancing competing needs, helped me stance myself ethically in relation to them and choose appropriate interventions to enable participant empowerment. Communing and presencing also helped create the sense of equity characteristic of partnerships, which action researchers are advised to seek.

The person-centred leadership focus on enabling associates to come into their own is timely, in light of recent concerns about healthcare leadership and calls for leaders to focus more on leader-associate relationships, associate wellbeing and empowerment, rather than on blame and production. Person-centred leadership offers those wanting to develop person-centred practices and effective workplace cultures a viable alternative to existing leadership styles, as it was developed within healthcare and shows the strongest match with the four values and 12 descriptors of person-centeredness. However, as this is the only study to date on person-centred leadership within a healthcare context, further testing and development is recommended, using critical and participatory research methodologies.

Studying leadership through an action research methodology is not common and using creativity even less so in leader research. Both were found to be very effective in this study. The use of creative expression helped participant leaders surface embodied, preconscious and difficult to verbalise knowledge. The cyclical and critical participatory nature of the research methodology helped participant leaders and I generate practice knowledge that had been tested in our own practices. The methodology was also conducive to workplace learning where leaders are facilitated in connecting their thinking with their doing in order to influence their future being within the workplace, using actual experiences and available tools and resources. Workplace learning could be an effective alternative to the current trend in development programmes and work-based learning, with its disadvantage of academic awarding requiring completion of time consuming assignments and frequent visits away from the workplace. However, closer collaborations between academia and practice institutions will be needed to utilise the best of both fields in the development of healthcare leaders in the workplace.

In short, the study has used an innovative approach to developing relational oriented clinical nurse leadership and generated a conceptual framework with practical and theoretical adequacy. It has the potential to contribute to associate, service user and organisational wellbeing where person-centeredness is seen as a desired goal.

All's well that ends well

Epilogue



INTRODUCTION

At the last interview during the field work in October 2010, Betty was leading the hospital wide homemaker team, Loes had announced she was intending to leave to start her own business, and Fleur felt she was the only one left to continue the work on person-centeredness. This epilogue brings the picture up-to-date.

In January 2014, four weeks before submission of this thesis, Betty, Loes, Fleur and I met to discuss the content of this epilogue. Using an open interview technique I invited each to share what they wanted to be included in the epilogue, the messages they would like to leave to round the whole narrative off. Each interview averaged 58mins. As I listened to all three audio-recorded interviews I summarised what was being said as well as transcribed a verbatim sections I felt held a strong message. Rereading the transcripts, I identified three key areas common to all three narratives. *The demise of person-centeredness within the context* is the participant leaders' account of how and why person-centeredness did become embedded within the ward culture. *The continued living of person-centeredness within the person* confirms the continued living of person-centeredness in each leaders being. *The need for a sparring partner* was something each leader missed and felt would help them to continue to be, and become, person-centred leaders.

CURRENT STATUS

Betty has since become sector manager in a large multi-centred organisation providing care for people living with learning disorders of all degrees. She leads four care teams based in four homes accommodating 12 clients each, as well as the medical team of specialist nurses and physicians providing care across the whole organisation. Loes now runs her own business offering day care to people living with dementia in the community and has 18 members of staff, at the moment. Her initial location offers care to 12 people per day, five days a week, the second day care centre is momentarily open 1 day a week. She has just finished renovating a Victorian villa which will become a home for 8 people living with dementia, where 24 hour care will be provided if and when a resident chooses. The vision is that residents will remain there until their death. Fleur now leads a team of 13 community nurses and carers who are just one of several community team attached to a large organisation offering living, rehabilitation and community care to the older person in particular. Approximately 30% of her role is spent providing direct patient care and the remainder developing the organisation's vision for self-directed teams and client-centred care.

THE DEMISE OF PERSON-CENTEREDNESS WITHIN THE CONTEXT

Loes' decision to leave her post as CN within the research setting was motivated more by the pressure to lead in a way she could not believe in than by her dream to start her own day care service. An organisational culture was developing where CNs were expected to manage, rather than lead others, and wards were expected to become small businesses and be performance orientated. Production and finances took centre stage, with a focus on throughput, reducing nursing hours and delaying replacing those off sick. Loes didn't believe that less contact with patients and staff and more administration was the right way forward for the CN role. This translated into continued/increased difficulty in collaborating with Clive, and magnified by the arrival of a new unit manager Clare, and CN Anita. Although Loes had space to lead, there was no trust or support from Clive or Clare that Loes' vision of person-centred leadership was, or could be, effective and efficient. Clive in particular began interfering with the running of the ward and staff, asking people, "Why are you standing here doing nothing?" Loes found herself having to take a stand: "Should you be doing this? Keep your peace, go into your office and do your own work. This is my work."

The weekly lunch meetings with Clive were tense, and Loes felt that whilst he wanted to know everything, he gave nothing. His only interest seemed to be telling the CNs what they could and couldn't do. The threat to destroying everything they had worked for was too much for Loes.

Loes: "The ward was in a bad place when we began and we invested heavily in people, and eventually everyone worked very hard but with a lot of pleasure, and it worked."

Since her departure, Loes has heard from several associates how the ward did not improve with the autocratic style of leadership being practised. Two consultant physicians also personally expressed to Loes how they now realise what peace, harmony and freedom the leaders had created on the ward. Loes' conclusion is that whilst the way they were leading may have seemed elusive to the physicians, it was palpable, as the physicians were now noticing the problems that were not being solved, as well as the loss of a sense of unity within the ward.

After Loes' departure in December 2010, Fleur noticed a lack of tolerance to any form of person-centred leadership or primary nursing from Clive, Clare and Anita. At a time when she was feeling vulnerable due to stresses on the home front, instead of receiving support from Anita and Clare, Fleur felt, "regularly punished for the way I interacted with associates." She tells of one incident where, after solving a problem with a night shift, she was suddenly called into a meeting arranged by Anita. Clive, Clare and Anita positioned themselves on one side of a table and Fleur was invited to sit opposite them. She was

severely criticised for the way she had solved the problem and how she gave leadership. There was no room or invitation to give her account of events.

Fleur: "They were trying to impose a style of leadership on me that didn't suit me, and didn't bother to ask themselves why I wasn't responding. I had the feeling that they were trying to brain wash me. I wasn't allowed to be too friendly with staff, show my vulnerability, talk to others about what happened behind closed doors, or show any form of negativity, whether I agreed with changes or not. I immediately lost all trust in the collaboration and any sense of safety."

The sense of safety within the ward disappeared for others too, as Fleur noticed that if she spoke openly to anyone they too were called into a meeting. The PN system was dismantled two weeks after Loes' departure, and without consultation. The PN's were removed from any tasks except direct care and it was made clear that their position was on the ward and not in the CN office. Chloé was reprimanded on several occasions for expressing her opinions too freely and consequently left the ward, as did the two new PN's who replaced the dual CN/PN role. Fleur found herself having to work with a colleague CN who she now described as someone with "a narcissistic personality", as well as a unit manager she did not trust. Her time on the ward ended after a period of burn-out.

Betty was less surprised by the course of events. Although she did not consider it good or acceptable, she understood Clare and Anita's rationale. Neither of them had experience in the nursing speciality and so saw opportunity to meet calls for increased efficiency by reducing staffing numbers if they returned to a traditional task-orientated system where the CN dictates nursing care. The lack of resistance from Clive was explainable as he already felt that nursing staff were given too much space to express their opinions and get involved in ward decisions. The loss of experienced nurses was not a problem as they could be replaced by younger, cheaper and more malleable staff. That Fleur was unable to withstand the pressure of the three adversaries was understandable too. Fleur was a relatively inexperienced leader who had never expected to lead with an autocratic vision.

Betty: "Although I don't consider it the right decision, I can understand why Anita, Clare and Clive crushed the nursing system and Fleur ... as management and control were considered the only right way to lead a team, there was no other way for them to regain control."

Whilst Betty carries no bitterness about what happened, she feels that the high turnover of staff, Clare's departure to a different unit, Anita's burn-out and the team resistance to her returning to the ward, are testimony to the benefits of person-centred leadership. In hindsight, Betty does feel that the situation with Clive could have been different if she had been able to find a way of positioning herself alongside him rather than opposite him and his constant attempts to control everything. At the time, she couldn't sketch the clear de-

tailed picture he wanted to see and hear. We were exploring person-centeredness rather than implementing an existing framework. However, she feels she could have asked him more often what he needed to hear, or know, in order to be able to follow developments on the ward. There must have been a common goal somewhere.

THE CONTINUED LIVING OF PERSON-CENTEREDNESS WITHIN THE PERSON

All three leaders felt that they have embodied person-centeredness, which is evident in how they describe their relationships with associates, colleagues and service users.

Fleur: "I notice that if I feel good about how I lead, then the team also feels good, which confirms that 'coming into own' is a positive outcome of person-centred leadership... the more they [associates] are supported in making their own choices and taking on responsibilities, the prouder they are, the more willing they are, the more committed they are and the better they do their best. The same applies to me. Whilst I find the bureaucracy tiresome, leading others gives me energy... For me the most important question is, "What does the other need from me in order to come into their own?" and whilst my team members were initially surprised by this question, they are now starting to think about it and formulate an answer."

Loes: "I like to think of us as a person-centred business which delivers an individualised service and programme. We focus on the individual client first and then his/her social context. We focus on relationships. Despite an economic crisis, my business has grown, probably because I approach clients and families differently to the rest. We organise our service around the client as far as possible, rather than try to fit the client into an existing system. People notice the personalised contact and service. The people who work with me tend to have a natural tendency to be person-centred, which is what I look for in interviews, and because we talk about the way we run the business, their natural tendency becomes stronger and identifiable, and we build a shared vision."

Each has found a context in which they experience the freedom and support to be a person-centred leader and are thriving again. Fleur and Betty now have leaders who seem to share a similar values base, but all three are noticing how unique their vision on leadership is. Other leaders have never considered leading in this way and are interested in the benefits. Associates appreciate the new style and some have chosen to stay in their post because of the leadership Betty, Loes and Fleur are demonstrating. Betty, Loes and Fleur still see enabling associates to come into their own as the primary goal, but balancing differing needs is a constant and extremely important process, even for Loes the businessperson and employer.

Loes: *"What I have noticed and proven to myself is that if people do not function or perform optimally, it costs me money personally now, but if they are given space and support, this is usually temporary and they bounce back, and that is better for me financially too. It is a business, and you can't sink so deep in person-centeredness that it changes into carrying the other. You do need to be in harmony with people."*

Although they are working in very different contexts to the hospital research setting, Betty, Loes and Fleur have again encountered leader dependency. The difference now is they feel equipped to support associates to see interdependency and appreciate individual strengths. They all feel that associates who experience person-centred leadership are also better able to consider, and inclined to be, person-centred in their relations with service users and colleagues. Leadership in developing person-centred cultures is important, even in small businesses.

Betty: *"Although the organisation wants to establish self-directed teams as quickly as possible, I will have to be person-centred in how I approach this development if I want the teams to be conscious of person-centeredness before they become self-directed and I have less influence in how care is provided."*

In an age when organisations are increasingly claiming to be client-centred, all three leaders are wary that the need to balance differing stakeholder needs is not being fully understood by management. For instance, in Betty's organisation the needs of clients require greater numbers of staff at certain points in the day. A problem here is that the organisation also has many full time/large percentage contracts. Higher management's solution to this problem is to call for reduced numbers of people employed with large contracts, for those with smaller contracts to work the same number of days per week. As Betty explained the situation, it reminded me of the Habermasian system and systems thinking overriding and suffocating the lifeworld or concern for people. As she expressed, *"Most people in this day and age would rather work one longer shift than two shorter ones. Whilst the organisation is very client orientated, I feel that I also need to take care of the wellbeing of associates too."*

Less of an issue for Loes and Fleur, who lead relatively small teams, span of control (or span of support as Betty now refers to it) has been a contextual challenge for Betty. With 83 members of staff, Betty has one of the largest sectors to manage in the whole organisation. She chose to build good relational connectedness with one team and gradually enable their empowerment so that her physical presence became less relevant. However, with this investment, critique has come from the other teams who feel they don't see her enough, even though the majority were surprised how much she knew about them

as individuals during their annual appraisals. Her next strategy is to start building local leaders.

Clive, Clare and Anita criticised the leadership being demonstrated by Betty, Loes and Fleur, as not business-like enough. All three have not encountered such feedback since, and Fleur was especially flabbergasted when associates fed back to her that she could be very business-like at times. However, as she later reflected, this is related to how people define business-like. Fleur found her own team members often 'nanny-like', or even patronising towards clients and each other. One positive emerging from this feedback is that Fleur has since been able to start dialogues with her team members on how they use language and the meaning of respect and caring.

THE NEED FOR A SPARRING PARTNER

All three leaders have now found contexts in which they can come into their own as person-centred leaders, but they miss the critical dialogues they shared during the research period. They miss the level of abstraction and viewing incidents within a larger context.

Betty feels, as a manager, she needs to distance herself from the day-to-day level of thinking to identify trends and patterns and is surprised how her colleague managers remain embedded at the incident level and engrossed in detail. Fleur misses the like-mindedness they shared, such as the belief that work and private contexts cannot be separated and influence each other. Even though Fleur sees the potential to learn from her current director, and she has started to observe him in action, she still misses the depth of discussion she shared with Betty, Loes and me. She is also noticing how she has become sensitive to leaders who only talk of negatives, what their associates cannot do and their judgement on performance based on their own standards. Whilst her own team is stable and steady, Fleur is not surprised that other team leaders are losing people. She feels that these leaders need to become more self-reflective and identify individual strengths within their teams. Whilst action learning sets are planned for the community leaders, Fleur wonders whether these will be challenging enough for her. The colleagues already come to her for advice and a listening ear, and she doubts whether they can offer that level of critical friendship she experiences when meeting up with Betty, Loes and I. After proposing that her new challenge could lie in facilitating the action learning sessions herself, structuring them as a CCRI, we left Fleur with something positive to think about.

Loes' situation is unique in that she has no leader to challenge and support her, or someone who asks her, "Is it right what you're doing now?" Although she sees the benefits of them each venturing into new fields and contexts, both personally and professionally,

she too notices the strong bond and sense of shared identity we share. Finding a sparring partner for herself is difficult too. Whilst she may not be seen by associates as their boss, she is still their employer and so feels that there are areas she cannot discuss with them. Equity may be present, but there cannot be true equality. Betty confirms this, stating that in such managerial roles, what one says is weighed differently by associates than if the same message came from a colleague of equal status.

CONCLUSION

This epilogue demonstrates that despite the troubles experienced at the end of the research study, all is well for the three leaders. Each has found a new context in which they can lead in a person-centred way and thereby achieve better working and service environments for associates and clients. Their narratives demonstrate that whilst person-centeredness as a value was not embedded within the research context to a degree that it could resist hierarchical power and autocratic leadership, it had become embodied within them. For Betty, Loes and Fleur, personal transformation had occurred. Their accounts of the research context development since their departure also suggests that more technical outcomes of person-centred leadership may need to be sought earlier in the transition period to gain attention and belief from those with hierarchical power. It seems that many of those left behind are only now starting to realise what they had after it has gone.

Appendices



APPENDIX 1: CRITICAL AND CREATIVE REFLECTIVE INQUIRY GUIDELINE

General overview:

	Descriptive Phase	Reflective Phase	Critical/ Emancipatory Phase
Process	'Surfacing' a detailed personal account of a leadership experience	Creative expression of individual interpretations of the narrative shared <i>and/or</i> Collective reflection on the meaning in terms of person-centred leadership	Critique of current leadership practice Identification of what the desired (<i>person-centred leadership</i>) practice is and how to achieve it
Levels of reflection	Reflectivity Affective reflectivity	Discriminant reflectivity Judgemental reflectivity	Conceptual reflectivity Psychic reflectivity Theoretical reflectivity
Products	Narrative of lived experience	Collective understanding Awareness of own values and beliefs Awareness of the values and beliefs of others	Awareness of effectiveness of current practice Reflected plan of action to 'improve' practice

The descriptive phase:

Sub-phases	Facilitation tips/suggested principles
Opening	Résumés of potential stories shared. Consensus about which story is to be critically reflected upon.
Telling	The narrator is invited to share his/her story. Listeners/observers show emotional attentiveness and engagement, without interruption, until the coda (a sign of narrative ending).
Elaborating	Initial question: "Is there anything else you would like to share with us?" The questioning stance is 'invitational' with simple, open and straightforward questions e.g. "Could you tell us more about ...?"; "What happened then?" etc. Each new question invites a natural progression of the narrator's trail of thought, inviting deeper exploration of the path being trodden or the exploration of potentially significant adjacent pathways. 'Why' questions should be avoided as the narrator may feel that he/she is being 'held to account' instead of being asked to 'tell their own story'. The narrator's answers are respected, the listeners' opinions kept to themselves and contradictions or inconsistencies heard in the narrative offered but not discussed/ argued. If closed questions are posed, such as: "Was anyone else present?", the narrator is given sufficient space to elaborate on his/her initial "yes/no" answer. An emotionally attentive and engaged stance is retained throughout, but now as interviewer.

The reflective phase:

Sub-phases	Facilitation tips/suggested principles
Creative expression	<p>Agreeing whether or not to use creative expression</p> <p>Creative expression(s) of the narrative as understood by the individual listener.</p> <p>If 'tableau vivant' is used, inquire into how participants 'feel' in their current stance.</p> <p>Clarifying questions e.g.: "Who is this representing?"</p> <p>Respectful sharing of interpretations – suggested prefixes include: "I see/ hear/feel/ imagine"</p>
Reflective dialogue with self and/or others	<p>Reflective questions could include:</p> <p>What is the key concept/message in this story? What was it about?</p> <p>What did X see, think, say and do?</p> <p>What were his/her intentions?</p> <p>What were the consequences of his/her actions, perceptions and thoughts?</p> <p>What role did the actions of others play in this story?</p> <p>Which contextual factors played a role in this story?</p> <p>Which values were demonstrated in this story in relation to leadership?</p> <p>How do you personally feel about the leader's actions narrated and underlying leader values?</p> <p>Retain an emotionally attentive and engaged stance towards each other during the dialogue.</p> <p>Although contestation can be relevant and appropriate, the ultimate aim is to seek consensus and shared understanding(s).</p> <p>Raise awareness of (associated) concepts and conclusions drawn in previous sessions.</p>

The critical/emancipatory phase:

Sub-phases	Facilitation tips/suggested principles
Critical dialogue with others	<p>Critical questions could include:</p> <p>Which leadership characteristics/qualities do we now consider desirable?</p> <p>Which processes and structures positively/negatively influence leaders' and others' behaviour?</p> <p>How does workplace/organisational culture influence the (<i>leader-staff</i>) relationships?</p> <p>What plausible explanations are there for what happened?</p> <p>What do we want to take away with us today and integrate into our own leadership practice?</p> <p>Retain an emotionally attentive and engaged stance towards each other during the dialogue.</p> <p>Although contestation can be relevant and appropriate, the ultimate aim is to seek consensus and shared understanding(s).</p> <p>Raise awareness of (associated) concepts and conclusions drawn in previous sessions</p>
Evaluating	Evaluation of: structure; process; facilitation and group dynamics

APPENDIX 2: STORYTELLING GUIDELINE

Basic structure of storytelling sessions (5-5-5mins):

- Descriptive phase – inviting the narrator to share their story is followed by exploratory questioning such as: “What happened then? Could you tell some more about?”
- Reflective phase – questioning of feelings, judgements, influencing factors, important concepts and processes as well as effectiveness of doing. For instance: “How did you feel when ...? Was that the right thing to do, or not? Which values are being demonstrated here? What influenced the situation? What processes/structures/people influenced the situation? What is this an example of? To what extent did people achieve their goals?”
- Conclusion – formulate (theoretical) explanations for what happened, what has been learnt and possible action plans. Example questions could be: “What have we learnt from this? Which elements of person-centred nursing were evident/absent in this narrative? How should we act in future?”

Areas of facilitator/observer focus:

- Primary modus is directive (technical) ↔ enabling (emancipatory)?
- Key processes used?
 - Consciousness raising.
 - Problematisation to help focus dialogue on core subject.
 - Self-reflection to help identify own role in situation.
 - Criticality to help identify contextual factors.
- Key strategies used?
 - Role modelling (questions, abstract/metacognitive thinking).
 - Use of self, own knowledge.
 - Questioning (open and non-suggestive).
 - Feedback (“I see/hear/feel ...”), echoing, paraphrasing, summarising.
 - Balanced challenge and support.
 - Creative expression (as alternative to verbal).
- Group dynamics, degree of person-centeredness towards each other:
 - Reciprocal adequacy – seeking commonality, no debate/discussion.
 - Acknowledging and respecting one another.
 - Equity – each has opportunity to have voice heard.

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