

Applying Situational Leadership to Redeployment Duties During COVID-19: Lessons Learned

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Background and Objectives: In March 2020, the coronavirus disease-2019 (COVID-19) pandemic caused many disruptions to usual operations and demands in excess of normal capacity at NYU Langone Hospital Long Island and NYU Long Island School of Medicine. Significant increases in volume of critically ill patients necessitated hospital administrators to redeploy faculty physicians and other staff to support other areas as a way of exercising option value. This commentary describes our experiences as 2 medical school deans and teaching professors where we recently applied the model of situational leadership during our redeployment as unit clerks on newly-created COVID patient care units at the height of the COVID-19 pandemic in our local area. Our experience yielded personal feelings of accomplishment and allowed us to exercise nonlinear thinking, which we believe contributed to greater staff operational efficiency, using principles of situational leadership during these hospital redeployment initiatives.

Key Takeaways: Situational leadership is an effective management model for hospital academic leaders who are not routinely in clinical operations to initiate in emergency conditions when unprecedented working scenarios and feelings of staff uncertainty are occurring, while option value is being exercised with faculty/staff redeployment. Our experience led to increased self-actualization. We provide recommendations to health care administrators on how to better prepare for future faculty/staff redeployments in the hospital.

Key words: COVID-19, option value, redeployment, situational leadership

In March 2020, the coronavirus disease-2019 (COVID-19) pandemic caused many disruptions to usual operations and demands in excess of normal capacity at NYU Langone Hospital-Long Island and NYU Long Island School of Medicine. Significant increases in volume of critically ill patients necessitated hospital administrators to redeploy faculty physicians and other staff to support other areas. To preserve the integrity of hospital operations at the time without disruption and employee layoffs, many faculty and staff were redeployed; they were given alternative work assignments as a way to exercise option value in this time of uncertainty and the need to act promptly.¹ Investing in spare capacity is often seen by management as inefficient in the short term, but like insurance, has clear option value due to the ability to respond to uncertain emergencies.² During the epicenter induction of the COVID-19 pandemic, this option value became starkly apparent in our hospital when the need to conserve supplies of personal protective equipment (PPE) arose, and the availability of testing for COVID-19, hospital

beds, ventilators, and number of staff became alarmingly demanded to meet the admission surge.³ Option value illustrates the risk of relentlessly driving to efficiency by cutting “system slack” down to meet only average needs. In such situations, atypical demand, though infrequent, can entirely break down a system. Thus, the need to build spare capacity into health systems emerged as an ethical requirement to assure the sustainability of the health system for future use, which was certainly the case for our hospital at this time.⁴

One of us is currently the Assistant Dean of Faculty Development and Mentoring and an Associate Professor of both Medicine and Rehabilitation Medicine at NYU Long Island School of Medicine, as well as a licensed occupational therapist with a background as a manager in hospital quality and safety (J.N.); the other is currently the Assistant Dean of Continuing Medical Education and former athletic trainer (R.M.). Like many others, we were redeployed as volunteers during the height of this pandemic into 2 ad hoc intensive care units (ICUs) created from surgical recovery units, specifically in the capacity as a unit clerk on a newly-created 18-bed COVID patient care unit (J.N.), and in a former postsurgical telemetry unit retrofitted with negative pressure for COVID infection control (R.M.). In this commentary, we describe our experience as academic leaders proficient in metacognitive thinking⁵ and applying situational leadership⁶ during this period. We describe the observed effect our intervention had on hospital staff in our respective assigned units, and suggest how we can utilize this model to better prepare institutional leaders to conduct future faculty/staff redeployments for optimal organizational

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adeptness, as well as to create ideal employee utilization by means of frontline feedback loops that encourage responsiveness in capacity planners.

BACKGROUND AND PURPOSE

It was a Sunday night when one of us received an email from our medical school administrator requesting she immediately join the redeployment labor pool (J.N.); the other was asked to report to a new assignment on 5 hours' notice after completing video training on donning/doffing of PPE (R.M.). Although anxious and fearful for what lay ahead given all we had seen on the news and from colleagues already working on the front lines, we each accepted these assignments and the responsibility to step up for our beleaguered clinical community. One of us (J.N.) was given general instructions to report to a particular ambulatory patient care area, which had been converted to an inpatient COVID unit 4 days earlier. J.N. describes: *No nurse manager was present when I arrived at 7:30 that morning, but I was greeted by a patient care technician who graciously assisted me with donning PPE including an N-95 respirator mask, gown, gloves, face shield, hair cap, and feet booties. No further instructions were provided to me. I quickly observed that the nurses and patient care technicians, who usually worked on a day procedure unit, were not accustomed to delivering critical care, and appeared overwhelmed. The unit did not possess much of the usual equipment that very ill patients typically require. For example, there was no machine to dispense medications within the unit, and no bedpans stocked for use by mobility-compromised patients. I was frequently asked to take trips to the pharmacy to retrieve medication, to Central Sterile for equipment, and to the lab to deliver specimens. In doing this, I would need to doff PPE, and then obtain a new set to don, of which items were in critical shortage at that time.*

The other of us (R.M.) was told to report as a safety monitor to observe and correct donning/doffing behaviors of ICU nurses. R.M. recalls: *In my unit we were told to do everything possible to conserve our rapidly dwindling PPE, and so on shifts I wore homemade cloth facemasks in order to preserve disposable mask stocks for use by the nurses working inside the negative pressure patient rooms. I was also asked to hourly swab all doorknobs, computer equipment, telephones and chair-arms with bleach, as a contributing factor of infection was believed at that time to be hard surfaces⁷ reflecting some of the unknown and uncertainly about the mechanism of infection of this virus. R.M.'s role willingly evolved from safety monitor (unneeded by nurses well aware of infection risk and adept at donning/doffing) to unit clerk, carrier, fetcher, hander, and communicator. Although counterintuitive to some in management, it was consistent with the principles of servant-leadership as espoused in the academic mentoring culture.*

The scenario we were dealing with was of critical importance in March 2020, which was the height

of the first wave COVID-19 pandemic in our local area when droplet-borne spread was understood as the most common vector,⁸ and before patient recoveries were seen, and we knew we had to approach the work day with the ultimate goal of safety. This safety tactic was of course for the patients but also for the staff, coupled with practicality and a team-oriented approach. As academic leaders in our hospital and medical school, both of us frequently carried out metacognitive thinking,⁵ where we have become keenly aware of how and when to use problem-solving strategies.

As an extension of sharp awareness and acting on our changing surroundings,⁹ situational leadership is a management framework describing 4 types of behaviors: *telling, selling, participating, and delegating*. The model states that one leadership style is not superior to another, and that leaders can use any one of these behaviors depending on the circumstances around them and the conditional demands.⁶ It has been shown to increase motivation among employees and, in turn, raise productivity levels.¹⁰

It is known that, to achieve organizational goals, commitment of employees is essential, and this is best fostered by leadership.¹¹ As our redeployment situation was imposed on us and unable to be prevented, our perception and reaction as leaders was crucial to the operations on our respective units.¹² J.N. employed the principle of *telling*, and told the nurses and staff that in order to be more efficient, we could batch all routine trips outside of the unit, with only urgent needs dealt with as needed. Without the presence of a nurse manager in the unit, the staff willingly agreed to this directive, as it appeared they were desiring an individual to lead, and as such, the following days were more resourceful. PPE was thus retained. R.M. also employed *telling* by encouraging nurses to save unnecessary steps in crossing the large unit, and to signal, call, or phone for supplies to be brought from their storage locales to the patient doorways and handed into the negative pressure rooms. Nursing traffic flow was thus conserved.

Many of the staff J.N. worked with expressed their fear, frustration, and overall increased stress working in these new conditions and taking care of very ill patients. As an "outsider" to their usual working group, J.N. found that what was best to offer them was a listening ear, and provide words of encouragement. J.N. incorporated the principle of *selling*, and offered positivity and hopefulness to the staff, reassuring them that she observed them to be doing the best that they could, and that our patients greatly appreciate them given that no visitors were permitted. Although they may not have been convinced, by providing inspiration, the hope was that it would push them to their next level of performance despite the circumstances. R.M. employed *selling* by expressing personal gratitude on behalf of the institution to the numerous out-of-state traveler nurses who arrived to work on the crowded units, and by chatting about small commonalities with them regarding pets, children, and hometown origins.

Both of us observed a positive response to the principle of selling, with increased comradery between us and the staff we were working with, and an enhanced sense of mutual trust.

J.N. also employed the principle of *participating* behavior. The new challenges the unit staff were encountering were numerous. Family members repeatedly telephoned to inquire about their loved ones, but the unit was not equipped with bedside phones, nor could nurses and staff frequently come to the desk to speak to the family members. J.N. willingly addressed these calls, counseling family members as best as possible and provided emotional support. By acting as part of the unit team and sharing in the responsibilities, this lifted some of the workload from the direct care staff. R.M. used *participating* behavior in offering to take onerous tasks off of nurses, such as hauling oxygen tanks to the refill bay, paging laboratory couriers, training new volunteers, assisting the restocking of crash carts, and portioning out various brands of donated phone chargers among a dozen ICUs in the hospital. As academic leaders entering the critical care hospital units, our presence as former-outsiders willing to pitch in with these *participating* behaviors improved morale among faculty and staff, as a sense of teamwork was fostered.

Although J.N. was requested to work from 8 AM to 4 PM, after 1 day of this assignment J.N. resolved to report at 6:30 AM to be present for the nursing staff change of shift. J.N. felt it was important to physically meet the nursing staff as they entered the unit, especially since many were traveling nurses from all over the nation who were new to the hospital. J.N. used the principle of *delegating*, to organize and assign many tasks throughout the day to staff and other more junior deployed volunteers. J.N. began to be perceived by the staff as the gatekeeper of information, and set up number of patient beds per staff member, time for breaks, and allotment of PPE. Similarly, R.M., who was deployed on a 4 PM to 12 AM schedule, used the principle of *delegating* to keep an excess number of deployed night volunteers occupied but unobtrusive to unit traffic. This was done by touring all new volunteers over a 4-floor route between the ICU, pharmacy, and Central Sterile area, organizing offset, longer dinner breaks among the volunteers to decant the crowded corridors of idle people, assuring continuous inbound phone call coverage, and assisting at telemetry watching to help extend the certified nursing aides who were understaffed at that time.

Our experience suggests that situational leadership is an effective strategy to implement behaviors that guide others during unprecedented times such as redeployment in a hospital during an emergency. Although it might seem customary for hospitals to possess certain procedures for emergency situations, we found that there were several areas that could be improved upon in considering the development of training modules for various redeployment roles. This can include:

1. maps of the hospital;

2. how to operate the phone system for routine calls;
3. protocols for urgent rapid responses;
4. procedural methods for obtaining area entry access not otherwise possessed; and
5. mechanisms for providing feedback to administration when volunteer redeployment decisions actually create crowding rather than helping.

We may achieve a greater level of efficiency by the redeployment of faculty and staff to roles that parallel their existing skill sets and to duties that are more in alignment with their current expertise. For example, as medical school deans and teaching professors, neither J.N. nor R.M. were given log-in access to the electronic health record, nor entry swipe access to many hospital locations we were asked to go to and from, both of which would be useful to the role of unit clerk in a COVID unit. However, with J.N.'s background in hospital leadership, teaching and learning, quality and safety, and as a licensed clinician, she could provide more clinically directed relief to faculty and frontline medical and nursing staff should the need arise in the future. With R.M.'s experience in mentoring and reflective practice, he could provide faculty with opportunities to consider how their clinical challenges can become scholarly efforts. Examples of relevant expertise can include:

1. organizing PPE distribution and education;
2. assisting colleagues in geriatrics or rehabilitation medicine (J.N.'s faculty appointments) with patient care including, for example, telehealth support groups;
3. scheduling virtual coaching time with medical school faculty to best help them plan their day-to-day routines during this new normal (J.N.);
4. assisting, recruiting, and training volunteers to join patient "proning teams" that reposition breathing-constrained patients (R.M.);
5. supporting medical school faculty with reformatting their teaching methods and curricular revisions (J.N.); and
6. mediating faculty and staff self-reflection with journaling on day-to-day discoveries and adaptations during redeployments (R.M.).

KEY TAKEAWAYS

Hospital executives and medical school leaders have the ability and responsibility to use their management skills during times of crises, and to grow from the challenges of this unprecedented time of COVID-19, but may fall back on habits of linear thinking that do not incorporate feedback from a rapidly changing situation. Situational leadership is a framework which various managers and leaders in the hospital setting can exercise to achieve organizational goals and foster a sense of employee motivation, as well as encourage distributed leadership behavior and staff self-reliance in times of crisis. Situational leadership and distributed self-reliance can increase system capacity, and thus institutional resilience, at very low

cost. As redeployed academic volunteers, we both displayed nonlinear thinking to meet demands that confronted limited system capacity, and we provided institutional learning and essential feedback about the frontline state to upper management peers, as we exercised our metacognitive training as educators who tap into intrinsic and extrinsic motivation.

Our time in redeployment allowed both of us to achieve a higher sense of self-actualization,¹³ where our full potential as leaders in uncharted territory was realized. J.N.: *Looking back on this time period, I realize that despite my early fears and the overshadowing uncertainty surrounding COVID-19 in the initial outbreak, I am proud to say that I served my organization and my community during this time. Similar to what my senior colleagues say about the HIV/AIDS epidemic in the early 1980's, this time period will forever be known as one of the most challenging and pressing times in history, especially for hospitals and healthcare organizations. I feel that I set an example for my colleagues, my peers, and on a personal note, for my three children. Sometimes in life, you have to do things that you do not want to do. It is how you respond to these instances that determines how your imprint is permanently left. Although we started our first shift together as complete strangers, by the end of day one of my redeployment, I had gained the trust and engaged in solidarity with the providers and staff assigned to our unit. Considering the continued pattern of changes in managing this pandemic, I will use the framework of situational leadership when faced with unfamiliar developments to establish shared confidence and mutual outcomes among my colleagues, both familiar and unfamiliar. Although I was not consciously aware of it at the time, my use of situational leadership during my redeployment is a testament to the mentoring and advising qualities that I have gained over the years as an academic leader, and it was fulfilling to put these skills to use in a way that I could not have predicted.*

R.M.: *My overarching developmental gain was a more integrated sense of the importance of continuous professional development to the clinical enterprise, as seen in the daily improvements, lesson-sharing and recalibrations of practice I saw being shared among the regular and traveler/locum staff on the ICU units. Trench medicine and trench adaptation reminded me that clinical education must always be outcomes-driven, and that there is significant professional growth to be found when non-clinical academic staff can be present in clinical contexts to see the radical empathy, ad hoc problem solving, and innovation that is daily, even hourly, summoned. The centrality of care teams, both intra- and inter-professional, to the success of an ICU unit, reminded me that as educators we sometimes privilege individual professional development opportunities (perhaps as easier to design and implement), when team-based improvement skills may actually have a demonstrably greater effect on*

patient outcomes and enterprise quality improvement, and require deliberate resourcing. And where full-time administrators may craft rules of operating order around deficit analysis to reach generalizable solutions for groups, clinicians orient to the one-on-one care encounter, customize effort to improve health or deliver care for individuals, and appreciatively strengthen assets, to “find the good and build on it.” The difficulty of scaling individual care makes our training of health professionals all the more important to optimize as a sustained workforce pipeline.

Our redeployment encounters during the COVID-19 pandemic can contribute to the knowledge base of situational leadership, as an underresearched theory of management effectiveness,¹⁴ particularly in the hospital setting. Self-reflective experiences such as ours can better prepare leaders and volunteers when future emergency situations require redeployment of medical school faculty and staff.

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