

1 **Title:** Person-centred Leadership: a relational approach to leadership derived through action  
2 research.

3  
4 **Abstract:**

5 *Aims & Objectives:* How does person-centred leadership manifest in clinical nursing.

6 *Background:* Person-centred practice fosters healthful relationships and is gaining increasing  
7 attention in nursing and healthcare, but nothing is known about the influence of a person-  
8 centred approach to leadership practice. Most leadership models used in nursing were  
9 originally developed outside of nursing.

10 *Design:* A three year participatory action research study where participant leaders planned,  
11 researched and learned from their practice development.

12 *Methods:* After an orientation phase, four action spirals focused on: critical and creative  
13 reflective inquiries into leadership practice change; leading the implementation and evaluation  
14 of a new nursing system; facilitating storytelling sessions with staff and annually reflecting on  
15 personal leadership change. Multiple data gathering methods offered insight into leadership  
16 development from several perspectives.

17 *Results:* Critical and creative thematic data analysis revealed a set of attributes, relational  
18 processes and contextual factors that influenced the being and becoming of a person-centred  
19 leader. Comparing the findings with nursing leadership literature supports a conceptual  
20 framework for person-centred leadership.

21 *Conclusions:* Person-centred leadership is a complex, dynamic, relational and contextualised  
22 practice that aims to enable associates and leaders achieve self-actualisation, empowerment  
23 and wellbeing.

24  
25 **Keywords:** person-centeredness; leadership; nursing leadership; action research

26 **What does this paper contribute to the wider global clinical community?**

- 27
- 28 • This paper offers deeper insight into clinical nurse leadership as a relational and  
contextual phenomenon.
  - 29 • The participatory action research methodology shows how clinical nurse leadership  
30 can be developed and researched in practice, with practitioners.
  - 31 • The conceptual framework offers clinical nurse leaders a reflective tool to support  
32 leadership development and the development of person-centred cultures.
- 33

34 **INTRODUCTION**

35  
36 With increasing concerns among service-users and practitioners about the nature, formation  
37 and maintenance of healthcare relationships, policy-makers, administrators and scholars are  
38 showing greater interest in the concept of person-centred practice. Berwick (2013) advises  
39 leaders at all levels to concern themselves more with the realities of frontline healthcare and  
40 develop cultures of learning, compassion and continuous improvement. Person-centredness  
41 has been identified as a core value of effective workplace cultures (Manley, Sanders, Cardiff  
42 & Webster, 2011) and person-centred practice defined as the formation and fostering of  
43 healthful relationships with service users and among staff, based on the humanistic values of  
44 respect for persons, individual right to self-determination, mutual respect and understanding

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

### 3 **Background**

4 Industrial age heroic and autocratic leadership, with its hierarchical and linear thinking,  
5 compartmentalization, surveillance and control has been criticized as new leadership styles  
6 emerge which address complexity, whole system and meta-thinking, outcome orientation,  
7 morality and purposefulness (Cook, 2001; Wheatley, 2006). New styles of leadership  
8 described and researched in nursing include authentic (Avolio, Gardner, Walumbwa, Luthans  
9 & May, 2004); servant (Greenleaf, 2003); transformational (Bass & Riggio, 2006; Kouzes &  
10 Posner, 2007) and situational (Hersey, Blanchard, & Johnson, 2001), although none of these  
11 originated from nursing research or the nursing context. This is of importance as, from a  
12 Bourdieusian perspective, ways of being learnt and embodied whilst a nurse will influence  
13 leadership practice (Lalleman, Smid, Lagerwey, Oldenhof, & Schuurmans, 2015). Also, many  
14 leadership theories, styles and research assume that leaders hold hierarchical positions and  
15 achieve outcomes by simply applying techniques, principles and practices i.e. a unidirectional  
16 flow of influence causing change (Cunliffe & Eriksen, 2011). However, effective leadership  
17 in healthcare is more complex as leaders need to consider “roles, relationships and practices  
18 that are made within contexts and through social interactions, while learning with people who  
19 share these contexts” (Fulop & Mark, 2013: 257). Inquiring into the work of nurses, DeFrino  
20 (2009) argues that it is through their unseen relational work that nurses achieve positive  
21 patient and professional outcomes. Such embodied history could flow over into nursing  
22 leadership relationships and, in contrast to task-focused nurse leaders, relationship focused  
23 leaders have been shown to improve nurses’ working life, care environments, productivity  
24 and patient outcomes (Cicolini, Comparcini, & Simonetti, 2013; Cowden, Cummings, &  
25 Profetto-McGrath, 2011; Cummings et al., 2010; Wagner et al., 2010; Wong, Cummings, &  
26 Ducharme, 2013; Lynch, McCormack, McCance & Brown, 2017). However, nursing  
27 leadership research predominantly views leadership from a hierarchical perspective and is  
28 rarely framed within relational leadership theory.

29 Relational leadership theory detaches leadership from management and hierarchical roles  
30 (Uhl-Bien, 2006) and has been defined as “a practice of caring for colleagues, enabling others  
31 to act, acknowledging and learning from one’s mistakes and being emotionally authentic”  
32 (Binns, 2008, p.601). How relationships and relational dynamics maintain, transform and/or  
33 construct social structures, conventions and practices becomes the focus of study (Uhl-Bien,  
34 2006). As a moral and dialogical practice, relational leadership is a way of “being and relating  
35 with others, embedded in everyday experience and interwoven with a sense of moral  
36 responsibility” (Cunliffe & Eriksen, 2011, p.1432). Several relationship-orientated leadership  
37 models and frameworks are described in nursing literature. Transformational leadership is a  
38 popular choice and frequently found in person-centred practice literature (e.g. McCormack &  
39 McCance, 2010; Beckett et al., 2013). However, neither Bass and Riggio’s (2006) nor Kouzes  
40 and Posner’s (2007) leadership models were developed within a nursing or healthcare context.  
41 Also, hierarchical power could be a means of aligning staff values, beliefs and behaviour to  
42 that of the organisation or the leader self. Measurement tools for these models do not reveal

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

## 7 **THE STUDY**

### 8 **Aims**

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

### 11 **Method**

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

### 24 **Context, participants and participation**

25 The PAR fieldwork was conducted in one unit of a Dutch urban general hospital between  
26 2009-2011. A general study design was collaboratively agreed with the unit team before the  
27 orientation phase and again before the action spirals were started. Initial participant co-  
28 researchers were the unit nurse manager (UM Betty) and two charge nurses (CNs Anne and  
29 Loes) who responded to an article describing the AR'ers (first author) interest in studying  
30 person-centred leadership. During the study, one CN became the unit clinical nurse specialist  
31 (CNS Anne), a new CN was internally recruited (CN Fleur), and two primary nurses (PNs  
32 Chloé and Tess) joined the group in action spiral 2. Proposed research activities were  
33 presented in planning meetings, with the AR'er and co-researchers dialoguing until details  
34 were collaboratively agreed. Each co-researcher self-determined the degree to which they  
35 would be active as a subject and/or researcher, per activity. The emergent and responsive  
36 nature of PAR also accommodated self-determined involvement of staff in various research  
37 activities throughout the study, for example, being interviewed post leader observation or co-  
38 interpreting results obtained in action spiral two.

## 1 **Data collection during the study**

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

16 **< INSERT FIGURE 1 HERE >**

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

24  
25 *Action spiral two* entailed the design and implementation of a new nursing system based on  
26 the principles of primary nursing (c.f. Manthey, 2002). Development of the system and  
27 enactment of the PN role offered deeper insight into clinical leadership. The CN's adopted a  
28 dual CN/PN role and two new PNs were internally recruited. To generate a shared vision on  
29 primary nursing, participant leaders engaged in a creative workshop and conducted semi-  
30 structured interviews with members of the care- and medical team as part of a second  
31 workshop on the PN role. Participant observation of the leaders in practice was conducted by  
32 the AR'er shadowing participant leaders at and away from the bedside. Observations sessions  
33 ended with a post-observation leader interview, sometimes accompanied by an interview with  
34 those being led during the session. This offered insight into individual leader intent as well as  
35 follower perceptions. The PNs also held regular meetings evaluating the implementation  
36 process and invited staff contributions via various methods, such as, an evaluation journal  
37 kept in the staffroom. They used Guba and Lincoln's (1989) claims, concerns and issues  
38 framework to structure and document evaluations.

39  
40 Staff perceptions on culture and leadership change were collected using various methods.  
41 Qualitative data on culture and practice change were gathered in a creative culture workshop  
42 with the care team. Quantitative data were obtained in a leader designed Likert scale staff

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

7  
8 In *action spiral three* the CNs facilitated weekly 20 minute storytelling sessions where  
9 nursing staff could share narratives and reflect on their care using McCormack and  
10 McCance's (2010) framework for person-centred nursing. CN experiences of facilitating these  
11 sessions were collected in post-observation interviews, initially by the researcher and later by  
12 each other. These too were audio-taped and transcribed.

13  
14 Whilst action spiral one created reflective space for daily leadership practice, annual reflective  
15 inquiries in *action spiral four* provided space to evaluate and reflect on personal growth.  
16 Individual creative expressions of leadership and growth were critically peer reviewed and  
17 findings compared to those of the previous annual inquiry. Whilst the PNs and CNS chose not  
18 to participate in these sessions, they did participate in a mid-term evaluation workshop on the  
19 research project. Having re-defined leadership during a CCRI as "a (non-)hierarchical  
20 relationship where one person supports individuals and groups in achieving common goals",  
21 participant leaders felt that the AR'er was also engaging in (person-centred) leadership. As  
22 critical (self-)reflection by an action researcher enhances research credibility (Trondsen &  
23 Sandaunet, 2009), it was agreed that the traditional researcher 'facilitator' role (c.f. Winter &  
24 Munn-Giddings, 2001) would be viewed as a 'leader' role. Data from the AR'ers annual  
25 inquires, alongside the AR'er journal, audio-recorded supervision sessions and notes from his  
26 own action learning set, therefore contributed to the data pool. The AR'ers leadership was  
27 also evaluated by participant leaders in a workshop facilitated by the external researcher.

28  
29 < INSERT TABLE 1 HERE >

### 30 31 **Data analysis**

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

42 < INSERT TABLE 2 HERE >

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

6 < INSERT BOX 1 HERE >

## 7 **Ethical considerations**

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

## 22 **Findings**

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

31 < INSERT FIGURE 2 HERE >

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32

<p>CN Loes: <i>“It shows an opposing balance to the loneliness depicted in the other pictures, that there is someone there who puts an arm around you and says, “You’re not alone. We want to think with you and help.” That doesn’t mean to say that you can completely take the despondency away ... sometimes just listening and showing understanding is enough and people then undertake action</i></p>	<p><b>&lt; INSERT FIGURE 4 HERE &gt;</b></p>
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<i>themselves to resolve a problem.”</i> (CCRI 4)	
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1  
2 These processes helped leaders decide how to position themselves in relation to associates  
3 (*stancing*), each moment anew. Four basic stances were identified: leading from the 1) front,  
4 inviting leader role modelling or ‘doing for’ associates; 2) side-line, offering instruction or  
5 reminders; 3) alongside, balancing challenge with support to enable action; 4) behind,  
6 stepping back and observing when comfortable with associate ability or enabling experiential  
7 learning. Initially, participant preferred/habituated stances were to lead from the front or side-  
8 line and more directive than invitational. The invitational approach proved to be effective in  
9 respecting self-determination and leaders became more responsive, moving reflectively and  
10 fluidly through different stances in any situation. Leading from behind was the most alien and  
11 challenging, requiring calculated risk-taking at times.

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

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

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

33  
34 Engaging in this AR exposed participant leaders to new ways of learning. They started to  
35 experiment in *creating safe and critical (learning) spaces* where multiple perspectives could  
36 be shared, horizons broadened, interpretations balanced, as well as shared power and  
37 responsibility nurtured. The PN’s, in particular, started to see and capitalise on learning  
38 opportunities around them, matching opportunities with associate need and readiness to learn.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 CN Fleur: “*The more we lead like this, the more we get back. The more*  
28 *person-centered we are the more person-centered they are to us ... ”*  
29 (Participant leader annual reflection)

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

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

6 CN Fleur: “*I don’t just act from gut instinct now ... The gut feeling is*  
7 *usually OK, it’s just that you need to be able to reason it and place it*  
8 *somewhere. Gut feeling alone is not enough.*” (Annual reflection, July  
9 2010)

## 10 Discussion

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

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

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

### 3 **A conceptual framework for person-centred leadership**

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

19 < INSERT FIGURE 3 HERE >

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

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

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

24 Whilst the process of *stancing* was broken down into four basic stances, observations and  
25 narratives demonstrated that different stances occur within any leader-associate encounter,  
26 reflecting responsiveness to own and associate being, as well as contextual changes. Leading  
27 from the front entailed offering directive support, such as role modelling or 'doing for' the  
28 associate. When leading from the side line, leaders offered instruction or advice. Leading  
29 from alongside or behind was less directive as associates were encouraged and supported in  
30 becoming more self-directive. Where leading from alongside showed more intense  
31 interaction, with high challenge and high support. Leading from behind was far less  
32 interactive as leaders stepped back and observed. These four stances could be confused with  
33 Hersey et al.'s (2001) four modes of situational leadership, however, there are differences in  
34 discourse and leader intent. Situational leaders are primarily concerned with follower  
35 performance, whilst person-centred leaders focus first on associate wellbeing, empowerment  
36 and self-actualisation (coming into own). Situational leaders 'tell' followers what to do in S1  
37 mode, rather than 'offer' direction, 'selling' and/or 'persuading' followers to psychologically  
38 buy in to what the leader wants in S2 rather than offering advice. In S3, situational leaders  
39 support follower confidence and involvement in problem-solving, using praise and  
40 compliments, and in S4 they delegate, convinced of follower task competency (Hersey et al.,  
41 2001). Person-centred leaders may choose to lead from behind even when associate  
42 competency is not evident. For instance, aware of the CNs' learning needs and preferred  
43 learning styles, the UM Betty restrained from intervening and stepped back, observing how

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

7 Based on staff and leader positive evaluations, three concepts were associated with the idiom  
8 'coming into own': empowerment, wellbeing and self-actualisation. The NHS NICE (2009)  
9 guideline recommends that front-line leaders focus on staff wellbeing and empowerment.  
10 Findings in the orientation phase reflected earlier research that Dutch nurses experience  
11 leadership as hierarchical, non-communicative and increasingly 'business-like' (van der  
12 Arend & Remmers-van den Hurk, 1999). However, as leadership practice changed, so did  
13 perspectives, with coming into own not restricted to associates. Participant leaders sought and  
14 developed their own empowerment. This is important as nurse middle-management leaders  
15 often do not feel empowered (Patrick, Laschinger, Wong, & Finegan, 2011; Regan &  
16 Rodriguez, 2011). Also, the relational approach to leadership meant that empowerment was  
17 seen as something that can be enabled (not given), individually experienced and  
18 contextualised. The person-centred approach respected that not everyone wanted the same  
19 level of responsibility and self-determination all the time. Also, structural empowerment as  
20 supporting access to opportunity, information, resources, support and (in)formal power  
21 (Kanter, 1977) was accompanied by psychological empowerment as supporting self-  
22 determination and self-efficacy in meaningful work (Conger & Kanungo, 1988). Although not  
23 empirically measured in this study, working simultaneously with both empowerment  
24 approaches has been shown to have a positive impact on nurses and nursing (Wagner et al.,  
25 2010).

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

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



1 There is a danger that person-centredness could be interpreted too individualistically i.e. too  
2 focused on own assumptions and the needs of one individual/group. Awareness of, and  
3 working with '*differing stakeholder needs*' helps balance such blinkeredness. Reciprocal  
4 influencing between the leader-associate relationship and other stakeholder needs was evident  
5 in the PAR, for instance: when leaders realised that absent persons could potentially be  
6 affected by decisions/actions they made in the here and now with one individual/group, and  
7 when PN's started to collaborate more with colleagues each shift after hearing fears that their  
8 range of nursing activities was declining. In contrast, the MM's attempt to regain control over  
9 nurses and nursing on the unit reflected an individualistic mindset and reflects Fealy et al.'s  
10 (2011) finding that interdisciplinary relationships are a potential barrier to clinical nurse  
11 leadership development, especially when nurses choose not to play the 'doctor-nurse' game  
12 (McMahan et al, 1994). *Organisational culture* refers to espoused values and practices across  
13 differing groups within an organisation (Kotter & Heskett, 1992) and whilst many believe this  
14 determines 'the way things are done' within organisations, Bolan and Bolan (1994) propose  
15 that groups and units within the organisation (idio-cultures) are both carriers and creators of  
16 culture. That nurse leaders can be seen as minor strategic players (relative to physicians and  
17 higher management), experience positional marginalisation and powerless responsibility has  
18 been documented (Fealy et al., 2011) and was evident within the research setting. However,  
19 collaborative reflection on such organisational values and practices raised awareness and  
20 conscious action. Comparing their leadership vision and development with colleagues of  
21 similar positions within the organisation aided this empowerment and the idio-cultural/unit  
22 findings support the view that leadership can enable the enactment of person-centred values in  
23 workplace cultures (c.f. Manley et al., 2011; Lynch et al., 2017).

24 Lastly, healthcare practices need *systems of evaluation* to maintain quality and safety, plus,  
25 perceptions and leadership practices evolve in time (Krugman, Heggem, Kinney, & Frueh,  
26 2013). Some evaluation systems monitor key performance indicators regularly whilst others  
27 are specific and transient/intermittent. All have the potential to influence and be influenced by  
28 leadership practice. For instance, based on primary nursing implementation evaluations, the  
29 CN's decided to alternate weekly between working bedside and working from the office, so as  
30 to meet their clinical and administrative responsibilities.

## 31 **Conclusion**

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

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

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

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

## 16 **Relevance to clinical practice**

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

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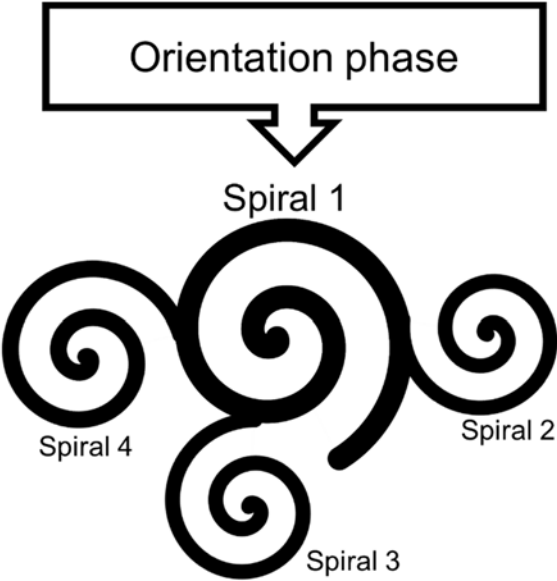
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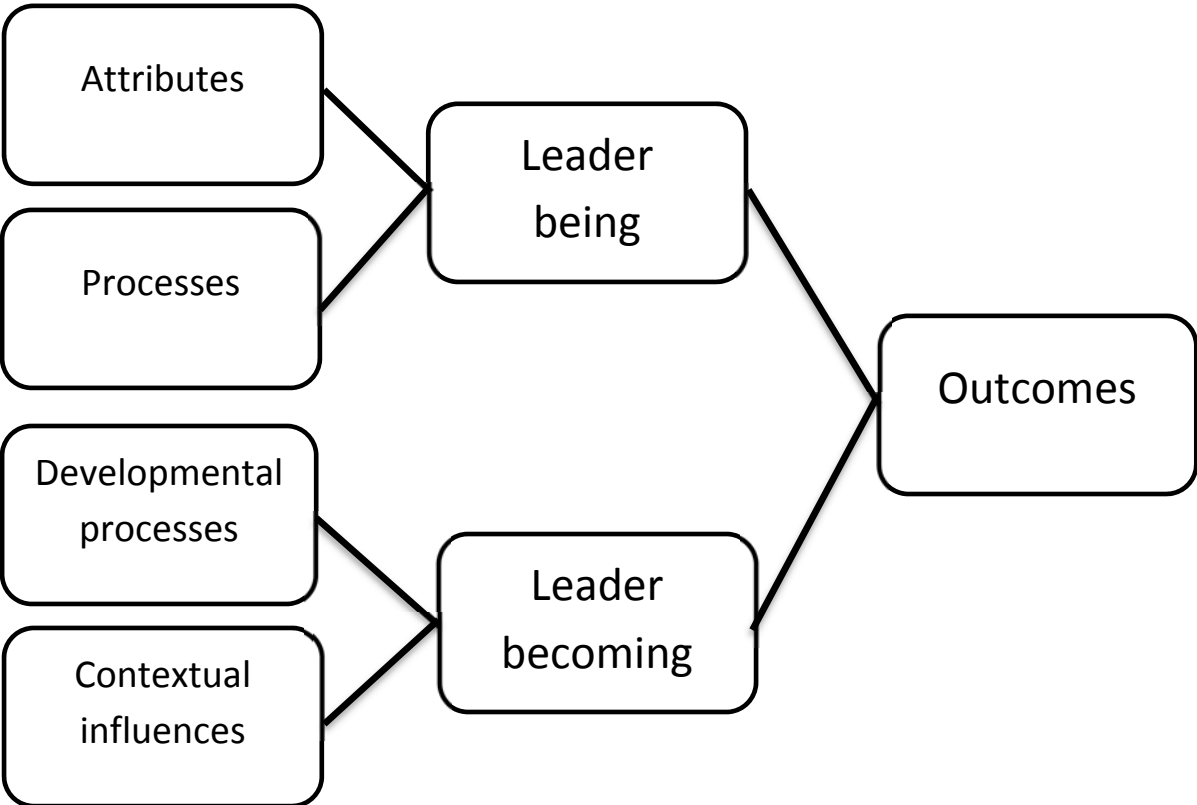
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**Figure 1:** Methodological framework



**Figure 2:** Thematic framework of findings

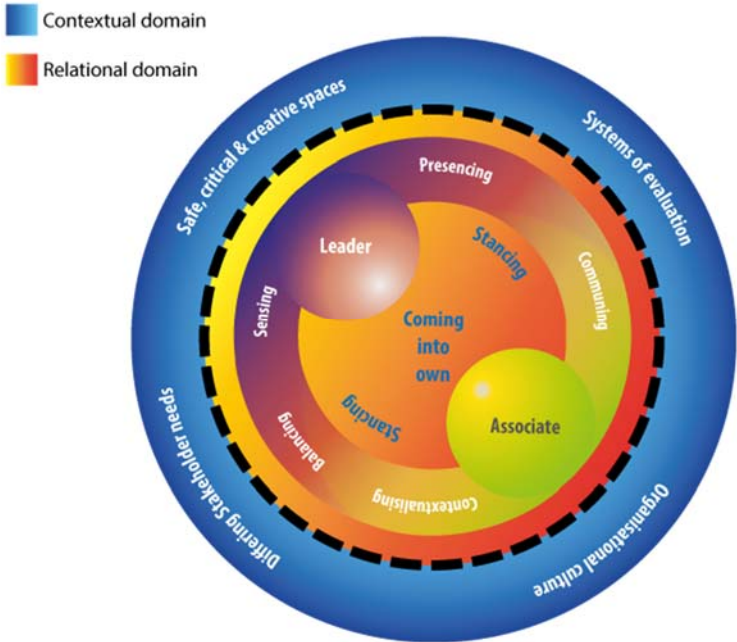




**Figure 4:** Photo accompanying citation 'CN LOES' (CCRI 4)



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



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

Phase	Primary goals & activities:	Participants
<b>Orientation</b>	<p><b>Goal: To gain insight into current relationships and context (structures, conventions &amp; practices)</b></p> <ul style="list-style-type: none"> <li>• critical and creative culture workshop</li> <li>• participant observations of context (x5)</li> <li>• participant observations of nurse leadership (x3)</li> <li>• narratives of care</li> <li>• narratives of nurse leadership</li> </ul>	<p>22 members of staff Staff &amp; patients CNs / UM / staff 8 patients + 16 staff 11 nursing staff + 1 physician</p>
<b>Action spiral 1</b>	<p><b>Goal: To gain insight into changing nurse leadership practice</b></p> <ul style="list-style-type: none"> <li>• 19 AR'er facilitated critical and creative reflective inquiry sessions on 15 narratives</li> </ul>	<p>2CNs + 1UM + 1CNS + 2PNs</p>
<b>Action spiral 2</b>	<p><b>Goal: To gain insight into leading change in the nursing system</b></p> <ul style="list-style-type: none"> <li>• Visioning primary nursing workshop, facilitated by the AR'er</li> <li>• Primary nurse role analysis workshop, facilitated by the AR'er</li> <li>• 23 AR'er participant observations of leadership + post-observation interviews with the observed leader (and those interacting with leader)</li> <li>• 4 PN implementation evaluation meetings</li> <li>• (Evaluative) critical and creative culture workshop, facilitated by 1UM + 1CN</li> <li>• Nurse leadership evaluation workshop, facilitated by an external researcher</li> <li>• Participatory analysis of a staff evaluation questionnaire (n=15), facilitated by the AR'er</li> </ul>	<p>2CNs + 2PNs 2CNs + 2PNs CNs (16 sessions) PNs (4 sessions) UM (3 sessions) 2 staff nurse interviews 2 student interviews 1 physician interview  2PNs + 2CNs 5 staff nurses 5 staff nurses 4 staff nurses + 1CN</p>
<b>Action spiral 3</b>	<p><b>Goal: To gain insight into leading storytelling sessions aimed at fostering person-centred care</b></p> <ul style="list-style-type: none"> <li>• 13 post-observation interviews of CN facilitated storytelling sessions</li> </ul>	<p>2CNs</p>
<b>Action spiral 4</b>	<p><b>Goal: To gain insight into nurse leader growth</b></p> <ul style="list-style-type: none"> <li>• 3 annual reflective inquiries into individual leader growth</li> <li>• 19 supervision sessions</li> <li>• 3 AR'er experiences reflected upon during Action Learning Set sessions with university co-workers.</li> <li>• AR'er leadership evaluation workshop, facilitated by external researcher</li> <li>• Midterm evaluation workshop of action research experience, facilitated by AR'er</li> </ul>	<p>2CNs + 1UM + AR'er AR'er + 4 supervisors AR'er ±7 set members 1UM + 1CNS + 2CNs 4 co-researchers</p>

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

Action Spiral	Primary data set:
1	<ul style="list-style-type: none"> <li>• 15 critical and creative reflective inquiries = 23 hours of transcript</li> </ul>
2	<ul style="list-style-type: none"> <li>• 23 observations of leadership practice + post-observation interviews = 10 hours of transcript</li> <li>• Unit leadership evaluation workshop = 1,5 hours transcript</li> </ul>
3	<ul style="list-style-type: none"> <li>• 8 post-observation storytelling session interviews = 4,5 hours transcript</li> </ul>
4	<ul style="list-style-type: none"> <li>• 3 annual reflective inquiries = 8 hours of transcript</li> <li>• Midterm evaluation workshop of action research experience = 2,5 hours transcript</li> <li>• AR'er leadership evaluation workshop</li> </ul>

**Box 1:** Thematic data analysis framework

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