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Distributed leadership: Building capacity to maximise collaborative practice in a new teaching research aged care service

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Chapter 1: Introduction

This chapter starts with a fictional scenario which identifies a business problem. This leads to the articulation of a possible business solution, which is phrased as two research questions. This chapter includes a brief overview of the state of the health and aged care system in Australia to frame the context for this research.

The overarching career goal of the researcher is to contribute to the design of health and aged care systems which are responsive to residents' needs and which maximise positive outcomes for residents utilising services.

1.1 Fictional scenario: Molly's experience

Molly is a 95 year old retired seamstress whose health has been slowly declining to the point where she can no longer live independently. In recognition that she needed full time support she shopped around to choose a nursing home to move into. She opted to move into ViTA South which is a new state-of-the-art teaching research aged care facility. She chose ViTA South as it has a gym and a healthy ageing approach to service delivery. This approach appeals to Molly as she wants to keep mobile and prevent unnecessary deconditioning so she can keep doing the things she loves like volunteering and learning new things. Molly also liked the idea that as a resident of ViTA South she could contribute to shaping the future health workforce through influencing the students who have their clinical placements at ViTA South. Molly has a range of chronic conditions including type 2 diabetes and she wants to shape the students' thinking about how this impacts upon her life. She is really keen to make sure that students see her as a person, as a grandmother, as someone who wants to continue to maximise the most of life through her volunteering and other activities; not just as a case example of a chronic disease.

Molly’s first day when she moved into ViTA South was exhausting. This was largely related to having to speak to an array of different health professionals. She was required to repeat her story and case history to the General Practitioner, the nurse, the physiotherapist, and the personal trainer time and again so they could each do their
individual assessments. While all well-intentioned and passionate about what they were doing, these health professionals were pushed for time and in her words ‘seemed to run around like headless chickens’.

Behind the scenes at ViTA South all the health professionals who had visited Molly on her first day were ‘beavering away’ individually in different offices working on a plan for how they could contribute to supporting Molly to achieve her goals of staying mobile and engaged. The plans they were preparing factor in all the challenges of the inflexible systems found in a hierarchical leadership structure. These operational systems were designed by a formal leadership team who were detached from the practical day to day operations of service delivery at the frontline with residents. While well-intentioned, the formal leaders created fixed, rigid, inflexible systems aligned with the organisational goals which only the senior managers understood.

The health professionals would do their best while working in ‘silos’ to support Molly achieving her personal goals but they recognised that the inefficiencies in the system could result in sub-optimal outcomes for Molly.

The health professionals longed for an opportunity to contribute to the design of systems to make the administrative component of their job easier so they could focus on the best part of the job: working directly with residents like Molly. They saw the potential to contribute to the design of systems which would enable them to undertake joint planning and joint decision making to work alongside other health professionals from disciplines different to their own.

The recent health care graduates who were now employees longed to work in the way that was spoken about when they were at university, that is, ‘interprofessionally’. Interprofessional collaborative practice includes two or more professions working alongside each other to undertake joint planning and joint decision making and in doing so health professionals learn from, with and about one another. In their opinion interprofessional collaborative practice was still an aspiration as the opportunity to practice this way was not available at the service delivery level.
The health care professionals wanted the opportunity to exercise distributed leadership by leading themselves, engaging others toward achieving outcomes and ultimately shaping the systems they were working including driving innovation. The formal leaders wanted the systems, structures and processes within their organisation to create the conditions for the healthcare professionals to do all of this in a safe and accountable manner. The formal leaders have to manage a safe system of work in a safe environment to minimise their exposures to all forms of risk.

The following two tables (Table 1 and Table 2) provide a summary of the key needs and concerns of stakeholders reflective of a traditional hierarchical leadership structure. Following the tables is where this fictional scenario ends and the real life research begins.
### Table 1 Summary of stakeholder needs from fictional scenario (Molly)

<table>
<thead>
<tr>
<th>Needs</th>
<th>Molly</th>
<th>Health Care Professionals</th>
<th>Students</th>
<th>Formal Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>To get on with her new life in her new environment and make sure she continues doing all the things that make her happy and contribute to her good life.</td>
<td>To translate what they have learnt at university into practice.</td>
<td>Need to gather adequate background information to plan for the highest quality of care for Molly.</td>
<td>Need good role models to showcase best practice.</td>
<td>Need to deliver high quality of care in a safe, effective and efficient way which meets aged care compliance requirements.</td>
</tr>
<tr>
<td>To be treated as a person not as part of a series of assessments, clinical decisions and health care plans.</td>
<td>Need to meet the timeframes to complete assessments for a new admission to meet aged care compliance requirements.</td>
<td>Need to juggle competing priorities to use time in the most efficient manner.</td>
<td></td>
<td>Need to ensure Molly is happy and settled in her new home environment.</td>
</tr>
<tr>
<td>To have all her needs considered – not just her medical needs.</td>
<td>Need to include Molly in the decision making process around her care.</td>
<td>Need to include Molly in the decision making process around her care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To be included in the decision making process around her care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 2 Summary of concerns as they relate to collaboration/leadership from fictional scenario

<table>
<thead>
<tr>
<th>Concerns as they relate to collaboration/leadership</th>
<th>Molly</th>
<th>Health Care Professionals</th>
<th>Students</th>
<th>Formal Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health professionals wasting her time by asking her the same questions multiple times.</td>
<td>Systems and processes which do not work effectively or efficiently.</td>
<td>What they have been taught at University relating to interprofessional practice appears not to be possible in practice as the systems and processes act as barriers to collaboration.</td>
<td>Staff not following the systems and process which have been set by management.</td>
</tr>
<tr>
<td></td>
<td>That the health professionals are not working together or don’t seem to talk as they are asking her the same questions multiple times.</td>
<td>Limited opportunities to engage with other health professionals in the planning process for Molly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health professionals who are seemingly task orientated – focused on completing a task such as an assessment rather than looking at Molly as a whole person.</td>
<td>Limited opportunities to drive innovation as they don’t understand what the organisational priorities are as it is all in the formal leaders’ head and discussed at executive meetings which they are not a part of.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.2 Business problem to be solved

The issues experienced by Molly highlight a business problem with leadership and organisational development work in aged care. Succinctly stated, the business problem is how to improve resident care and organisational efficiency through the practice of distributed leadership in ViTA South. The decision to use a distributed leadership approach was based in the assumption that distributed leadership has the potential to enhance interprofessional teamwork, collaborative decision making, and ‘whole resident’ care. This project used action research to tackle this business problem. The practical health and aged care setting of ViTA South, a new, purpose built, teaching, research aged care service which opened in Adelaide, South Australia in June 2014 — was the context for this work.

The research facilitated the process of interpreting current health leadership theory for use and application in the practice-based setting of ViTA South. The research design was tailored to make a contribution to practice and to further advance existing theory on what is known about distributed leadership.

The research also facilitated the organisational development work involved with developing the leadership strategy which incorporated distributed leadership at ViTA South. This leadership strategy was a part of a new operational model which was designed specifically for ViTA South. The use of an action research approach enabled application of distributed leadership, within the design of the operational model for ViTA South, as a key driver for engendering sustained collaborative practice. It was anticipated that by establishing an environment that creates the conditions for staff to exercise distributed leadership, teams will be able to collectively address the ‘systemic’ problems that inhibit collaborative practice.
The organisational development work undertaken within this research was guided by the following research questions which seek to provide a business solution for ViTA South:

1.3 Research question

How can distributed leadership be incorporated within a new operational model for ViTA South as a driver to maximise sustained collaborative practice in service delivery?

1.3.1 Further sub-questions

1. What existing workplace structures and processes within ViTA South need to be changed to support the operationalisation of distributed leadership as a means of maximising sustained collaborative practice in ViTA South?

2. What new workplace structures and processes within ViTA South need to be developed to support the operationalisation of distributed leadership as a means of maximising sustained collaborative practice within ViTA South?

1.4 Research context

1.4.1 ViTA South

ViTA South is part of ACH Group which is a not-for-profit organisation which has been supporting older South Australians since 1952. ACH Group offers a wide range of services including retirement and residential options, domestic, personal and nursing care in the home, respite choices and short term transition services.

ViTA South has been designed to provide a new approach to aged care, to maximise collaboration and promote innovation in service delivery. The aims for ViTA South are to embed teaching and research within the delivery of services which promote restoration and rehabilitation for older people in short term and long term care (ACH Group, 2012). ACH Group led the design and development of a new operational model for ViTA South.
A ‘teaching research aged care service’ or ‘teaching nursing home’ as it is often referred to is an aged care facility which has an affiliation with an education or training provider and brings together research, service delivery, education and training (Barnett et al., 2011). In the case of ViTA South the partnership is between ACH Group, Flinders University and The South Australian Department of Health (SA Health).

The goals for ViTA South are similar to those articulated in the Teaching Nursing Home Scoping Study undertaken by Barnett et al. (2011). They are:

- To become a best practice example of a teaching research aged care service
- To create an environment that models a culture of learning
- To promote and facilitate interprofessional learning
- To educate and prepare the future aged care leaders and workforce
- To deliver services which contribute to maximising quality of life for older people
- To promote re-ablement & restoration for older people in a flexible environment
- To test and disseminate evidence-based best practice
- To showcase a culture that supports a rights-based approach to person-centred care
- To promote positive perceptions and images of older people and aged care services.

There are three distinct service delivery models in operation at ViTA South. These are:

- 60 aged care places (permanent residential)
- 40 transition places (short term stay – not part of this research study)
- 20 rehabilitation places (run by SA Health and not part of this research study).

The ‘teaching nursing home’ concept aims to support collaborative practice and learning amongst clinicians, teachers, researchers, students and managers (Barnett et al., 2011). While many teaching research aged care services have aspired to achieve a collaborative approach to practice and learning, it is reported that few have realised this goal (Barnett et al., 2011). In a review of the literature, Chilvers and Jones (1997) concluded that the originally intended collaborative focus of a teaching nursing home should be re-emphasised in developing future models in Australia.
ACH Group saw an opportunity to focus on organisational development work toward advancing collaborative practice within and across the organisation. ACH Group believed that a collaborative approach would contribute to a holistic approach to research and knowledge development. The organisation also believed the collaborative approach would bring together the skills and expertise of these professionals to create a culture of learning which would contribute toward improving quality of life for older people. Collaborative practice has been shown to be an effective approach to improving service delivery as it has demonstrated a positive impact on service quality and safety in an effort to improve health outcomes (WHO, 2010).

Promoting and sustaining collaborative practice is recognised as a priority leadership challenge for health and aged care (Dickson & Tholl, 2014; Forman, Jones, & Thistlethwaite, 2014). Dickson and Tholl (2014) succinctly describe the leadership challenge for health care as a need “…to convert a fragmented set of activities into a well-functioning whole” (p.7).

To achieve this, sustained collaborative practice within service delivery requires whole system change (WHO, 2010). Leadership is recognised as a crucial element in creating systems which unite divergences towards a common goal (Drinka & Clark, 2000; Greenfield, Braithwaite, Pawsey, Johnson, & Robinson, 2009; Orchard, Curran, & Kabene, 2009).

Therefore a commitment for the organisational development work undertaken for ViTA South was to have a significant emphasis on developing systems which support and drive sustained collaborative practice. The organisational development work developed systems which contributed to extending collaboration beyond the traditional aged care workforce to include teachers, researchers, students and managers.

A conscious business decision was made to not rely solely on a traditional hierarchical leadership approach. Rather, it was decided the leadership strategy should also incorporate distributed leadership. The application of distributed leadership within the ViTA South operational model aimed to engage staff at all levels to shape the
systems. Realising the vision for ViTA South was dependent on professionals of different backgrounds, administrators and researchers working together. It was anticipated that distributed leadership would unite divergences toward a common goal and maximise sustained collaborative practice (ACH Group, 2012).

1.4.2 Contextualising the problem within the Australian health and aged care system

Within Australia and across the globe demand for health and aged care services is increasing due to growing population health needs and the demographic challenges impacting on the health workforce (Jeon, Glasgow, Merlyn, & Sansoni, 2010). Health and aged care organisations are faced with the challenge of how to do more with less; a challenge that comes at the same time as health consumers' expectations are increasing (Dickson & Tholl, 2014).

Consequently, ‘a business as usual approach’ is no longer an option (Health Workforce Australia, 2012b; Productivity Commission, 2011). Change, reform and innovation in the health and aged care sector in Australia are no longer a choice, but an ongoing requirement (Endacott, Boulanger, Chamberlain, Hendry, Ryan & Chaboyer, 2008; Health Workforce Australia, 2012b; Youngson, 1999). Leadership is integral in addressing current and future challenges (Endacott et al., 2008; Health Workforce Australia, 2012b; Sherman & Bishop, 2007; Youngson, 1999). In recognition of this reality ACH Group identified effective leadership as critical to the success of ViTA South (ACH Group, 2012).

South Australia, where this research study takes place, has the highest proportion of older people compared with other states in mainland Australia (Australian Bureau of Statistics, 2015). Currently one in six people are over the age of 65 (South Australian Government, 2007). In the next 15 years this population will nearly double as the ‘baby boomer’ generation ages, substantially increasing the demand for aged care services (South Australian Government, 2007). The effect of an increasing number of older people will be compounded by people living longer; having fewer children, and an ageing workforce. It is predicted an ageing population will bring an increase in chronic
conditions and disability and therefore an increase in demand on the Australian health system and in this regard the aged care sector (Hugo, 2007).

Given the increasing demand, service delivery models across the health and aged care sectors need to evolve to increase efficiencies and improve quality of care for residents like Molly. These efficiencies are required to ensure the delivery of safe, high quality services and the need to support the health workforce in adapting to change, compliance with reform and advancing innovation (Health Workforce Australia, 2012b). This is a key driver which influenced the design of the new operational model for service delivery at ViTA South.

1.5 Organisational development: a new operational model for ViTA South

The new operational model sought to enable a way of working, organising, and operating that effectively utilises scarce resources in delivering services in a cost-efficient manner to best meet the needs of the resident. The new operational model included leadership strategy, workforce and governance structures which were specifically designed to maximise collaborative practice.

As an organisational development strategy for generating sustained collaborative practice ACH Group made a decision to interpret and apply contemporary leadership theory within the new operational model developed for ViTA South. The intention was to create the conditions for staff to exercise distributed leadership as articulated in Health LEADS Australia: the Australian health leadership framework. This framework has been informed by research and designed specifically for the health industry (Health Workforce Australia, 2012a).

Organisational development strategy was facilitated and led by the ViTA South formal leadership team. The team comprised four ACH Group staff, including the researcher, who were assigned responsibility for establishing the services at ViTA South.
The new operational model for ViTA South was designed, implemented and tested over three action research cycles. The first cycle guided the design and planning of the operational model prior to implementation. The second cycle informed further development of the operational model during the six months after implementation. The third cycle informed the further development and refinement of the operational model over the subsequent six months.

1.6 How the research fits within the strategic planning process for ViTA South

The organisational development work associated with developing the leadership strategy was one element of a new operational model designed for ViTA South. Aged care service operational business models have multiple elements and have interdependencies which act as complex adaptive systems (Anderson, Issel, & McDaniel, 2003). In the case of ViTA South the other elements of the operational model included a workforce plan, a budget, a complete systems overview, a student program, a research strategy, a partnership strategy, and a learning and development plan.

A diagram (Figure 1) has been developed to articulate the underlying frameworks and concepts which demonstrate characteristics of a complex adaptive system within ViTA South. The diagram has been designed to be read starting from the base of the diagram working upwards. Connecting arrows are used between each of the six tiers of the diagram to show multiple interdependencies.
Figure 1 Underlying theories, concepts and frameworks demonstrating complex adaptive system characteristics within ViTA South
The base tier in Figure 1 illustrates the underlying theories and concepts which formed the foundation of thinking for ViTA South.

The second tier from the base illustrates the six key frameworks which are used to conceptualise the underlying theories and concepts which guide strategic plans in ViTA South. Of the six frameworks three were internally designed by ACH Group and three were externally designed frameworks adopted from research literature. The three internally designed frameworks are the Healthy Ageing Framework, the Customer Impact Framework (CIMPACT) and the Interprofessional Learning (IPL) Framework. The three external frameworks which ACH Group adopted for use are the Action Self Enabling Resource Tool (ASERT) designed by Jones, Harvey, Lefoe and Ryland (2014) Senge’s Principles of a Learning Organisation (Senge, 1999) and the Health LEADS Australia: Australian health leadership framework (Health Workforce Australia, 2012a).

The third tier illustrates the two key strategic plans which are the ViTA South Design Principles and the ViTA South Operational Model. The six key frameworks on the tier below were used to provide a shared understanding and influenced the design of the ViTA South Design Principles and the ViTA South Operational Model.

The fourth tier illustrates the eight plans within the ViTA South Operational Model which were specifically designed for ViTA South to guide the establishment of services to meet strategic intent. These plans were: The Workforce Plan, The Budget, A Complete Systems Overview, The Student Program, The Research Strategy, The Partnership Strategy, The Learning and Development Plan and The Leadership Strategy.

The fifth tier illustrates the features of the culture which the plans are designed to create or influence.

The sixth tier narrows down to the focus of the specific goals of the Interprofessional Learning (IPL) Coordinator role (the researcher’s professional appointment within the organisation of ViTA South) and how the role fits within the
system of ViTA South. Given this, the seventh tier identifies two of the perceived expected outcomes of maximising collaboration within the system. These are improved resident satisfaction and improved safety and quality of service delivery. A summative evaluation of progress toward these outcomes was not included as part of this research.

The top tier represents the big picture strategic outcomes for ViTA South. A summative evaluation of whether the outcomes listed on the sixth and seventh tier were achieved was not included as part of this research.

With its contribution to developing a shared understanding for the research, the diagram also provides an insight into how this research contributes to the overall organisational development work undertaken for ViTA South. It emphasises that the work and research which the IPL Coordinator undertook did not happen in isolation; rather the work was happening within and around a complex interplay of organisational goals, priorities and systems.

The highlighted segments in yellow made throughout the diagram narrow in on the components of the system which form the focus of this research. These highlights demonstrate where this research applied distributed leadership (bottom tier) as articulated in the two key frameworks: Health LEADS Australia framework and the Action Self Enabling Resource (ASERT) which have been incorporated within the leadership strategy within the ViTA South operational model. This has been done with the aim of contributing to the culture which creates the conditions for staff to exercise distributed leadership.

The ‘features of the culture’ articulated within the diagram (the fifth tier in Figure 1) show the multiple characteristics of the aspirational culture within ViTA South. As is often typical within complex adaptive systems, the multiple features of culture need to work in synergy (Rouse, 2008). The priorities for organisational development at ViTA South were not solely focused on creating the conditions for staff to exercise distributed leadership (which is the focus of this research). Additional organisational development work was undertaken to contribute to the cultural characteristics of the ViTA South
workforce associated with cultivating a ‘learning’ organisation, exceeding workforce legislative standards, providing a human-rights based approach to service delivery and embracing innovation.

1.6.1 The workforce at ViTA South

The ViTA South workforce in 2012 comprised 137 employees. This team was responsible for delivering services and providing supervision for students and trainees as part of the service delivery model. Administrators, health professionals and researchers were engaged to work collectively. The role of the manager of ViTA South extended to include working collaboratively with other site managers across the broader organisation to achieve common organisational goals.

The roles within the paid workforce at ViTA South included registered nurses, enrolled nurses, care workers, a nurse practitioner, a personal trainer, a lifestyle coordinator, administrative staff, cooks and cleaners. Allied health services such as physiotherapy, occupational therapy, speech pathology, podiatry and dentistry were provided by sub-contractors. There were also visiting General Practitioners (GPs). The paid workforce was complemented by a large volunteer workforce who assists with social activities.

In line with the statistics associated with the broader aged care workforce, care workers made up the majority of health care personnel working at ViTA South. The role of the care worker was to provide individual tailored support for residents of ViTA South to enable them to undertake activities of daily living. This ranges from support to undertake personal hygiene, attend appointments, and enjoy mealtimes but also to support the residents to participate in meaningful activities such as cooking and shopping. The care workers at ViTA South were trained to adopt a strengths-based approach which supports residents to achieve maximum independence which is not typical of a traditional aged care service delivery model.
The organisational development work associated with recruitment of the workforce for ViTA South included the development of a traineeship program. The traineeship program was developed to recruit the care worker workforce within the residential service. The intention was to attract people from other industries who did not have fixed mindsets on how services should be delivered in aged care facilities. Many of the care workers recruited had been made redundant from other industries and were part of a government funded re-skilling program. The trainee care workers recruited to work at ViTA South participated in an intensive six month on-the-job training program complemented by training workshops.

1.6.2 The formal leadership team at ViTA South

The formal leadership team at ViTA South comprised four members referred to throughout this research as the ‘ViTA South formal leadership team’. This team had not worked together at a leadership level before starting at ViTA South. The four roles within the formal leadership team were the Site Manager, the Clinical Nurse Consultant, the Quality Manager and the Interprofessional Learning Coordinator (who is the researcher).

The ViTA South Site Manager had worked for ACH Group for 10 years as a site manager of another of ACH Group’s services. She had previously participated in formal leadership training. The ViTA South Site Manager’s role was to lead the commissioning of the ViTA South building and establish the services operating within ViTA South. This included the residential services at ViTA South (which this research is concerned with) and also developing the transition care services (not part of this research).

The ViTA South Clinical Nurse Consultant had previously worked at ACH Group for 12 years as a registered nurse. She did not have formal training or experience in leadership or management. The Clinical Nurse Consultant role had clinical oversight for the residential services at ViTA South. The role was also referred to as ‘Second in charge at ViTA South’. 
The ViTA South Quality Manager came to ViTA South from another local aged care organisation. She had extensive experience with 20 years as a site manager operating an aged service of a similar size. She had previous formal training in leadership. The role was to lead all aspects of quality planning toward the site ‘exceeding’ accreditation requirements.

The researcher was a member of the ViTA South formal Leadership Team in the professional organisational role titled Interprofessional Learning Coordinator. Details of this role are described below.

1.6.3 The Interprofessional Learning Coordinator role

A new role titled ‘Interprofessional Learning Coordinator’ was established by ACH Group in 2012. The researcher was recruited into this new position and has held this position since its inception. The new role was formulated based on the identified business need to develop an interprofessional learning framework which would contribute to organisational development work to maximise collaboration across ACH Group.

The researcher’s role during the life of the research study was specifically focused on organisational development work. This involved leading service design to maximise collaboration at ViTA South. This included facilitating an interprofessional learning student program.

In the spirit of promoting and maximising collaboration the Interprofessional Learning Coordinator developed an ‘Interprofessional Learning Leadership Group’. This group undertook joint planning including the development of strategies and initiatives to improve collaborative learning and sustained collaborative practice across ACH Group. This group included 16 members who represented a variety of healthcare professionals (e.g. care worker, occupational therapist, physiotherapist) from different business divisions across the organisation.
1.6.4 The organisational decision to adopt distributed leadership within leadership development

One of the key activities undertaken by the ACH Group Interprofessional Learning Leadership Group in 2012 was to review Health LEADS Australia: the Australian Health Leadership Framework which at the time had been recently approved by the Australian Health Ministers’ Advisory Council as a nationally agreed health leadership framework (Health Workforce Australia, 2012a). Chapter 2 of this thesis includes a background and overview of Health LEADS Australia.

The ACH Group Interprofessional Learning Leadership Group were asked to draw on their individual and collective experiences in practice to determine if they saw the potential for Health LEADS Australia to be used as the foundation for interprofessional leadership development and collaborative practice within ACH Group.

All members of the Interprofessional Learning Leadership Group were unanimous that Health LEADS Australia described leadership capabilities that were easy to understand and were practical. Members of the group agreed that if staff exercised these capabilities within practice it had the potential to maximise sustained collaboration. The group recommended that Health LEADS Australia be adopted as the foundation for interprofessional leadership development and collaborative practice within ACH Group.

Based on this recommendation the researcher in the role of Interprofessional Learning Coordinator and the ACH Group Residential Services Manager (the Executive leading the planning for ViTA South) considered how Health LEADS Australia could be applied within the service model being designed for ViTA South. At the request of the Executive the researcher was instructed to explore this.

As will be further explained in the literature review the researcher identified distributed leadership was incorporated into the Health LEADS Australia framework. The researcher reviewed the literature to identify organisational development approaches to distributed leadership modelling and development.
The ‘business problem’ of identifying organisational development approaches to developing distributed leadership therefore formed the basis for this doctoral research study.

1.7 Researcher’s personal perspective

A paradigm shift is needed to transition from formal leaders being solely responsible for designing systems toward engaging staff at all levels. The researcher believes the application of distributed leadership is integral to the development of sustained collaborative practice. By creating the conditions for staff to exercise distributed leadership the formal leaders are creating an environment where staff at all levels are then able to lead and influence the design of the systems they work within. It is these redesigned systems which bring the potential to maximise sustained collaborative practice.

As a systems thinker, the researcher is interested in the processes or organisational routines and tools that enable sustained collaborative practice within health and aged care teams. Systems need to be flexible and responsive to continual improvement and to be able to respond to changing demands. The researcher believes that in order to improve organisational routines and tools a critical success factor is for formal leaders to engage staff at all levels to shape the systems in which they are working to enable sustained collaboration.

It has been the researcher’s first-hand experience that in some health and aged care organisations strategic goals are often nebulous and detached from pragmatic day to day operations. The researcher believes it is necessary for the formal leaders to connect and align the pragmatic day to day operations with the organisation’s strategic goals. This requires providing explicit frameworks (outside of the formal leader’s head) to enable a shared understanding. This articulation of organisational routines as ‘aspects of situation’ may facilitate the engagement of staff at all levels to shape the systems they are working in.
1.8 Thesis outline

This thesis consists of five key chapters including this first introductory chapter. The first chapter provides the background context to the research study and it introduces the research questions. It includes the presentation of a fictional scenario which illustrates some of the current deficiencies and stakeholder conflicts which exist in many health and aged care services. The scenario illustrates how lack of collaboration and a hierarchical leadership structure can potentially contribute to sub-optimal health care and a lack of responsiveness to the needs of the resident.

The second chapter provides a review of the professional and academic literature that has shaped this research. The literature review sought to understand the nature of distributed leadership and identify relevant theoretical constructs associated with organisational development associated with leading strategic change initiatives. This chapter concludes with a conceptual framework which brings together the findings from the literature review which were used to guide this research study.

The third chapter discusses the action research study design. The chapter justifies the methods and techniques which were adopted and applied. It discusses the data collection instruments and provides an outline of how the data were analysed.

The fourth chapter is structured to provide an audit trail to show how the business problem was solved for ViTA South. A chronological narrative outlines the organisational development work undertaken within each of the three action research cycles. The chapter is designed to provide a detailed insight into the application of distributed leadership into the practical research workplace setting of ViTA South.

The fifth chapter presents a discussion of the key findings from the research. Conclusions and implications for future research are also presented. This final chapter presents a revision of the original fictional scenario presented this time showing where distributed leadership in practice contributes to a positive resident experience.