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EMPIRICAL RESEARCH – QUALITATIVE

Nursing leadership to facilitate patient participation in fundamental care: An ethnographic qualitative study

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Abstract

Aims: To explore and describe hospital nurses' perceptions of leadership behaviours in facilitating patient participation in fundamental care.

Design: An ethnographic interview study.

Methods: Individual semi-structured interviews with 12 nurses with a bachelor's or master's degree working at a university medical centre were conducted between February and April 2021. The interview data were analysed using thematic analysis.

Results: Six themes were derived from the data: (1) nursing leadership; (2) patient participation; (3) using patients' preferences; (4) building relationships; (5) task-focused nursing; (6) need for role modelling.

Conclusion: Nurses indicated leadership behaviour to facilitate patient participation in fundamental care as inviting patients to participate and eliciting and supporting patients' preferences. Although nurses also regarded leadership as motivating colleagues to act and enhancing evidence-based practice, they appeared not to practise this themselves about patient participation. Role modelling was indicated as a need for improvement.

Impact: The findings established that not all leadership behaviours mentioned were used in practice about patient participation in fundamental care. Role modelling and the use of evidence-based practice are needed to increase patient participation. Further research will be necessary to develop and test leadership interventions to improve patient participation in fundamental care.

KEYWORDS
ethnography, fundamental care, nurses, nursing leadership, patient participation, patient-centered care, qualitative research

1 | INTRODUCTION

Meeting the fundamental care needs of patients is essential for optimal safety, recovery and positive experiences in any healthcare setting (Kitson et al., 2010). Patient participation is one of the fundamental care aspects and is increasingly recognized as a key component in healthcare. Of all healthcare professionals, nurses spend the most time with patients, which places them in a unique position

to enable and encourage the participation of patients in their care (Tobiano, Bucknall, et al., 2016). Nonetheless, little is known about how nurses effectively encourage patient participation in hospital care. Dedicated nursing leadership is key to promote and support working approaches that improve patient-centred, fundamental care, including patient participation (Conroy, 2018; Pentecost et al., 2020).

1.1 | Background

Recent developments in healthcare, such as increased complexity of patient care, an ageing population, an increase in several chronic illnesses, a worldwide nursing shortage and the current COVID-19 pandemic, emphasize the crucial role of nurses (World Health Organization, 2020). Nurses play a vital role in providing healthcare services, and they have a significant influence on nurse-sensitive outcomes, such as medication error, falls, pneumonia, urinary tract infections, unjustified restraints and pressure ulcers (Dubois et al., 2013). The heart of the nursing profession has been justly described as the delivery of Fundamental Care (Kitson et al., 2010). The FoC Framework (FoCF) encompasses physical, psychosocial, and relational aspects that are required by every patient regardless of their clinical condition (Alison Kitson et al., 2013). The nurse–patient relationship forms the core of the FoCF and is about approaching patients in an individual manner, developing trust with patients, being able to focus on them, anticipating their needs, getting to know them and assessing the quality of the relationship (Feo et al., 2017). Nurses who successfully address these relational elements of care work effectively to meet patients' needs (Feo et al., 2017).

Fundamental nursing care is deeply entwined with patient-centred care, which is promoted in hospitals internationally as a cornerstone for high-quality healthcare. Patient-centred care focuses on respect for patients' individuality, values, perspectives, knowledge and autonomy and is characterized by shared responsibility and communication (Hughes et al., 2008). Delivering patient-centred care includes patient participation, wherein patients are participating as respected and autonomous individuals (Alison Kitson et al., 2013). Sahlsten et al. (2008) defined patient participation as an established relationship between nurses and patients, a surrender of power or control by the nurses, shared information and knowledge, and active engagement together in intellectual or physical activities (Sahlsten et al., 2008). The definition establishes the nurse–patient relationship as the core of effective patient participation, which is also at the centre of the FoCF (Feo et al., 2017). Examples of participation in nursing care involve acknowledging patients as partners, who partake in planning and managing self-care, through a dialogue attuned to patients' preferences and experiences as well as to professionals' expertise (Oxelmark et al., 2018; Tobiano, Marshall, et al., 2016). Patient participation has numerous beneficial effects, including improved patient satisfaction, safety, therapy adherence, reduced patient anxiety, shortened hospital stay and enhanced quality of care, which leads to better healthcare outcomes (Vahdat et al., 2014).

Despite these advantages, nurses seem reluctant to enable patient participation in nursing care (Theys et al., 2020). In the literature, several challenges in patient participation are described, also at the patient level, such as the patients' physical condition, different cultural backgrounds, language, health literacy and characteristics related to the nature of the work, such as nursing routines, and traditional culture of not involving patients (Oxelmark et al., 2018). The need to maintain control over care, reluctance to engage in deep conversations, fear of being seen as unprofessional by patients and even fear of repercussions from physicians hinders nurses from facilitating patient participation in hospital care (Theys et al., 2020). Patients experience a lack of participation in their care, and whilst they would like to be more involved in it, they feel restricted in their opportunities for participation owing to an imbalanced relationship in which nurses hold the power (Tobiano, Bucknall, et al., 2016). The biomedical model of care still dominates over more patient-centred psychosocial models, resulting in lower patient participation (van Belle et al., 2020). Therefore, true patient participation is seldom encouraged, although there seem to be ample opportunities for it (van Belle et al., 2020).

The established benefits of patient-centred care emphasize the need to improve patient participation and to generate more insight into how this could be achieved. Previous research suggests that dedicated nursing leadership is needed to enhance fundamental nursing care, including patient participation (Pentecost et al., 2020). Conroy (2018) indicated that nursing leadership has the potential to influence the nurse–patient relationship and the active involvement of patients, for example by role modelling expected behaviour (Conroy, 2018). Whilst an unambiguous definition of nursing leadership is lacking, there is a consensus that it requires competencies such as innovating, inspiring, supporting and teaching, along with a concern for improving the quality of care (Heinen et al., 2019). It focuses on delivering excellent patient care and concerns topics such as collaboration with professionals, implementation of innovations, enhancing evidence-based practice, and reflection (Northhouse, 2014). Nursing leadership has the potential to improve patient safety, patient satisfaction and reduce adverse events (Wong et al., 2013). However, the literature shows that as yet not much research has been done into how nurses working in direct patient care use leadership behaviours to achieve a systematic and consistent approach to patient participation (Conroy, 2018). Therefore, it is necessary to further explore how these nurses use leadership behaviour to facilitate patient participation in fundamental nursing care in order to create opportunities for improvement.

2 | THE STUDY

2.1 | Aims

The aim of the study was to explore and describe hospital nurses' perceptions of leadership behaviours in facilitating patient participation in fundamental care.

2.2 | Design

An exploratory ethnographic qualitative design was used to obtain insight into nurses' perceptions of leadership and patient participation in fundamental care. This design was chosen to explore and describe the perceptions of a culture sharing group (Creswell, 2018). The study was conducted and reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) and the Standard for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

2.3 | Sample/Participants

The study was conducted in a university medical centre (UMC) in the Netherlands with the study population consisting of nurses. Nurses meeting the following inclusion criteria were eligible for participation: (a) Dutch-speaking, (b) possessing a bachelor's (BSc) or master's degree (MSc), (c) working in a nursing ward and (d) providing direct care to patients for at least 8 h per week. Nurses working in wards with specialities such as maternity care, paediatrics, and critical care were excluded from participation because in these specialized wards the relationship with the patient is formed differently on account of the typical character of these wards. Physician assistants and nurse practitioners were excluded from participation because they do not provide direct bedside care. Convenience sampling of nurses was used in two different ways. First, the members of the Nursing Science Group (NSG) of the UMC were invited to participate in the interviews. The NSG is an innovative group of about 40 nurses with a master's degree who are partially working in nursing research. Their aim is to share knowledge and expertise on research, implementation and evidence-based practice, to improve interprofessional collaboration, functioning of nursing teams and quality of care. Second, the managers of clinical wards and the members of the NSG of the hospital provided the names of nurses with a bachelor's degree who might be willing to participate. In total, 31 personalized email invitations were sent to nurses. Six respondents did not meet the inclusion criteria, and three respondents declined to participate because they were busy or on sick leave. Nine nurses did not respond to the email invitation, and one participant withdrew from the study because of health-related problems. Finally, 12 nurses were included (Figure 1).

2.4 | Data collection

Semi-structured, individual interviews were conducted on the basis of an interview guide by the executive researcher [WO] between February and April 2021. The interview guide was created on the basis of relevant literature and by discussing the topics with the research group (EB/MH) (Appendix S1). The interview guide focused on the following topics: (1) nursing leadership, (2) patient participation and (3) nursing leadership to facilitate patient participation. The guide included questions such as: 'How do you understand nursing leadership?', 'What are examples of how you currently practice patient participation in hospital care?' and 'How do you show nursing leadership to enhance patient participation in hospital care?' The interview guide was refined after a pilot interview with a nurse with a master's degree, who had not been included in the study. Throughout the interview process, the interviewing researcher critically reflected on the content and procedure of the interviews in the research group (EB/MH), with the aim to enhance critical reflectivity. The interviews were held face-to-face at a place preferred by the participant or were conducted online via Microsoft Teams, mainly owing to the COVID-19 pandemic restrictions. Only the researcher and participant were present at the time of the interview. Directly after the interview, contextual memos were made, reflecting the behaviour of the participant, as well as the setting of the interview. All interviews were audio-recorded and transcribed verbatim. However,

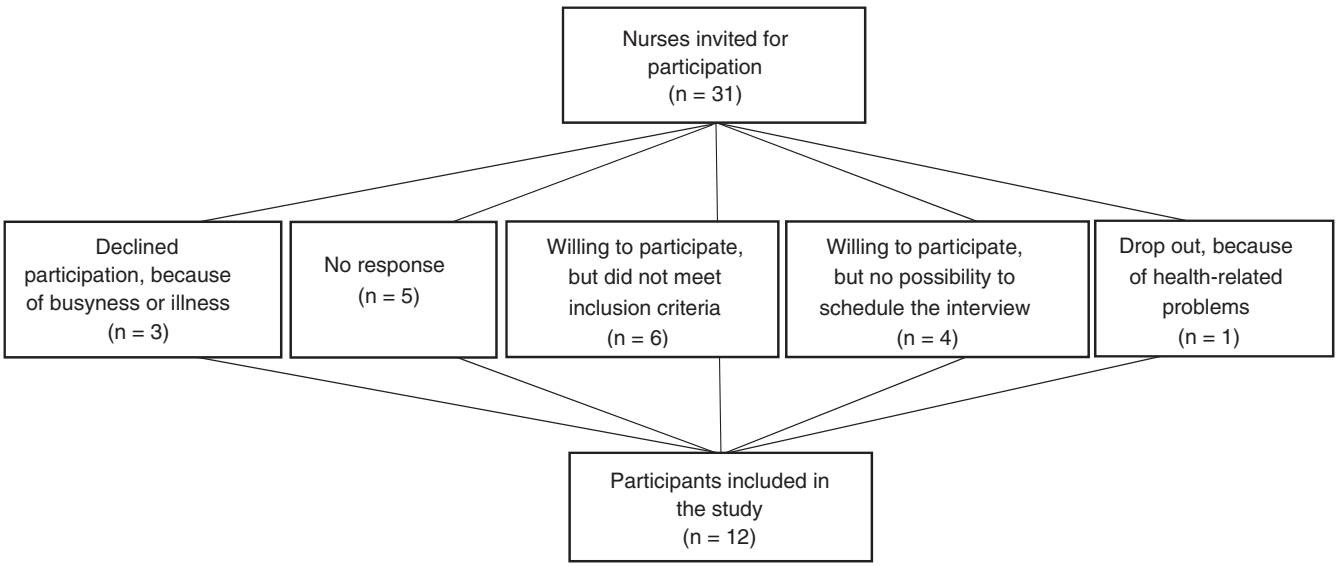

FIGURE 1 Flow chart of the recruitment of nurses, including reasons for non-participation.

one interview was not completely recorded due to technical problems. The transcript of this interview was further elaborated based on the notes made during the interview. Transcripts were returned to the participants for comments and verification. Eleven participants agreed that the interview was representative of their views. We added a clarification to the interview with the participant with whom the interview had not been fully recorded, which was based on a discussion of the transcription of the interview.

Respondents' demographic data were gathered at the start of each interview. As part of the demographics participants were asked to complete the Leadership Practice Inventory (LPI) questionnaire a week before the interview. The LPI is a 30-item validated questionnaire containing five subscales for practices of exemplary transformational leadership (Tourangeau & McGilton, 2004). Each subscale contains six questions with a 10-point Likert response scale, where higher scores indicated more frequently shown leadership behaviour (Tourangeau & McGilton, 2004). The LPI was used to determine whether there was a homogeneous sample of nurses concerning leadership behaviour (Rendle et al., 2019).

2.5 | Ethical considerations

The study was exempted from formal medical ethical review in accordance with the Dutch Medical Research Involving Human Subjects Act (File nr. 2020–7212). All respondents provided verbal or written informed consent, depending on the means of conducting the interview (face-to-face or via digital video conferencing).

2.6 | Data analysis

Interview data were analysed using thematic analysis (Braun & Clarke, 2006). The analysis followed six phases, supported by Atlas.ti 8.4.20 software (Friese, 2014). First, the entire text was read to become familiar with the data. Second, features of interest with regard to the study aim were identified by codes. The work in this phase was conducted independently by two researchers (WO and AB/EB/MH) to ensure the researchers' triangulation. The assigned codes were subsequently discussed, and the consensus was reached. After four interviews, a concept code map was established and applied to subsequent interviews by the executive researcher (WO). The codes of the other interviews were checked by a senior researcher (EB). Comments were discussed and the allocated codes were adjusted or clarified. In the third phase, codes were aggregated according to similarities and potential thematic patterns were examined. Afterwards, in the fourth phase, the themes were reviewed and compared again with the interview data. In the fifth phase, the themes were further defined and refined. The work in the third, fourth and fifth phases was performed by the executive researcher (WO), and the final analysis was validated in the research group (EB/MH). The research process moved from data collection to data analysis and back until the description was comprehensive, as an iterative process. The analysis process continued until no new information had been identified. Data from the LPI were analysed using descriptive statistics in Microsoft Excel.

2.7 | Rigour

The rigour of the study was enhanced by the use of different techniques (Lincoln & Guba, 1985). The trained interviewer extensively discussed the technique and content of the first two interviews in the research group to ensure accuracy. To enhance transparency, the executive researcher, who is a nurse herself, critically reflected on her own beliefs by making self-critical memos, which she subsequently discussed with the research group (EB/MH/AB/JM). Furthermore, an audit trail was used to trace decisions made during the research process. To guarantee dependability, data collection and analysis were undertaken simultaneously in a cyclic manner, contributing to the explorative nature of the study. Finally, a thick description was used in the final report to enable the reader to assess whether the findings are transferable to another setting.

3 | FINDINGS

A total of 12 nurses were interviewed (Table 1). The interviews lasted between 38 and 64 min (mean 52 min). The study participants ranged in age from 27 to 40 years, with the majority of nurses being female. Nurses had been practising for 8.3 years on average. All nurses had a Bachelor of Nursing degree. Six of them also had a master's degree, the majority being in Nursing Science, and they were all members of the NSG. These nurses worked partly as a nurse and partly as a nurse scientist, policy advisor or nurse teacher. One of the participating nurses did an in-service training to be a manager but still worked as a nurse and did not have a formal role as a manager. The nurses' self-reported leadership practice (LPI) mean score was 7.4 (range 6.0–8.9) on a 10-point Likert scale.

On the basis of the interviews, a total of 313 codes were identified, of which 130 codes focused specifically on nursing leadership, 118 codes reflected views on patient participation, and 65 codes concerned the actual use of leadership to facilitate patient participation. On the basis of all codes, the following six main themes were identified: (1) nursing leadership, (2) patient participation, (3) using patients' preferences, (4) building relationships, (5) task-focused nursing and (6) need for role modelling. The first two themes concerned the perceptions of nurses about leadership and participation. The following themes reflected on how to use leadership behaviours for patient participation, the relationship as a prerequisite, task-focused care as hindering, and role modelling as a need for improvement (Figure 2).

3.1 | Nursing leadership

The participants described a nurse leader as a competent, reflective, enthusiastic, inspiring, and critical professional, with a helicopter

TABLE 1 Nurse characteristics

n	12
Male/female, *n*	3/9
Age, mean in years (range)	32 (27–40)
Bachelor's degree/Master's degree, *n*	6/6
Years of work experience as a nurse, mean (range)	8.25 (2.5–15)
Clinical ward where the participating nurses were working, *n*	
Surgical departments	5
Internal departments	6
Other departments	1
Years of work experience on current clinical ward, mean (range)	7.50 (2.5–15)
Hours of work per week in patient care, mean (range)	25 (8–36)
Positions of MSc nurses next to patient care, *n*	
Nurse scientist	3
Nurse policy advisor	1
Nurse teacher	1
Hours of work per week in position next to patient care, mean (range)	19 (12–27)
Result of the Leadership Practice Inventory (LPI), mean (range)	7.4 (6.0–8.9)

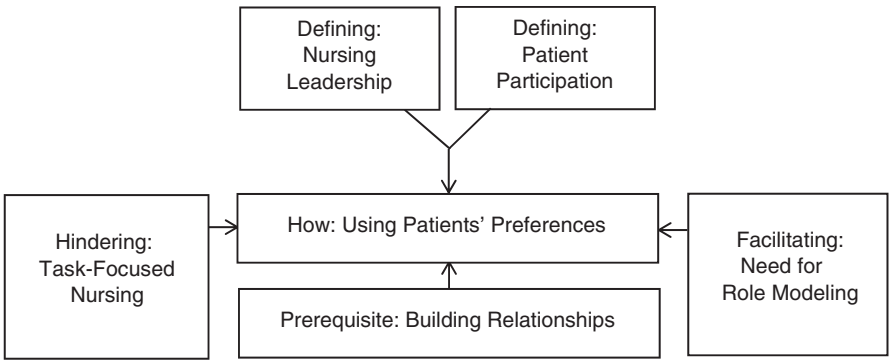

FIGURE 2 Themes about the use of leadership to facilitate patient participation in fundamental care.

view on patient care and who continually aims for improvement. Nurses emphasized that their leadership behaviours developed over time, on the basis of work experience and exploration of the leadership style that suits them best. Nurses described a wide range of leadership behaviours. Some nurses emphasized enhancing evidence-based practice as an important part of nursing leadership and indicated that they played a leading role in quality improvement, innovation or implementation.

> 'The protocols we have on the Q portal [digital protocol database] are nice of course, but they are most of the time very old and often there is no evidence given. I try, with the protocols we have on the wards, I try by means of a literature review or in contact with the medical doctor to substantiate them, so that we are really working according to the most recent insights.' (Female/MSc/34 years.)

Nurses regarded motivating colleagues to act as a part of nursing leadership, for example by keeping each other involved in quality projects, sharing knowledge, discussing care issues, asking critical questions, acting as a team, and supervising new colleagues or students. Furthermore, showing professional pride about the nursing profession, in general, was regarded as a part of leadership. Nurses cited examples such as promoting the nursing profession as a 'serious profession' to the outside world, advocating more awareness for the delivery of fundamental care, encouraging professionalization through more nurses receiving further education, and promoting the nursing profession as one that is of equal importance as that of physicians. Moreover, nurses described leadership as supporting patients, for example during medical rounds, or by organizing a patient or multidisciplinary consultation. In addition, some nurses described leadership behaviour as delivering patient-centred care, representing patients' interests, and making them feel safe. Motivating and stimulating patients in self-care and mobilization to promote their independence and recovery was also regarded as leadership.

> 'But I think that every nurse can show nursing leadership, like in patient care, by making decisions together with the patient and finding out, what does someone [the patient] want. And sometimes,

that clashes with the treatment policy that is prescribed by the doctors. And that you also stand for the patient and dare to represent them.' (Female/MSc/28 years)

3.2 | Patient participation

Most nurses viewed patient participation mainly as ensuring active patient involvement in care and more personal control for patients. Nurses described seeking an equal collaboration with patients, writing their daily reports together and having conversations to determine patients' preferences and needs as examples of how to ensure the active involvement of patients in their care.

'Yes, I think also providing patients' own control, I think. But also having a conversation with the patient. What do you want? How do you see this? How do you experience this? What is the meaning of quality of life for you, you know, and does this [treatment policy] fit? Empathize with patients' perspectives and identify what is right for them.' (Female/BSc/32 years)

Furthermore, nurses indicated that involving family in care also enabled patient participation, for instance by offering rooming-in, which facilitates family involvement in physical care and decision making. Sharing information about the course of hospitalization and treatment options was mentioned as another means of enabling participation, to ensure that patients made informed choices. Making use of the unique experiences of patients was also indicated. Nurses mentioned that they sometimes experienced a conflict between the patients' preferences and experiences and their own expertise or treatment policy on, for example, medication use, manner of physical care or frequency of mobilization. Some nurses regarded the expertise of the patient as paramount, only making exceptions for unsafe care. Other participants described the medical treatment guidelines as more important, whereas others preferred to find a compromise. Nurses also regarded supporting self-care as enhancing patient participation. They indicated that they discussed the patients' preferences for the manner and timing of washing or mobilization, provided that this suited the nurses' own planning.

'One supports self-management and self-care participation. It is your task as a nurse to encourage patients to be involved and to help themselves.' (Female/MSc/29 years).

Nurses mentioned several developments in the near future that might have an impact on the demand for patient participation in care, such as a more patient-centered approach, more multidisciplinary collaboration, and greater use of technology. They elaborated that patients will be more assertive and critical and will take the lead, which requires more multidisciplinary collaboration between patients, nurses, and other healthcare professionals. Nurses believed that technology will lead to more opportunities for patient participation, for example, patients using devices to monitor their own nutritional status or level of activity.

'I think that patient participation will become more and more important owing to technical developments. We will ask more of a patient. Sometimes, we will appeal more to their own responsibility. So, I think that patient participation goes hand in hand with nursing leadership, how we can support patients but also with technical advancements and other new developments.' (Male/BSc/28 years).

3.3 | Using patient preferences

Some nurses indicated that they use leadership behaviours to initiate patient participation by informing patients to take more personal control, mainly with regard to formulating their needs of the day and making daily appointments about washing or mobilization. Furthermore, nurses described being aware of their own role and responsibility to invite patients to share preferences or expectations as part of leadership behaviour. Thereby, nurses described emphasizing towards patients that they do have a say in their own care and during the disease process they are going through.

'Well, anyway, being aware that you can ask a question about how they [patients] wish to participate in their care that day. That is a part of leadership.' (Female/MSc/36 years)

'Well, by saying to patients you know, you can, you can have a say in your own disease process. You can tell the doctor that you do not see this [treatment] happening.' (Male/BSc/40 years)

Nurses described several exemplary practices in which they use their leadership behaviour to promote patient participation. In their contacts with the patient, some nurses indicated that they deviated from the protocols or treatment plans to create more room for their patients' preferences and to prioritize patients' wishes above the daily ward structure.

'A certain protocol, guideline, or care plan does not fit everyone. But if you notice, together with the patient, that the next step in a care plan is too early or does not fit, you discuss which alternatives exist and what the patient could do or wants instead.' (Female/MSc/29 years)

During the physicians' round, nurses described asking critical questions to physicians in accordance with their patients' needs, and

reminding physicians to involve their patients. In working with their colleagues, nurses regarded working together as a team to realize patients' preferences as important, for example by discussing who is able to support a patient if they would like to be washed in the afternoon and the nurse does not really have time at that particular moment. Furthermore, nurses indicated discussing patient cases including their personal goals during team meetings, although this was not often the case.

> 'And if you are struggling with involving patients you should also discuss this together. The nurse manager of course can also have a certain role in this, but I think that also, actually there is a role for every team member.' (Female/MSc/29 years).

Nurses regarded nursing leadership and patient participation as inextricably linked and described that leadership is important to facilitate participation. However, they felt that the level of leadership behaviour for patient participation is rather disappointing in colleagues. Some nurses indicated unfamiliarity about the meaning and practice of nursing leadership for patient participation in daily care.

> 'I notice that inexperienced colleagues achieve less patient participation, because they are not yet able to show leadership. They cannot rely on their expertise and knowledge, and then they work more to achieve the goal and do not take the patient with them in this process.' (Female/MSc/40 years).

> 'So, if we, when you ask everyone, do you, do you think that it should [showing leadership to involve patients], they say yes, we have to do that, this is what we stand for. But are we doing it really? I think that is still really a bit disappointing.' (Female/BSc/28 years)

3.4 | Building relationships

Nurses indicated that building a relationship with patients was prerequisite to showing leadership as well as to facilitate patient participation. Nurses described showing leadership by deliberately making time to build up a relationship with patients, which would lead to improved patient participation and positive experiences in healthcare. Nurses highlighted the need for getting to know the patient, taking time for informal and meaningful dialogue, active listening, giving undivided attention, feeling responsible, empathizing with patients, signalling and responding to patients' needs, and creating a comfortable, safe and trusted environment. The participants also described the need for equal partnership between patients and nurses.

> 'Having a relationship is really important, or at least [ensuring] that patients feel that they have an opportunity to discuss something. If they only see me coming and leaving in two seconds, and that is the only contact we have, I do not believe, when I imagine I am a patient, that I would feel safe discussing a sensitive topic.' (Female/MSc/29 years)

> 'The moment you start with it, then you start working on this trusting relationship, that can lead to patient participation. So it is, again, that you bring some nursing leadership, by giving that patient a bit more trust, and building a relationship with each other so that they can maybe trust you sooner, whereby you can feel strengthened, and think, hey, I am actually more aware, do I have to stand up for this patient, or will they manage themselves, it really has an impact on myself. It is an integral process I think.' (Male/BSc/40 years)

Furthermore, nurses indicated demonstrating leadership aimed at facilitating patient participation by communicating with patients about treatment policy or care processes in an open, honest and clear manner, to ensure that patients have opportunities to pose questions, discuss ambiguities and participate in their care.

> 'I think that transparency creates participation.' (Male/BSc/28 years).

3.5 | Task-focused nursing

Nearly all nurses were convinced that the existing and strong focus on task completion hinders showing leadership in patient participation. Nurses explained that they acted often from a pragmatic perspective to prioritize the order and fixed daily structure of the day instead of integrating patients' needs. Time and work pressure with respect to task completion were considered by nurses as barriers to showing leadership behaviour and enhancing patient participation.

> 'Yes, I think we, as nurses, tend to think about our own interests and [about] tasks that have to be done, and we really like to tick these boxes on our list. Yes, I think that we are on the right track seeing patients as partners, but there is still a lot of potential [for improvement].' (Female/MSc/29 years).

> 'We are too much used to our own structure. In our daily structure, we do medicines and vital signs at 8 o'clock, and afterwards activities of daily living, and at half past ten we drink coffee and continue with the medical round with the physicians. [...] But I think it is more a habit. So, we have not organized our processes in a way that we can be flexible.' (Female/MSc/29 years).

Some nurses indicated that they were questioned by colleagues when they had not completed all their tasks at the end of their shift, even though this occurred because of their patients' preferences.

> 'I regularly see that some patients need to receive temazepam rectally in the evening, and then sometimes the patient says: 'I do not want to go to sleep yet.' Should I reply, 'Even so, I am going to administer it to you right now'? No, my answer is: 'Please give me a signal when you want to sleep and then my nightshift colleague will come.' And then, during handover, I see my nightshift colleague thinking, why do I still have to do that? I thought, why are you sulking that you still have to do that, when this is patients' wish?' (Female/BSc/28 years).

3.6 | Need for role modelling

Nurses described several necessary changes evolving around role modelling to facilitate leadership about patient participation. They indicated that more knowledge in nurses about the meaning and different ways of patient participation, as well as communication and coaching skills, are amongst the first things that will be necessary to improve leadership and patient participation.

> 'I think I would like to highlight again what we stand for and what patient participation exactly means, and what we think is important about it. […] But, I think there is a role for awareness, you have different degrees of patient participation I think, and I think that maybe a bit more awareness is needed.' (Female/BSc/28 years).

Further, it was indicated that patients need to be better informed by nurses about how they actually can participate in their own care during hospitalization. Therefore, more attention and emphasis on these aspects will be required during the nursing intake interview, for example by asking patients about their personal goals. One of the nurses described a 'preoperative education day' as a good example of preparing patients for admission. On such a day, the patients receive information about their hospitalization, which help them to understand what to expect during admission. This could lead to more active patient involvement, for example about mobilization, use of medication, and nutrition. Nurses also indicated the need to formulate a shared vision of patient participation at the ward level, so that all nurses will model patient participation in the same way.

> 'I think what could help us is a shared vision on patient participation. When you share this vision with each other, everyone supports this vision, and we promote it in the same way. Right now, I think that everyone just does whatever they think is best.' (Male/BSc/33 years)

Nurses indicated that they need someone to set the tone for the ward in showing leadership behaviour for patient participation. A few nurses described how they felt they could be a role model themselves, for example by showing how to make partnerships with patients to realize making shared decisions, paying extra attention to reporting psychosocial care and nursing care plans, and holding other nurses accountable for showing leadership and enabling participation.

> 'I can take, of course, a clearer leading role, together with other nurses who partly do this already, to create a small group in which we motivate other nurses on the ward, to have a conversation in that way and report in that way [in medical files].' (Female/MSc/34 years)

4 | DISCUSSION

The results of this qualitative study provided insight into nurses' perceptions of how they use leadership behaviour to facilitate patient participation. Six themes were identified: nursing leadership, patient participation, using patients' preferences, building relationships, task-focused nursing and need for role modelling. First, the results about nursing leadership and patient participation are discussed as separate concepts in the light of the international literature, followed by the additional identified themes, in which nursing leadership related to patient participation in fundamental care is discussed.

About nursing leadership four domains can be identified in the literature: the clinical, professional, health system, and health policy leadership domains (Heinen et al., 2019). The participants of our study described perceptions of nursing leadership that predominately resemble the provision of 'good' fundamental care, which corresponds mostly with elements of the clinical leadership domain. Clinical leadership competencies are focused on promoting health, facilitating self-care management, optimizing patient engagement, and preventing future decline (Heinen, 2019). These elements recurred in the perceptions that nurses described with regard to nursing leadership, whereby they mainly described examples of leadership such as optimizing patient care and engagement. Furthermore, clinical leaders are expected to act as clinical experts, engage in evidence-based practice, and collaborate with other healthcare professionals (Heinen et al., 2019). On a more individual level, a leader acts as a resource person, preceptor, mentor or role model, demonstrating critical and reflective thinking (Sievers & Wolf, 2006). Although the nurses in our study described leadership as motivating and inspiring colleagues to act, this leadership behaviour was mainly focused on enabling others to act (Tourangeau & McGilton, 2004). Nurses described only a few examples of how they are modelling the way themselves, whils this is an important part of leadership behaviour (Heinen et al., 2019; Tourangeau & McGilton, 2004).

The nurses' perception of patient participation is largely congruent with its description in the international literature. Tobiano, Marshall, et al., 2016 described activities undertaken by nurses and

patients to promote patient participation, such as nurse–patient dialogue, sharing of knowledge, and involvement in planning and managing self-care (Tobiano, Marshall, et al., 2016). Although nurses initially described a wider spectrum of hypothetical possibilities to involve patients in care, examples about how they truly exercised the facilitation of patient participation were limited to informing patients and encouraging them in physical care. When asked about setting goals with patients or involving them in other aspects of care, nurses indicated this was often not the case. Literature suggests three levels of patient engagement, including consultation, involvement, and partnership (Carman et al., 2013). Reaching a partnership can be achieved by involving patients in decision making, but nurses find it challenging to specify how they do this in practice (Sahlsten et al., 2008). This was also observed in our study, where the examples of their actual practice mainly gravitated toward consultation or perhaps involvement. Therefore, nurses do not seem to achieve all different levels of patient participation, which is consistent with previous findings (van Belle et al., 2020).

Nurses indicated that they practised leadership to facilitate patient participation mainly by inviting patients to participate, using their preferences, and supporting their needs. This is consistent with nurses' perceptions about leadership in general as supporting patients' care needs. Nurses and patients have different priorities when it came to attending to patients' needs (Mudd et al., 2022). Therefore, the leadership behaviour of nurses is required to achieve prioritization of patients' needs, such as modelling expected behaviours, setting the tone for the ward, and providing resources to support the psychosocial fundamental care delivery (Conroy, 2018). The nurses in the current study described the need for having role models and to act as role models themselves. In addition, nurses experienced difficulties about practising leadership for participation, due to uncertainties about the meaning and different ways of participation, which seemed to recur in the described examples about patient participation. It is reported that nurses experienced a lack of knowledge on how to invite, motivate, and suitably promote patient participation (Oxelmark et al., 2018). There is room for improvement by generating more knowledge and coaching skills in nurses to reach a higher level of patient participation through true partnership and shared decision making with patients. Furthermore, searching, practising and implementing evidence-based strategies, such as hourly nursing rounds or bedside handovers, could promote seeing patients as partners (Tobiano, Marshall, et al., 2016). Although nurses described enhancing evidence-based practice as part of nursing leadership, they did not indicate that they actually practised this about patient participation.

Another challenge nurses described was pressures from daily routines and their peers as hindering leadership for patient participation. Task-focused nursing care has been recognized in earlier ethnographic studies as a barrier to participation (van Belle et al., 2020). Interestingly, none of the nurses mentioned tasks, such as supporting patients in their preferences or questioning patients' goals, as part of their daily routines. Nurses suggested questioning patients' expectations and goals for hospitalization during the nursing intake, which seems a way to claim time and awareness for patient participation. Integrating relational and psychosocial aspects in daily care routines is needed to promote patient participation. More importantly, nurse leaders are expected to optimize patient engagement, but respondents described that nurses mainly invested time in involving patients when it suited their planning. This calls for action from nurses to reroute from task-focused nursing to acknowledging patients' preferences. Examples of rerouting from tasks were however limited, which implies that there seems to be an inability to respond in a patient-centered way to task-oriented thinking. Strengthening the ability to reroute from the focus on task completion, and changing behaviours of nurses would show real leadership of nurses in daily practice. Leadership interventions such as mentoring could be helpful in this (Cummings et al., 2021).

The nurse–patient relationship was described as a prerequisite for executing leadership practices to enhance patient participation. The ability to build a relationship is associated with nursing leadership because it involves the ability to understand and respond to the feelings of others (Feo et al., 2017). Relating to patients is also identified as a method of enabling patient participation (Tobiano, Marshall, et al., 2016). Feo et al. (2017) described how an established nurse–patient relationship consists of five essential relational elements: developing trust, giving undivided attention, anticipating patients' needs, getting to know the patient and evaluating the quality of the relationship. The participants in this study described that they practised most of these aspects of establishing a relationship, except for the evaluation of the quality of the nurse–patient relationship. These findings are rather promising, as delivering care centred on such relationships is challenging (Feo et al., 2017). Even so, there is still room for improvement about the evaluation of the quality of the nurse–patient relationship, by talking to patients about their perception of the relationship, and determining whether patients' expectations have been met and where improvements can be made (Feo et al., 2017). Reflection on practice will help to create awareness of the nurses' current approaches toward their role in engaging with patients and can lead to nurses acknowledging patients' needs in a more patient-centred manner. This reflection seems to fit the role of a nurse leader as a reflective thinking professional (Heinen et al., 2019).

In terms of strengths, this study is one of the few qualitative studies exploring nurses' perceptions of leadership behaviours for enhanced patient participation in fundamental hospital nursing care. Leadership behaviours for fundamental care including patient participation are not widely investigated in daily practice. This study provides a preliminary exploration of the relation between leadership behaviours and patient participation and provides rich data based on 12 interviews about this interrelationship, conducted amongst nurses possessing either a BSc or MSc, working in a wide range of clinical wards, and having varying levels of work experience.

5 | LIMITATIONS

This study also has some limitations that need to be addressed. First, it could be argued that convenience sampling might have led to some

selection bias, as participants were included in their willingness to participate. Therefore, perhaps only nurses showing stronger leadership behaviour may be involved, which is reflected in an average to high mean score on the LPI. On the contrary, this fits with the explorative ethnographic nature of the study and shows how these experienced nurses describe their leadership behaviours for patient participation. Second, asking the nurses to fill in the LPI might have led to giving some direction in discussing leadership behaviours in the interviews. However, we expect this to have only a limited impact in getting insight into the perceptions of nurses on how they enact leadership for patient participation, as concepts of the LPI had not been integrated in the interview guide. Finally, we acknowledge that we only had a rather small number of participants, which is however not exceptional for qualitative research. The perceptions of the participating nurses seemed to be representative of nurses working in this health facility.: during the last interview no additional data was found to further develop the properties of the themes, and only individual variation existed concerning examples of leadership for participation.

6 | CONCLUSION

Nurses use leadership behaviours to facilitate patient participation in fundamental care by inviting patients to participate and eliciting and supporting their preferences. Although nurses described nursing leadership also as motivating colleagues to act and enhancing evidence-based practice, they did not practise this behaviour themselves with regard to patient participation. Evidence-based strategies and role modelling leadership behaviours about patient participation are needed. Further research will be necessary to develop and test leadership interventions to improve patient participation in fundamental care, such as mentoring or role modelling.

AUTHOR CONTRIBUTIONS

All authors have contributed to the conception and writing of the paper. All authors have had a significant doing in drafting and revising the article for important intellectual content, and have agreed on the final version. WO, AB, EB, MH: Made substantial contributions to conception and design, acquisition of data or analysis and interpretation of data. AB, EB, JM, GH, MH: Involved in drafting the manuscript or revising it critically for important intellectual content. WO, EB, AB, JM, GH, MH: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. WO, EB, AB, JM, GH, MH: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICTS OF INTEREST

The authors declare that they have no conflicting interests.

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DATA AVAILABILITY STATEMENT

Data available on request from the authors. The data that support the findings of this study are available from the corresponding author upon reasonable request.

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