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# Unprecedented Leadership: How Nurses Responded to the COVID-19 Pandemic



American Organization  
for Nursing Leadership



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An inquiry was posed to nurse leaders in December 2020 by the American Organization for Nursing Leadership (AONL) as the first wave of the COVID-19 pandemic peaked. More than 100 responses were received and organized into themes based on problems, solutions, and unique innovations that were employed. These themes included a return to team-based care, redeployed providers, work design, space accommodation, technology applications, provider support, and the advancement of community-based partnerships. Four exemplars highlight these themes.

In times of crisis, nurses are at the front line to lead and save lives. Whether in a natural disaster or violence caused by terrorists, nurses have proven to be risk-taking healers. The COVID-19 pandemic, which became evident in March 2020, created a path of devastation then incomprehensible to the public and caregivers. By December 2020, patients surges pulsed in geographic sectors of the country and across the world and the severity of the disease became real locally, nationally, and globally. Deaths mounted amidst scenes of gloved and gowned caregivers in filled intensive care units, sometimes soothing the dying.

From the onset, AONL was a timely resource for health care leaders and the public. Early to affirm the depth and breadth of the crisis, AONL curated reliable information and used its educational network to cultivate the rapid uptake of organizational strategies surrounding protective equipment, therapeutic strategies, staffing models, and more. In December 2020, with the first wave of the pandemic afoot, a national inquiry was sent to nurse leaders. Real-time responses from leaders guiding high-stakes initiatives were captured, revealing innovations, solutions, and issues. This article reflects the process and findings that led to breakthrough exemplars of leadership excellence. While this paper highlights several such exemplars, a featured resource on the AONL website including a series of podcasts and panel discussions entitled *Leadership Beyond the Pandemic* augments this narrative.

## MOTIVATION AND PROCESS

An important reason to examine group and organizational behavior at this crucial juncture is the historic nature of the pandemic in duration, tragic impact, strained resources, and trauma on health care workers. The

Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services reports that an estimated 1.7 million viruses exist in the animal world, of which 827,000 could infect people. In the report, Daszak et al. notes that the same human activities that drive climate change and loss of biodiversity enhance future pandemic risk by adversely affecting the environment.<sup>1</sup> This report clarifies the relevance of prevention in human-environmental interactions to offset what could become known as the pandemic era. To this end, the myriad of manuscripts and reports on COVID-19 requires leaders to think in the bigger context. Lessons learned – to improve the health system infrastructure and shore up knowledge of managing diseases with the power to create mass casualties – matter. Equally important are the innovations that emerge out of sheer necessity. Power and role structures that limit the boundaries of creativity are gone.

To create this bank of resources, nurse leaders responded to broad questions about COVID-19 concerns and solutions tested. They also outlined the innovations they led. With more than 100 responses representing the continuum of care, each was reviewed and organized into the subject/topical groups reported below. Feedback garnered from the survey stimulated a leadership development agenda and promoted time-sensitive knowledge transfer. *Leadership Beyond the Pandemic*, noted above, was developed and implemented within four months of data collection.

## SURVEY THEMES AND DISCOVERIES

### Return to Team-based Care

Two themes were standouts regarding initiatives undertaken – the return to team-based care to

accommodate the high-volume, high-risk care needs of patients swarming the health system, and role development to accommodate specialized demands. Team-based care, credited to Eleanor Lambertson in the 1950s, developed the care model to accommodate the influx of soldiers returning from WWII.<sup>2</sup> Like in WWII, the pandemic demand for care parallels the massive surge of patients admitted during the pandemic, and team nursing again became the default care delivery model. Team nursing accommodates caregivers with varied skill sets who could be supported and mentored by experienced RNs while optimizing the talents of each provider. Presumably, team nursing offers peer support and has efficiency factors built in to accommodate intense tasks, such as patient proning.

Perioperative nurses, licensed practical nurses (LPNs), and medical assistants from ambulatory or clinic settings were commonly redeployed to inpatient units closely resembling intensive care units during the pandemic. To upskill or reskill the redeployed workers, staff development educators provided tailored just-in-time training using various teaching methods. One organization adapted the team nursing model by creating nursing tiers, in which Tier I nurses led acute care oversight and Tier II nurses performed tasks in partnership with a Tier I nurse. The data reflected numerous examples of partnering and pairing teams in various configurations to provide care. New roles also were created, in and beyond team nursing. Included were post-mortem care roles, proning teams, patient attendant safety aides, and airway management teams. Patient care technicians added skills to perform bundled tasks to minimize staff and patient exposures, and nursing students completed portions of their education in a COVID technician role as staff supplements. An exemplar highlighting team nursing is available on the AONL website at <https://www.aonl.org/leadership-beyond-pandemic/team-based-care-part-1>; <https://www.aonl.org/leadership-beyond-pandemic/team-based-care-part-2>.

### **Work Design, Space Accommodation, and Technology Adaptations**

A third theme involved work redesign. As noted, care providers faced mandates to organize care to mitigate infectious exposures. Pre-COVID care might involve nurses, patient care technicians, phlebotomists, physical therapists, and others to enter the patient's room at will. Those entering the COVID patient's room designed their work to accomplish as many clinical assessments and interventions as possible per patient interaction, considering the fatigue and psychosocial interaction required to provide holistic care. A fourth theme intersected with work redesign, using technology such as I-Pads to communicate with patients and, more importantly, to connect patients with their family members. The fifth theme included ways

that organizations adapted space to house infected patients, staff, and equipment. There were examples of designating space for COVID patients, retrofitting space to hold and care for persons with COVID, and using existing space to operate a monoclonal antibody infusion clinic.

The expanded technology use theme transcended inpatient acute care settings. Telehealth and remote patient monitoring exponentially grew across the care continuum in virtually all medical specialties. It then expanded to include patient triage as part of a bed management schema, ensuring the best use of limited resources and avoiding high-risk emergency department waiting. If the patient could manage at home, telehealth became a mechanism for family support. This care method then assisted with patient-family teaching, reducing social isolation, alleviating fears and anxieties, and coordinating care. For admitted patients awaiting discharge, telehealth became a home-based intervention to continue as an adjunct to care management and the likely associated fear factors tied to COVID-19. An exemplar highlighting technology acquisition and adaptation in a rural setting is available at <https://www.aonl.org/leadership-beyond-pandemic/technology-influence-on-care>.

### **Provider Support, Training, and Monitoring**

One factor that makes the current pandemic stand out from other catastrophic events is its duration. The surges and waves of regional patterns placed constant stress on suppliers, scientists, and mostly, care providers. Health care workers with persistent and longitudinal exposure to COVID also faced staffing and supply shortages, placing them at higher risk for acquiring COVID-19. This risk often required separations from family and friends. Health care workers have seen the severity of the virus on patients that the public may never fully comprehend, and they have seen the pain, fear for survival, and social isolation of the disease—all of which can lead to posttraumatic stress disorders.<sup>3</sup>

Nurse leaders recognized the immediate and long-term consequences of unabated stress on staff by the end of COVID's first wave. One organization developed resiliency rounds that included a psychiatrist on the rounding team. Another employed an ethics consultation team to bring unit staff coping resources and assistance with visitation, resuscitation, self-endangerment, and moral distress. Others provided tools in various forms of meditation, self-care breaks and meals, and more.

The psycho-social-spiritual toll required close attention to organizational throughput. Bed capacity monitoring tools, staffing capacity software, and deterioration reports provided leaders with hard data on where key stress points were most likely. Staff development and infectious disease professionals provided

face-to-face and hybrid learning models to reduce the anxiety associated with knowing about the disease, the discoveries unfolding, and the skills and abilities needed to adapt. To hear an exemplar about the role and functions of the ethics consultation team to support health care providers listen to the podcast “Resilience Rounds and Other Strategies to Elevate Moral”, available at <https://www.aonl.org/leadership-beyond-pandemic/podcast-series>.

### Beyond the Hospital Partnerships

The final theme emanated from expanded partnerships that closed gaps across the continuum of health care entities. One state developed a transfer center to ensure that all beds were utilized when resources were depleted in a multi-state region. Another state developed a staffing pool to resource small and rural hospitals. Local health departments shared physical and human resources bi-directionally to coordinate care and testing, ramp up staffing, and engage in multi-sector decision-making. Examples of using mobile care clinics to reach at-risk populations, such as homeless veterans and the elderly, were reported. The final exemplar presents a model for statewide bed coordination at <https://www.aonl.org/leadership-beyond-pandemic/marriage-actute-care>.

### SUMMARY

Creativity amid urgency, adaptability amid the unknown, and caring practices when humanity is threatened are all evidenced in the responses to this inquiry. The survey was conducted outside the realms of formal research to capture real-time experiences in the spirit of sense-making, social connectedness, and innovation. With thematic coding, patterns emerged that formed the basis of leadership development programming, providing a more comprehensive description to guide future formal research and the appreciative inquiry that will ensue.

Questions evolved from the analysis. Why did the default to team nursing and freedom to optimize roles and human capacity come so naturally during this crisis? Why aren't these models and actions used in regular operations? What have we learned about using technology for training and development that could improve serving point-of-care providers? How were nurse leaders able to act in the pandemic with such a commanding presence, including broadened authority and responsibility, than they did in pre-COVID operations? How do we more creatively utilize the technology in our work arsenals?

The exemplars provided are but a part of the story that unfolded during the pandemic; they are starting points for scaling new strategies and interventions for organizational effectiveness. The

pandemic has slowed, but is not over. State-by-state vaccination rates show some regions remain vulnerable, offering opportunities for new variants to proliferate.<sup>4</sup> Science continues to provide new clinical options and treatment protocols. Decision-making models must be translated from individual care to organizational outcomes and practices. Nurse leaders must continue to take action and extend their informed influence to ensure the continuation of holistic leadership practices.

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