Accepted: 27 June 2017

DOI: 10.1111/jocn.13949

ORIGINAL ARTICLE

WILEY Journal of Clinical Nursing

The development of the Person-Centred Situational Leadership Framework: Revealing the being of person-centredness in nursing homes

Brighide M Lynch BSc, PhD, RGN, Research Associate[1] | Tanya McCance BSc, DPhil, RGN, Director of the Institute of Nursing and Health Research[2] | Brendan McCormack BSc, DPhil, RGN, Head of Division of Nursing[3] | Donna Brown BSc, DPhil, RGN, Lecturer in Nursing[1]

[1]Faculty of Life and Health Sciences, Institute of Nursing and Health Research, Ulster University, Jordanstown, UK

[2]Faculty of Life and Health Sciences, Ulster University, Jordanstown, UK

[3]Queen Margaret University, Edinburgh, UK

Correspondence
Brighide M Lynch, Faculty of Life and Health Sciences, Institute of Nursing and Health Research, Ulster University, Jordanstown, UK.
Email: b.lynch@ulster.ac.uk

Aims and objectives: To implement and evaluate the effect of using the Person-Centred Situational Leadership Framework to develop person-centred care within nursing homes.

Background: Many models of nursing leadership have been developed internationally in recent years but do not fit with the emergent complex philosophy of nursing home care. This study develops the Person-Centred Situational Leadership Framework that supports this philosophy. It forms the theoretical basis of the action research study described in this article.

Methods: This was a complex action research study using the following multiple methods: nonparticipatory observation using the Workplace Culture Critical Analysis Tool (n = 30); critical and reflective dialogues with participants (n = 39) at time 1 (beginning of study), time 2 (end of study) and time 3 (6 months after study had ended); narratives from residents at time 1 and time 2 (n = 8); focus groups with staff at time 2 (n = 12) and reflective field notes. Different approaches to analyse the data were adopted for the different data sources, and the overall results of the thematic analysis were brought together using cognitive mapping.

Results: The Person-Centred Situational Leadership Framework captures seven core attributes of the leader that facilitate person-centredness in others: relating to the essence of being; harmonising actions with the vision; balancing concern for compliance with concern for person-centredness; connecting with the other person in the instant; intentionally enthusing the other person to act; listening to the other person with the heart; and unifying through collaboration, appreciation and trust.

Conclusions: This study led to a theoretical contribution in relation to the Person-Centred Practice Framework. It makes an important key contribution internationally to the gap in knowledge about leadership in residential care facilities for older people.

Relevance to clinical practice: The findings can be seen to have significant applicability internationally, across other care settings and contexts.

KEYWORDS

culture change, nursing homes, older people, person-centred practice, person-centredness, personhood, residential care, situational leadership

1 | INTRODUCTION

The endorsement of a leadership approach that will change the culture of care for older people living in nursing homes is an important agenda internationally. There are, however, few robust studies in the literature that explore the correlation between transformational leadership and effective nursing care in long-term care facilities for older people (Lynch, 2015). Although several models of leadership have been developed for acute care settings and for management and policy situations, many of them are not appropriate for nursing home contexts (McCormack, Roberts, Meyer, Morgan, & Boscart, 2012). Contemporary nursing home care espouses the concept of "person" and "personhood" and is increasingly influenced by the philosophy of "household," where the physical environment of the nursing home and all its features are designed to mirror a true home for the residents (Chapin, 2006; Shields & Norton, 2006; Thomas, 2004). The development of a theoretical framework of situational leadership in residential care for older people (Lynch, McCormack, & McCance, 2011) can be considered as an approach that supports this philosophy—the Person-Centred Situational Leadership Framework (PCSLF). The framework integrates person-centred theory as depicted in the Person-Centred Nursing Framework (McCormack & McCance, 2006, 2010, 2017) with situational leadership theory (Hersey & Blanchard, 1982, 1997). The PCSLF emphasises the key behaviours and contextual variables involved in the process of developing others to accomplish the optimum outcome of effective person-centred practice. The framework was used in an action research study in residential care as the foundation for developing and facilitating a leadership intervention programme for six leaders. The purpose of this study was to report on one aspect that emerged from this complex action research study, focusing on seven core themes/attributes that contribute to our understanding of person-centred situational leadership in residential care settings.

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

- This study makes an important key contribution to the gap in knowledge about leadership in residential care facilities for older people.
- A model of leadership is presented (the Person-Centred Situational Leadership Framework) that is facilitative, enabling and person-centred and is the first of its kind in residential care.
- This study illustrates that engagement in a facilitated critical reflective process is fundamental to the development of person-centred leadership and more person-centredness among care staff.

2 | BACKGROUND

The nursing home, as a community for older people living together and a place where staff come to work, embodies a complex array of relationships, interactions and connections. This complexity often leads to a control model of management and leadership that can be observed in the way staff schedules and routines control the space, the time and the people in the building (Brown Wilson, 2009; Grant & Norton, 2005). Over the past 10 years, there has been a significant change in the philosophy of nursing home care for older people internationally (Ragsdale & McDougall, 2008). In the USA and Canada, this change stemmed from the recognition that older people living in nursing homes were lonely, bored and helpless (Thomas, 2004). Several culture change models advocating the radical transformation of nursing home care were developed around the same time and included Wellspring (Stone, Reinhard, Bowers, Zimmerman, & Phillips, 2002), Eden Alternative (Thomas, 2004) and the Household Model (Shields & Norton, 2006). To date, there is a lack of empirical evidence in the literature to demonstrate the impact this culture change movement has had on the quality of life of the residents living in nursing homes (Petriwskyj, Parker, Brown Wilson, & Gibson, 2015).

Consistent with international reviews (Bamford-Wade & Moss, 2010; Bowles & Bowles, 2000; Govier & Nash, 2009; Thyer, 2003), recommendations from a number of reviews in the Republic of Ireland (HIQA, 2009; Murphy, O'Shea, Cooney, Shiel, & Hodgins, 2006) all call for a change in the culture of care and a move to a more person-centred approach led by a transformational nurse leader. More recently, the Francis report (2013) highlights the need for the nursing profession to develop skilled nurse leaders who will enable the delivery of effective person-centred care.

2.1 | Culture change and person-centredness

There are opposing views in the literature as to how the culture of an organisation can be changed. Some writers suggest that the culture can be manipulated by the leader (Bate, 1994; Schneider, 1994), while others describe a shaping and moulding of the culture by the actions and reactions of the leader, and the leader in turn being shaped and moulded by that culture (Bass & Avolio, 1994). Within these opposing views, a consensus still exists suggesting that leadership and culture are strongly interwoven (Schein, 1992). With reference to nursing homes, culture change involves the complete transformation of the institutional practices, routines and schedules that govern the delivery of care to residents—in other words, a person-centred culture. McCormack and McCance (2010) define person-centredness as:

> *an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, older people and others significant to them in 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 & McCance, 2010; p. 31)*

For over a decade, the literature on nursing leadership has demonstrated the endorsement of transformational leadership as the preferred style in leading nursing through a constantly changing healthcare environment (Bamford-Wade & Moss, 2010; Bowles & Bowles, 2000; Govier & Nash, 2009). To date, very little work has been performed to make a correlation between transformational leadership and effective nursing care in nursing homes. McCormack et al. (2012) carried out a review of several new models that claim to have a person-centred focus and aim to de-institutionalise care settings for older people. In their review, the authors explore the implications of these models for the role of the registered nurse in residential care and caution against their implementation in the absence of a clear understanding of the concept "person" and "personhood." McCormack et al. (2012) argue that for an effective person-centred culture in nursing homes to develop, the personhood of all persons (residents, staff members and family members) needs to be honoured and respected so that meaningful relationships are created within a supportive context that enables person-centred care to take place. Nolan, Davies, Brown, Keady, and Nolan (2004) conclude that "relationship-centred care" is a more suitable term (Nolan et al., 2004, p. 47). However, as an understanding of the concept of personhood and meaningful relationships is essential to the implementation of person-centred care, it is apparent that a like-minded view between person-centred care and relationship-centred care exists. The Person-Centred Situational Leadership Framework (PCSLF) in nursing homes (Lynch et al., 2011) can be considered an approach that supports these principles.

2.2 | An overview of the Person-Centred Situational Leadership Framework (PCSLF)

Working from the premise that transformational leadership is situational leadership enacted within the Person-Centred Nursing (PCN) Framework, a theoretical framework of situational leadership in nursing homes was developed that brings together previous empirical research by McCormack and McCance (2006, 2010, 2017) and Hersey and Blanchard (1982, 1997)—the PCSLF. This action research study was used to demonstrate the use of the framework.

The PCSLF focuses on the leader's ability to diagnose the performance, competence and commitment of the follower. By adopting a flexible approach, the leader modifies their style of leadership to align it with the developmental level of the follower. Blanchard (2007) defines the "follower" as:

> *the person being led by the situational leader (p. 88).*

Through the process of "partnering for performance" (Lynch, 2015), the situational leader diagnoses the follower's effectiveness in delivering person-centred care. This is established by determining where the follower sits on the developmental continuum in relation to the five prerequisites of professional competence, commitment, interpersonal skills, clarity of values and beliefs and knowledge of self, outlined in the Person-Centred Practice Framework (McCormack & McCance, 2017). For example, in relation to performing a specific task to deliver care, the leader and the follower agree on the diagnosis of the follower's developmental level, ranging from D1 (enthusiastic beginner) through to D4 (self-reliant achiever). Using a person-centred approach, the situational leader adopts a leadership style, ranging from S1 (directing) through to S4 (delegating) and aligns it to the follower's developmental level. By combing high and low supporting behaviours with high and low directing behaviours, the situational leader takes the follower through the developmental levels in order to manage the care environment and deliver effective person-centred care (Lynch et al., 2011).

3 | THE STUDY

3.1 | Aim

The main aim of the study was to implement and evaluate the effect of using the PCSLF to develop person-centred care within nursing homes.

3.2 | Objective

- To use the PCSLF as the foundation for developing and facilitating a leadership intervention programme for six leaders.

3.3 | The context

The research study was undertaken in the Republic of Ireland in established privately operated nursing home. The nursing home had 84 residents who lived in three households, within the facility. Each household mirrored a normal home environment, with its own kitchen, sitting room, dining room, bathrooms and bedrooms. The services provided in the nursing home included residential care, nursing care for the frail older person and care for the person living with dementia. The leaders in the nursing home were the director of nursing (DON) and her assistant, the care manager (CM). Each household had a clinical lead (a registered nurse) and a house lead (a senior member of care staff), and they reported directly to the DON and CM. At the time of recruiting the leader participants, there were six leaders in the nursing home: one household did not have a clinical lead appointed and another household did not have a house lead appointed. All the leaders in the nursing home ($n = 6$) participated in the study: Rose (DON), Bell (CM), Dot and Jen (clinical leads) and Polly and Iris (house leads). These are pseudonyms for the leaders.

4 | METHODS

The study adopted an action research approach similar to the process described by Lewin (1946/1948; p. 206):

It proceeds in a spiral of steps, each of which is composed of a circle of planning, action and fact finding about the results of the action.

A qualitative approach to the evaluation of the implementation of the PCSLF was adopted. This approach focused on gaining a deep understanding of the relationship between situational leadership processes and how these processes are operationalised in the context of person-centred culture change.

4.1 | Data collection

In order to gain a deep understanding of leadership practices and principles and how these were understood by team members, residents, managers and the leaders themselves, the data came from several sources:

- The Workplace Culture Critical Analysis Tool (WCCAT; McCormack, Henderson, Wilson, & Wright, 2009) is a nonparticipatory observation tool that uses combined practice observations and critical dialogue approaches to data collection. It was used in the study to analyse the culture of the practice settings where the leaders work. The tool itself adopts a holistic and person-centred perspective and the observation criteria are specifically designed to explore the processes of practice and the extent to which they reflect person-centred principles, team relationships and the way these do or do not support person-centred practice.
- Critical and reflective dialogues between the lead researcher (BL) and each of the six leaders helped to generate a deep understanding of the culture and the experiences of the leader participants. These conversations were initiated during initial workshops, debriefing following observations of practice and monthly meetings with leaders.
- Narratives from residents at time 1 and time 2 of the study. The main aim of the narration was to gain an understanding of how residents perceived leadership in the nursing home. At the commencement of the narrative interview, the resident was given an explanation of the purpose of the study and the main focus of the narration was identified. Bauer (1996) suggests that the narrative interview uses an ordinary day-to-day method of communication that combines the telling of a story with listening and in so doing, gathers data in a natural way.
- Focus groups held with staff at time 2. Participants were asked to focus on what they saw as the particular skills required by the leader to lead person-centred care effectively and how they felt the PCSLF had or had not contributed to the developmental level of the team in the household.
- Reflective field notes helped tie the whole process together. The reflective field notes by the lead researcher (BL) were structured to capture a description of the experience, the issues that arose during it, the feelings about the experience, what could have been changed and the learning from the experience.

4.2 | Sample/study participants

The study participants were recruited from the staff and residents in the nursing home. Different approaches to sampling were adopted dependent on the method of data collection. For the observations of practice, a convenience sampling strategy was used to include all team members as key participants during the negotiated time period of each observation. Convenience sampling was used for the resident narratives at time 1 and time 2 of the study. A purposive sampling strategy was used to recruit six participants for the staff focus group. The participants were recruited from across the three households and included a registered nurse and a carer from each household. All six leaders in the nursing home were included as a convenience sample for the focus group with leaders. Clarification of the overall sampling process used in the study is presented in Table 1.

4.3 | Data analysis

In order to analyse the data, different approaches were adopted for the different data sources. Table 2 provides a summary of how each data source was analysed separately and then the overall results of the thematic analysis brought together in the final stage.

The planning and co-ordination of data analysis took place during the supervision sessions of the study and involved a team approach. Getting immersed in the raw data helped to uncover the feeling and flavour of the common threads, the differences, the unique occurrences and the tentative themes that were arising from the data set as a whole (across the three time periods). The results of the thematic analysis were brought together using the process of cognitive mapping (Eden, 2004). Cognitive mapping techniques help to structure a large amount of data material from different sources while encouraging creative ways of working and displaying the data clearly in a map (McCormack and Garbett, 2003; Semple and McCance, 2010). The overall cognitive map was large; however, a section from the map is presented in Figure 1.

4.4 | Ethics

Ethical approval for this research study was received from Ulster University Research Ethics Committee, ethical approval number: REC/10/0193. Participation in the study was voluntary and informed consent procedures were designed to provide the leaders/team members/residents with sufficient information so that they could make an informed decision about the potential inconveniences and benefits of participating in the study. Participants were assured of anonymity, confidentiality and their right to withdraw.

5 | RESULTS

Through the process of cognitive mapping (Figure 1), seven core themes were identified, and as part of the analysis, a descriptor was developed for each of the seven themes. The themes have been

TABLE 1 Clarification of the overall sampling process

Method of data collection	Sample	
11 observations of practice	A convenience sampling strategy was used to include all team members as key participants during the negotiated time period of each observation	
	Observation	Participants
	Activity in household	(*n* = 4) 1 leader and 3 staff members
	Meal and mealtimes	(*n* = 6) 2 leaders and 4 staff members
	Meal and mealtimes	(*n* = 2) 1 leader and 1 staff member
	Meaningful interactions	(*n* = 5) 1 leader and 4 staff members
	Leadership behaviour	(*n* = 2) 2 leaders
	Leadership behaviour	(*n* = 3) 3 leaders
	Leadership behaviour	(*n* = 2) 2 leaders
	Connecting with the residents	(*n* = 5) 1 leader and 4 staff members
	Team meeting	(*n* = 11) 3 leaders and 8 staff members
	Team meeting	(*n* = 11) 3 leaders and 8 staff members
	Leadership meeting	(*n* = 6) 6 leaders
Residents' narratives at time 1 and time 2	A convenience sampling strategy was used to recruit participant residents at time 1 and time 2.	
	Four resident participants at time 1 and four different resident participants at time 2 were selected on the basis that they volunteered to share their narratives (*n* = 8).	
Focus groups/leaders time 2	All six leaders in the nursing home were included as a convenience sample in the study	
Focus groups/staff time 2	A purposive sampling strategy was used to recruit six participants. The team member participants were recruited from across the three households and included a registered nurse and a carer from each household. The criterion was that all 6 team members were working in the respective households during the period of time that their leader was participating in the study.	

synthesised with the evidence in the data and emerge as specific core attributes of transformational leadership that need to be present in the situational leader in order to bring about person-centredness. The seven core themes are as follows:

- relating to the essence of being;
- harmonising actions with the vision;
- balancing concern for compliance with concern for person-centredness;
- connecting with the other person in the instant;
- intentionally enthusing the other person to act;
- listening to the other person with the heart; and
- unifying through collaboration, appreciation and trust.

5.1 | Relating to the essence of being

Descriptor The situational leader experiences an arising awareness and a witnessing of their emotions as they relate to the other person in the moment.

The first example of a clear synthesis between the evidence in the data and the theme "relating to the essence of being" comes at time 1, during the workshop with the six participant leaders to introduce the PCSLF. The critical dialogue that took place following the workshop revealed that, up to this point, none of the leaders had ever considered how they were "being" as leaders when managing the care environment, nor had they thought about the style of leadership that they most frequently used with the members of their team (e.g., directive, coaching, supportive or delegating).

> *I have a fear of delegating various aspects of the dementia care programme to members of my team in case they don't get it done adequately…I tend to make the changes in the House myself …I always relate with the them as the leader because I am the one who has to take responsibility. I know now … from the PCSLF… my style of leadership is quite a directive one.*
>
> *(critical dialogue with Iris, following initial workshop; time 1)*

> *The PCSLF isn't just about me developing them as leaders, it's also about developing me…I'm not only a facilitator for this group of leaders but also a situational leader as well.* *(BL reflective field notes; time 1)*

A second workshop with leaders at time 1 focused on the principles of the WCCAT. Following this, several initial WCCAT observations of practice took place that looked at the leaders' changing practice. The first observation looked at meal and mealtimes for the

TABLE 2 Approaches used to analyse the data

Data source	How were the data analysed?	By whom?	When?
The Workplace Culture Critical Analysis Tool (WCCAT)	Analysis followed six-step process of thematic analysis (McCormack et al., 2009). Information was read /re-read by each individual member of the group who captured meaning and shared with the others. Each participant themed/refined the data and shared themes and explanations with rest of the group. The final shared tentative themes were agreed upon and the data sources identified.	Lead researcher worked with leaders and staff in household where observation took place to support them in theming the data.	Immediately following each observation of practice
Residents' narratives	Duration of recorded narratives ranged between half an hour to 1 hour—each one transcribed verbatim. Thematic approach for each analysis (Riessman, 2008). Set of themes inductively created by identifying key words/ideas/ impressions from the data and linking themes together using short extracts and examples from the narratives.	Took place during the supervision sessions of the study and involved a team approach.	Time 1 and time 2 of the study
Critical and reflective dialogues	Thematic approach—similar to the approach adopted for the residents' narratives (total of 114 conversations over 227 hrs)	As above	At the 3 time periods of the study
Focus groups with staff	Inductive approach to analyse the data (Ely, Anzul, Friedman, Gardner, & McCormack Steinman, 1991; McCormack, 2002). Transcription of tape recordings verbatim, making notes and creating initial tentative themes across the data set and matching data extracts to the themes.	As above	At time 2 of the study
Entire data set	Immersion in the entire data set. Reading and re-reading all the extracts (including BL's reflective field notes). Process helped determine whether the themes were representative of overall data set and helped identify additional themes. Results of the thematic analysis brought together using the process of cognitive mapping (Eden, 2004)	As above	Final stage of analysis

residents and Iris, house lead, was an observer during this observation. Iris noted that staff member Rhonda, who was assisting a resident with eating and drinking, was not communicating with the resident or relating to her in any meaningful or person-centred way. Rhonda made no eye contact or attempt to communicate with the resident and walked away leaving food residue dripping from the resident's mouth. During the dialogue with Iris afterwards, she reflected:

> *I actually felt uncomfortable, to the degree that I wanted to step in and take over… I didn't, I just stayed observing, which was very difficult… she [Rhonda] didn't relate to Mary [resident] at all! I knew from the workshop on the observations of practice that if I stepped in it would have an effect on the outcome… I just took deep breaths and kept observing…*
>
> *(reflective dialogue with Iris; time 1)*

Iris, who had revealed after the initial workshop that her dominant style of leadership was directive, had the impulse to walk in and take over during the observation of practice but held back and continued observing—she remained present in the moment. Her reflective dialogue captures how she sensed her essence of being: she experienced a total awareness and a witnessing of her emotions. From the reflective dialogue, it was evident that there were a development and an enlightenment taking place with Iris, facilitated by the learning from both workshops. Iris coached Rhonda over several weeks in assisting the residents with their nutrition and reflected:

> *Learning how to coach Rhonda has really helped me to see the benefit of working in a partnership way with her. She feels much more capable in assisting the residents with their meals … she's at the "capable but cautious contributor" stage… she can now really relate with the resident in a meaningful way for them… with who they are in essence…*
>
> *(reflective dialogue with Iris following partnering for performance with Rhonda; time 2)*

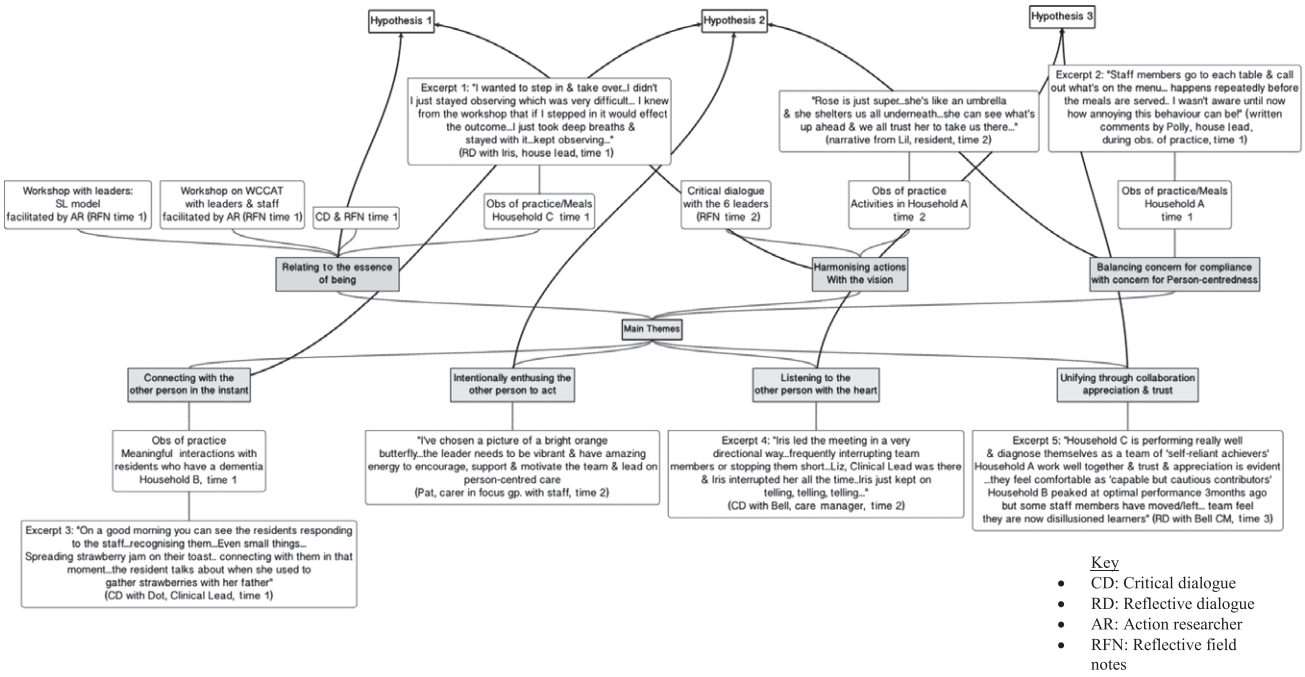

FIGURE 1 A section from the cognitive map

5.2 | Harmonising actions with the vision

Descriptor The uncovering of an authentic vision of person-centredness is dependent on the situational leader giving the team and the residents the space and presence to reflect on, and refine their individual values and beliefs, so that their overall intention is revealed naturally.

An observation of practice that looked at activity in Household B at time 2 revealed that some care practices in the care environment were not aligned or in harmony, with the person-centred vision that Household B espoused. In the critical dialogue with Rose following the observation of practice, Rose expressed concern about what she had just observed:

> *It really goes against the vision.*

Rose described the vision for the household as being:

> *The residents who live in Household B have a great life here and our mission is to work as a team to make this vision a reality.*

These words were visible in a framed vision statement on the wall of Household B and Rose confirmed that all the staff were aware that this was the goal of their household. However, during the dialogue, she agreed that the statement gave the impression of a guideline that was set in time but not "a living ethos." BL and Rose discussed examples of the practices that Rose might witness in the care environment if the actions of the team members were aligned, and in harmony, with the detail of what "having a great life" looked and felt like for the residents living there.

In partnering Rose for performance, BL focused on diagnosing Rose's ability to support the individual team members in articulating their values and beliefs and thereby enlist the overall team in a common vision for the household. Rose felt she was at the enthusiastic beginner stage with respect to facilitating a values clarification exercise as a way of developing a common vision with the team. Therefore, BL used a directing style of leadership with Rose initially, taking her through the principles of Manley's (2000) values clarification tool:

> *...In your own home a visitor wouldn't come in and change the TV channel...why should they do it here? When Rose asked me about my values that's what I said... I value people treating here as if it was my home they were coming into...*
>
> *(narrative from Sarah, resident, Household B; time 2)*

A narrative from one of the residents at time 1 illustrates the resident's confidence and trust in Rose's leadership skills and indeed in her ability to inspire a shared vision for the residents and the team:

> *Rose is just super, no use in saying otherwise... she's as straight as a rush... there's no back doors with Rose. She's like an umbrella and she shelters us all underneath...guides us along the path to where we're going-...she can see what's up ahead and we all trust her to take us there...*
>
> *(narrative from Lil, resident, Household B; time 1)*

5.3 | Balancing concern for compliance with concern for person-centredness

Descriptor The situational leader supports the follower in moving from a complete focus on the "doing" perspective of a care process for the resident, to a greater focus on "being" totally present in the moment with the resident while carrying out the care process.

During a second observation of practice that looked at lunchtime for the residents (time 2), Polly, house lead, observed various members of the staff going over to each table where residents were seated, and prior to the meal being served, they repeatedly called out what was on the menu. In the consciousness raising and problematisation phase of the WCCAT, following the observation, Polly and her team discussed this practice. The consciousness raising and problematisation phase of the WCCAT is the phase where clarification of uncertainties with team members is discussed in order to gain a deeper understanding of specific aspects revealed during the observation of practice. During this stage, it became apparent that compliance with the requirements of the inspection and regulation authority (know in the Republic of Ireland as the Health Information and Quality Authority [HIQA]) was the uppermost thought in the minds of the staff and indeed was what drove their actions during this specific aspect of the observation. This incongruence between compliance and person-centred care became apparent to Polly during the observation and she reflected on this after the observation:

> *. . .HIQA want to see that we're giving the residents a choice of meals. The inspectors look for staff demonstrating the practice of telling the residents what choice there is as well as having the menus on the table. . .we're not being compliant if we don't. . .so I suppose its over emphasised. . . looking at it from outside, its not very person-centred at all!*
>
> *(Polly, speaking during the consciousness raising and problematisation phase of the WCCAT—meal & mealtimes; time 2)*

In addressing this, a main focus of the action plan was to identify alternative ways of demonstrating that residents were offered a choice at mealtimes. The team agreed that the best action would be to discuss the issue with the residents and let them decide on the best way for staff to facilitate their choice. Using a process similar to that described as "a learning circle" (Norton, 2006; p. 94), residents were invited to sit around in a circle free of any obstructions with Polly facilitating the discussion. Everyone present in the circle was given an opportunity to speak and express their own views on this particular aspect of practice and residents who had communication difficulties were supported by staff members who sat beside them in the circle. As Rose was familiar with this method of generating meaningful discussion, she used a coaching style to support Polly in facilitating the group. The residents made the decision that the best way to let them know what was on the menu was to see a sample of each choice plated and they could then choose the food they preferred. The main outcome from this action was that the care practice of demonstrating the offer of choice to residents at mealtimes became one that was visual, tangible and meaningful for the residents, including those residents who had a cognitive impairment. It also fulfilled the regulatory requirements and aligned a person-centred approach to care with concerns for compliance:

> *The discussion circles are great for getting everyone's opinion. I've told them that I think there's a lot of waste. . .food waste and there shouldn't be food wasted with all the countries that are starving. . .you know. . . They really want to know our thoughts about different things. . . I feel we make our own decisions now. . .*
>
> *(narrative from Mary, resident, Household "A"; time 2)*

During the focus groups with staff at time 2, participants were asked to focus on what they saw as the particular skills required by the leader to lead person-centred care effectively. They were invited to choose a card from a collection of colourful cards with various images, to help them focus:

> *A flamingo looking at its own reflection in the water represents the importance of getting the balance right between compliance and the culture of person-centred care. It constantly changes. . . sometimes the ripples make the reflection bigger. . .when a HIQA inspection is due. . .compliance seems heavier than person-centredness. . .constant emphasis on paperwork. Having a consistent team helps to keep the balance. . . the images of the flamingo are equal then. . .*
>
> *(Maggie, staff nurse in focus group with staff; time 2).*

Jen was appointed as clinical lead of Household A just prior to the commencement of the research study. The household therefore had two team leaders: Jen with a nursing background and Polly, house lead, who had a carer background. The appointment of two leaders to the one household was intended to assist in establishing a balanced and co-ordinated approach to leading the team, while at the same time, ensure that each leader was supported in their role. During the critical and reflective dialogues with Jen and Polly at time 2, both leaders identified inconsistencies in clinical practice with reference to a person-centred approach. Jen articulated the challenges she faced in her new role that caused her anxiety and frustration and which impinged on her effectiveness in managing the care environment:

> *What I find frustrating is the constant struggle with getting the balance of interacting in a meaningful person-centred way with each resident in the household and*

ensuring clinical compliance. . .medication management, wound care management, maintaining and evaluating the residents' care plans. . .they're tasks that have to be done. . . *(critical dialogue with Jen; time 2)*

Jen and Polly tended to work in the household on opposite shifts to each other during the week with very little time for overlap or face-to-face communication. Following an observation of practice that looked at leadership and managing the care environment, Rose (line manager to Jen and Polly) concluded:

One thing I'm certain of. . . we have to 'marry' both aspects. . . the clinical piece with person-centredness. . .it can only start to happen if Polly and Jen work alongside each other, support each other and present a united front as leaders to the team. . ..
(comments by Rose during the consciousness raising and problematisation phase of the WCCAT—managing the care environment; time 2)

Jen and Polly, supported by Rose, made the decision to partner each other for performance in order to achieve a balance between being compliant with the standards and delivering person-centred care. They identified a resident, and with the resident's agreement, worked together to tailor the resident's shower, breakfast, medications and dressings all around what suited the resident—not as a series of isolated tasks, but in a smooth integrated way. The two leaders brought this change in practice to the monthly household team meeting in order to increase the staff's knowledge and understanding of person-centred care using the "living" example, and to help integrate the approach into their day-to-day practice. With the resident's permission, this approach to practice was also brought to the residents' discussion circle for their views and opinions. By this stage, the weekly resident discussion circles had become a normal part of household life, helping to tease out issues as they arose in the house or any new changes that were being proposed.

5.4 | Connecting with the other person in the instant

Descriptor The situational leader "models the way" by demonstrating an alert stillness in their interaction with the other person, where judgement is suspended in order to gain a deep understanding of what the other person is experiencing.

Dot was the clinical lead of Household C where residents who had a dementia resided. Several months previously, Dot and her team had taken part in a development programme to improve the quality of dementia care in the nursing home. Quite a bit of work had gone into changing the environment and the ambiance of the household in order to create meaningful spaces where person-centred interaction with the individual residents could occur. The underlying philosophy of the dementia care programme was to develop the knowledge and skills of staff caring for residents with a dementia so that they could interact meaningfully, moment by moment, with the residents, using a person-centred approach that is based on sensory comfort and stimulation (Kitwood, 1997; Sheard, 2008). An observation of practice at time 1 was undertaken to capture staff members' interactions with the residents during a morning period in the household. In her observation notes, Dot expressed her disappointment and summed up the practice she had just observed as "a bad morning." During the critical dialogue with BL, Dot reflected on what "a good morning" would look like:

When a good morning happens it looks like a whole natural connection. . .staff connecting with residents, residents connecting with staff. . .staff connecting with staff. . . its all synchronised. . .responding to the resident, making them feel good, bringing something out. . .a smile, a nod. . . even if its only for a moment. . . they're connected. . .and the staff are doing this continuously. Because of the attitudes and approaches of the staff. . . on a good morning you can see the residents responding to them. . .recognising them. . .Even small things. . .spreading strawberry jam on their toast. . .getting them to smell the strawberries in the jam. . .connecting with them in that moment. . .the resident talks about when she use to gather strawberries with her father. . .
(critical reflection by Dot, clinical lead; time 1)

Beatrice was the nurse leading the house on the morning of the observation and she held the view that connecting on a moment-by-moment basis with the person did not work when the staff were "busy." During the critical reflection above, Dot became more aware of her leadership style and she realised that she usually adopted a "nonconfrontational" approach with Beatrice, refraining from challenging Beatrice's assumption that connecting on a moment-by-moment basis with the person did not work when the staff were "busy." Following the critical reflection by Dot, she worked alongside Beatrice for 2 weeks, coaching her using critical reflection and "modelling the way" (Kouzes and Posner, 2003), During this period, Dot demonstrated real living examples of how Beatrice (in her "busy-ness") could transform caregiving moments and day-to-day activities into opportunities to connect in the instant with the resident.

Several weeks later, Dot carried out an observation of practice on a morning when Beatrice was leading the team. In a critical dialogue with Beatrice following the observation of practice, she was encouraged to reflect on how she felt as she engaged in continuous interaction with individual residents in an effort to make each moment more meaningful to them:

Dot really helped me to see the connections I could make using simple things in the environment. It has changed my attitude to the way I interact with the residents. . .I feel more relaxed and able to be myself. Its

important to respond to the residents in the right manner… you may have to say something several times a day but you must remember, for them, it's the first time. When only one person in the team is doing it…engaging with them in meaningful moments…that's more difficult…its important that all team members take part so that one person in the team can take over from the other…

(critical dialogue with Beatrice, staff nurse following observation of practice; time 2)

5.5 | Intentionally enthusing the other person to act

Descriptor The arising moment-by-moment awareness in the situational leader is the "how" of what the leader does and this state of consciousness is the source from which the leader's actions originate. These are the actions that direct the waves of enthusiasm in the follower, bringing a deep enjoyment to what they do.

The theme "intentionally enthusing the other person to act" became evident during the thematic analysis when evidence in the data highlighted the various ways in which the leaders worked with the followers, helping them to move along their developmental level: Rose with Polly and Jen; Polly with the team members and residents; Iris with Rhonda; Dot with Beatrice; and BL with each of the individual leaders:

I've chosen a picture of a bright orange butterfly…the leader needs to be vibrant, have amazing energy to support the team, engender trust and lead on person-centred care… (Pat, carer in focus group with staff; time 2)

I've chosen a picture of the Christmas star to represent how Dot interacts with all of us…She treats us all like we all have star qualities—she knows the stage each of us is at. I think she works hard at getting us enthusiastic about doing the best we can …She's always supporting us to develop innovative ways to give care in a person-centred way…

(Noleen, staff nurse in focus group with staff; time 2)

5.6 | Listening to the other person with the heart

Descriptor The increased awareness in the situational leader opens up a space, free of conceptual thinking, where full alert attention is given to the other person and to the words they are speaking.

Following the initial observation of practice, Bell worked with Iris for about 6 months "partnering" Iris for "performance," using a supporting style. However, Iris agreed with Bell's evaluation that she still remained at the level of "disillusioned learner" with regard to effective communication with the team. Bell's account of how Iris communicated with her colleagues revealed that Iris's way of leading the team meeting was very directional:

Iris led the meeting in a very directional way and when team members contributed with suggestions or opinions, Iris seemed not to have her heart in what they were saying…she frequently interrupted them or stopped them short in mid sentence …In the end people stopped contributing…Iris didn't seem to notice…she kept on telling, telling, telling… (critical dialogue with Bell; time 2)

Bell's account of how Iris communicated with her colleagues in the team highlights an inability by Iris to truly listen to the other person. It was apparent that when the other person spoke, the greater part of Iris's attention was taken up by the dialogue in her head. While the content of what a person is listening to is important, the act of listening itself is of greater importance and features strongly in the process of "graceful care," as described by Titchen (2004, p. 159). Listening with the heart to the other person involves clearing the barriers created by ongoing thinking and:

opening up a space where the person listening receives the words of the person speaking with full alert attention (Tolle, 2003).

Bell worked with Iris giving her direction on how she could develop techniques to help her free up her "thinking mind" enough to create the necessary space where Iris could then listen to the other person in the moment. During the meetings, she also coached Iris in ways to move from a directive style of leadership to a more coaching/supportive style with the individual members of the team.

Bell continued to meet Iris on a regular basis, partnering her performance using a coaching style to support her in preparation for her team meetings that "fed" into the monthly leadership meetings, co-chaired by Rose (DON) and Bell (care manager). The leadership meetings brought all the clinical leads and house leads together to discuss recent developments, future plans and issues in each household and afterwards share the learning with the teams in each household.

5.7 | Unifying through collaboration, appreciation and trust

Descriptor The situational leader adopts an uncritical, all-encompassing, inclusive approach to dialogue with the collective members of the team, where the presence of each person is honoured and a trusting relationship is nurtured within an open communicative space.

A critical dialogue was held with each of the leaders at time 3 of the study, 6 months after the study had ended, in order to evaluate the sustainability of the intervention that was based on the PCSLF in residential care:

> *The recent team building sessions have strengthened each team member's contribution to the overall team and their belief in the vision. . .*
>
> *(Mary, carer in focus group with staff; time 2).*

> *The team work together like a wall with bricks and cement. . .both crucial, the trust is evident. . .there's no hierarchy and everyone appreciates everyone else's efforts*
>
> *(narrative from John, resident, Household "A"; time 2)*

Over the course of the research study, Rose and Bell had become so familiar with working with the model of situational leadership in residential care that they were able to adapt it themselves and apply the concept to developing their teams. Using the same processes of diagnosis, flexibility and partnering for performance (the leadership behaviours that underpin the model of situational leadership in residential care), Rose and Bell realised they could diagnose the stage that each of the three teams in the households was at and support each team's development:

> *. . .One household is really performing very well and diagnose themselves as a team of "self-reliant achievers," they are an enthusiastic, flexible and confident team and both leaders of the household work well together showing trust and appreciation for each other and for the overall team. . .the second team works well together also and trust and appreciation is evident. . .however they are "comfortable" with diagnosing themselves as a team of "capable but cautious contributors". . .the third team peaked at optimal performance and due to several changes in staff. . . they were experiencing some conflict. . . they felt they were "disillusioned learners". . .*
>
> *(reflective dialogue with Bell, care manager; time 3)*

Rose and Bell engaged in critical dialogue to help the team diagnose their own developmental level and provided support to each of the three teams in developing action plans on how to move forward. Both leaders became so familiar with working with the model of situational leadership in residential care that they were able to adapt it themselves and apply the concept to developing their teams.

6 | DISCUSSION

The findings of this research provide support for the PCSLF as a leadership framework (Lynch et al., 2011) in nursing home care and in so doing highlight an arising awareness and a quality of being present in the situational leader that emerge as seven specific attributes of "the being of person-centredness."

Although the term "developmental level" suggests a linear progression, Wilber (2006) describes the levels of "being" as "waves" which are fluid. Rather than sitting one on top of the other like building bricks, they flow and unfold in "a series of nested spheres that transcend and include" those at a lower level (Wilber, 2006, p. 61). Coming from this premise and in the light of the findings, it is the situational leader who brings about the sequence of gentle waves of the being of person-centredness in the prerequisites of the follower. They unfold in "nested spheres" as the situational leader "relates," "harmonises," "balances," "intentionally enthuses," "connects," "listens" and "unifies" at the level that is appropriate to both the context and the developmental level of the follower. At this level, the follower is enabled to manage the care environment and deliver effective person-centred care. The attributes of the being of person-centredness, unfolding within each of the five prerequisites, introduce a new construct to the Person-Centred Nursing (PCN) Framework of McCormack and McCance (2006, 2010) and bring a depth about leadership that was previously absent. The Person-Centred Situational Leadership Framework (PCSLF) is illustrated in Figure 2.

6.1 | The unfolding of the being of person-centredness

The attributes of the being of person-centredness bring a "primary knowing" (Senge, Scharmer, Jaworski, & Flowers, 2007, p. 97) and the arising of a deeper moment-by-moment awareness in the situational leader who, in turn, nurtures it in the follower. The focus of the follower's competence shifts somewhat from the "doing" perspective of "undertaking a task" that is tied up solely with a future outcome, to a focus on being totally present in the moment while "undertaking a task." The arising presence manifests as successful action and the follower's level of competence increases in that action. An example of this can be seen with Iris as she becomes aware of how she is "being" while observing Rhonda in the care environment. She is then able to adjust her directive style of leadership and coach Rhonda to use a person-centred approach in assisting the resident with eating and drinking.

Person-centred practice requires that both the situational leader and the follower have developed interpersonal skills that take into account a heightened degree of sensitivity for the needs of the other person. The concept of sensitivity is particularly evident in the three attributes, "connecting with the other person in the instant," "relating to the essence of being" and "listening to the other person with the heart." Similar to mindfulness, sensitivity requires judgement to be suspended (Dyer, 2010; Tolle, 2008). The arising awareness promotes the desire to connect with the other person in the moment and gain a deep understanding of what the other person is experiencing (Senge et al., 2007). One example can be seen in the way Dot coached and supported Beatrice using critical reflection

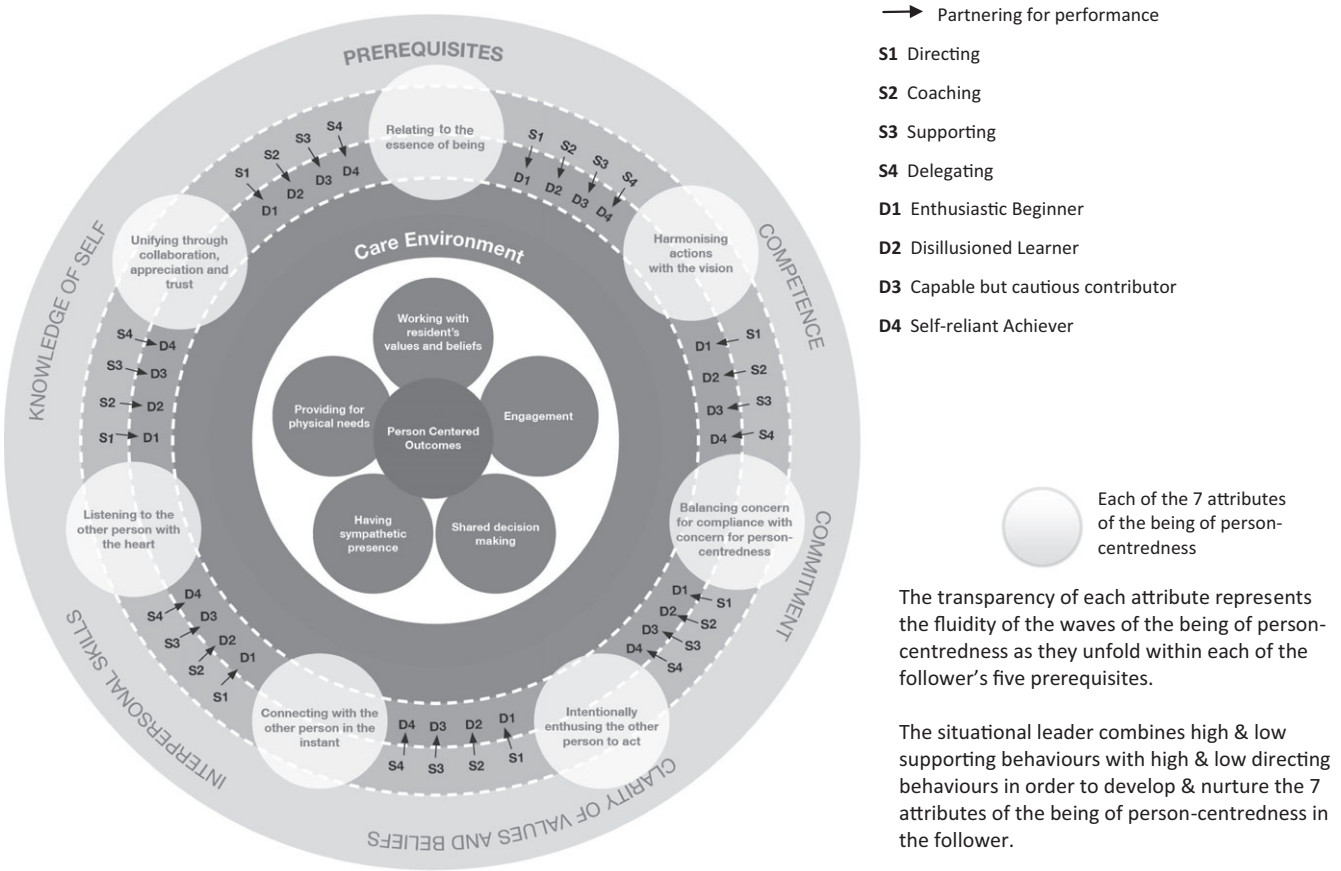

FIGURE 2 The re-presentation of the Person-Centred Situational Leadership Framework [Colour figure can be viewed at wileyonlinelibrary.com]

and role modelling. Dot helped Beatrice to increase her awareness of the multiple opportunities throughout the day when a meaningful connection could be made with the resident in the moment.

Senge et al. (2007, p. 138) describe the uncovering of an authentic vision as *"crystallising intent."* Witnessing the harmonising of actions in line with the vision requires the practitioner to periodically stand back and, more importantly, stand "still," while observing this unfolding in the care environment. Through critical dialogue with the team immediately following the observation, the situational leader and follower open up new approaches to "doing" their practice and "being" in their practice, thereby deepening their understanding and self-awareness through reflexivity.

The clarification of one's values and beliefs is an integral part of gaining knowledge of self. McCormack (2003) suggests that the practitioner's personal horizon or value system can unconsciously or consciously influence the patient's (or resident's) decisions and it is therefore important for practitioners to increase their self-awareness through critical reflection. On the basis of the study's findings, the attributes of the being of person-centredness deepen this reflection and awareness in the situational leader.

The attributes of the being of person-centredness bring a level of dynamism to the relationship between the situational leader and the follower that nurtures true commitment at each stage of the developmental continuum. The arising moment-by-moment awareness in the situational leader is the "how" of what the leader does and this state of consciousness is the source from which the leader's actions originate. These actions direct the waves of enthusiasm in the beginner, bringing a deep enjoyment to what they do. They coach the learner through moments of confusion and disillusionment by inviting participation and collaboration. They support and strengthen the contribution of the cautious follower by bringing a wave of creative energy to their capabilities. They also confidently delegate responsibility for meaningful and significant activities to the self-reliant follower. By achieving them, the self-reliant follower feels competent, autonomous and fully aligned with the vision of person-centredness.

7 | CONCLUSION

The development of the Person-Centred Situational Leadership (PCSL) Framework provides a model of leadership that is facilitative, enabling and person-centred and is the first of its kind in nursing home care. This is the first study to demonstrate how the dynamism of the relationship between the leader and the follower enables person-centredness to be brought into practice on an everyday basis. The findings reveal that engagement in a critical reflective process is fundamental to the development of the being of person-centredness.

Consequently, there is significant value in building a critical reflective approach into formal education programmes for nurse leaders and practitioners. Such an approach would not only focus on assisting practitioners to develop a better understanding of their assumptions around what they are "doing" in their practice but would also help them develop a depth of awareness on how they are "being" in their practice. The PCSL Framework therefore has the capacity to support the process of continuous learning within the care environment.

8 | RELEVANCE TO CLINICAL PRACTICE

Although the study took place within nursing home care, the findings can be seen to have significant applicability internationally, across other care settings and contexts. In order to test the future potential of the PCSL Framework, it is important that the framework is implemented and researched in practice settings where a leader and a follower work together in a dynamic context to create a person-centred culture.

CONTRIBUTIONS

Study design: BL, TMcC, BMcC; data collection and analysis: BL, TMcC, BMcC, DB ; manuscript preparation: BL, TMcC, BMcC, DB.

REFERENCES

Bamford-Wade, A., & Moss, C. (2010). Transformational leadership and shared governance: An action study. *Journal of Nursing Management*, *18*, 815–821.

Bass, B. M., & Avolio, B. J. (1994). *Improving organizational effectiveness through transformational leadership*. Thousand Oaks, CA: Sage.

Bate, S. (1994). *Strategies for cultural change*. Oxford: Butterworth Heinemann.

Bauer, M. (1996). The narrative interview. Comments on a technique for qualitative data collection. *Papers in Social Research Methods Qualitative Series no 1, October*. London School of Economics and Political Science: Methodology Institute.

Blanchard, K. (2007). *Leading at a higher level: Blanchard on how to be a high performing leader*. Harlow, England: Pearson Education Limited.

Bowles, A., & Bowles, N. B. (2000). A comparative study of transformational leadership in nursing development units and conventional clinical settings. *Journal of Nursing Management*, *8*(2), 69–76.

Brown Wilson, C. (2009). Developing community in care homes through a relationship-centred approach. *Health & Social Care in the Community*, *17*(2), 177–186.

Chapin, M. (2006). *Creating innovative places: Organizational and architectural case studies of the culture change movement in long-term care*. Southern Gerontological Society Annual Meeting. Lexington, KY.

Dana, B., & Olson, D. (2007). *Effective leadership in long term care: The need and the opportunity*. American College of Health Care Administrators Position Paper – Effective Leadership in Long Term Care, 1–27.

Dyer, W. (2010). *The power of intention: Learning to co-create your world your way*. California, CA: Hay House Inc.

Eden, C. (2004). Analyzing cognitive maps to help structure issues or problems. *European Journal of Operational Research*, *159*, 673–686.

Ely, M., Anzul, M., Friedman, T., Gardner, D., & McCormack Steinman, A. (1991). *Doing qualitative research: Circles within circles*. London: The Falmer Press.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. London: The Stationery Office, Department of Health.

Govier, I., & Nash, S. (2009). Examining transformational approaches to effective leadership in healthcare settings. *Nursing Times*, *105*(18), 24–27.

Grant, L. A., & Norton, L. (2005). *A stage model of culture change in nursing facilities*. New York, NY: Commonwealth Fund.

Health Information and Quality Authority (HIQA). (2009). *National quality standards for residential care settings for older people in long stay care settings in Ireland*. Dublin: HIQA.

Hersey, P. K., & Blanchard, K. H. (1982). *Management of organizational behavior*, 4th ed.. Englewood Cliffs, NJ: Prentice Hall.

Hersey, P., & Blanchard, P. (1997). *Management of organizational behavior: Utilizing human resources*. Englewood Cliffs, NJ: Prentice Hall.

Kitwood, T. (1997). *Dementia reconsidered: The person comes first*. Buckingham: Open University Press.

Kouzes, J. M. & Posner, B. Z. (2003). *Exemplary leadership*. San Francisco: CA: Jossey-Bass Publishers.

Lewin, K. (1946/1948). Action research and minority problems. In G. W. Lewin (Ed.), *Resolving social conflicts* (pp. 201–216). New York, NY: Harper & Row.

Lynch, B. M. (2015). Partnering for performance in situational leadership: A person-centred leadership approach. *International Practice Development Journal*, *5*, Special Issue on Person-centredness Article 5, 1–10.

Lynch, B. M., McCormack, B., & McCance, T. V. (2011). Development of a model of situational leadership in residential care for older people. *Journal of Nursing Management*, *19*, 1058–1069.

Manley, K. (2000). Organisational culture and consultant nurse outcomes: Part 1-Organisational culture. *Nursing in Critical Care*, *5*, 179–184.

McCormack, B. (2002). The person of the voice: Narrative identities in informed consent. *Nursing Philosophy*, *3*, 114–119.

McCormack, B. (2003). A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice*, *9*, 202–209.

McCormack, B., & Garbett, R. (2003). The characteristics, qualities and skills of practice developers. *Journal of Clinical Nursing*, *12*(3), 317–325.

McCormack, B., Henderson, E., Wilson, V., & Wright, J. (2009). The workplace culture critical analysis tool. *Practice Development in Healthcare*, *8*(1), 28–43.

McCormack, B., & McCance, T. V. (2006). Developing a conceptual framework for person-centred nursing. *Journal of Advanced Nursing*, *56*(5), 472–479.

McCormack, B., & McCance, T. V. (2010). *Person-centred nursing: Theory and practice*. Oxford: Wiley-Blackwell.

McCormack, B., & McCance, T. V. (2017). *Person-centred practice in nursing and healthcare: Theory and practice*. Oxford: Wiley-Blackwell.

McCormack, B., Roberts, T., Meyer, J., Morgan, D., & Boscart, V. (2012). Appreciating the 'person' in long-term care. *International Journal of Older People Nursing*, *7*, 284–294.

Murphy, K., O'Shea, E., Cooney, A., Shiel, A., & Hodgins, M. (2006). *Improving quality of life for older people in long-stay care settings in Ireland*. Report No. 93. Dublin, Ireland: National Council on Ageing and Older People.

Nolan, M., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'Person-centred' care: A new vision for gerontological nursing. *Journal of Clinical Nursing*, *13*(3a), 45–53.

Norton, L. (2006). Leadership transformation. In S. Shields, & L. Norton (Eds.), *In pursuit of the sunbeam: A practical guide to transformation from institution to household* (pp. 93–118). New York, NY: Action Pact Press.

Petriwskyj, A., Parker, D., Brown Wilson, C., & Gibson, A. (2015). What health and aged care culture change models mean for residents and their families: A systematic review. *The Gerontologist*, *56*(2), e12–e20.

Ragsdale, V., & McDougall, G. J. Jr (2008). The changing face of long-term care: Looking at the last decade. *Issues in Mental Health Nursing*, *29*, 992–1001.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage.

Schein, E. H. (1992). *Organizational culture and leadership*, 2nd ed.. San Francisco, CA: Jossey-Bass.

Schneider, W. (1994). *The reengineering alternative: A plan for making your current culture work*. New York, NY: Irwin.

Semple, C. & McCance, T. (2010) Experience of parents with head and neck cancer caring for young children: a qualitative study. *Journal of Advanced Nursing 66*(6), 1280–1290.

Senge, P., Scharmer, C. O., Jaworski, J., & Flowers, B. S. (2007). *Presence: Exploring profound change in people, organizations and society*. London, UK: Nicholas Brealey Publishing.

Sheard, D. (2008). *Inspiring: Leadership matters in dementia care*. London, UK: Alzheimer's Society.

Shields, S., & Norton, L. (2006). *In pursuit of the sunbeam: A practical guide to transformation from institution to household*. New York, NY: Action Pact Press.

Stone, R., Reinhard, S., Bowers, B., Zimmerman, D., & Phillips, C. (2002). *Evaluation of the wellspring model for improving nursing home quality*. No. 550. New York, NY: Commonwealth Fund.

Thomas, B. (2004). *What are old people for? How elders will save the world*. Acton, MA: VanderWyk & Burnham.

Thyer, G. I. (2003). Dare to be different: Transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management*, *11*, 73–79.

Titchen, A. (2004). Helping relationships for practice development. Critical companionship. In B. McCormack, K. Manley & R. Garbett (Eds.), *Practice development in nursing* (pp. 148–174). Oxford, UK: Blackwell Publishing Ltd.

Tolle, E. (2003). *Stillness speaks*. Novato, CA: New World Library.

Tolle, E. (2008). *Oneness with all life: Inspirational selections from a new earth*. New York, NY: Penguin Books Ltd.

Wilber, K. (2006). *Integral spirituality. A startling new role for religion in the modern and postmodern world*. Boston, MA: Integral Books.

How to cite this article: Lynch BM, McCance T, McCormack B, Brown D. The development of the Person-Centred Situational Leadership Framework: Revealing the being of person-centredness in nursing homes. *J Clin Nurs*. 2018; 27:427–440. https://doi.org/10.1111/jocn.13949