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Nurse Leaders Advocate for Nurses Across a Health Care System: *COVID-19*

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The COVID-19 pandemic emphasizes the importance of nursing care globally. Nurses are the frontline staff in the care of individuals stricken with this highly infectious and deadly illness. Nurse leaders must advocate for nursing staff when staff are immersed in often overwhelming conditions. Through a case study, this article outlines how one healthcare system's Chief Nursing Officer council worked collaboratively, jointly and with the Emergency Incident Command Structure, to operationalize CDC guidelines and support, protect, educate, and empower staff. These initiatives resulted in creative solutions, technological advances for the system, and nursing staff and leaders rising to the challenge.

NURSES ON THE FRONTLINES OF MASS CASUALTY EVENTS

As the largest sector of the health care workforce, nurses are vital to the provision of care in any setting and circumstance, including pandemics. Although physicians provide much needed in-the-moment medical treatments such as prescriptions and surgery, nurses are there for the long haul; the labor-intensive, time-consuming care essential for recovery and rehabilitation.[1] Historically, nurses have played a central role in the care of individuals stricken with deadly illness when there is no effective medical intervention, including the Spanish flu epidemic, severe acute respiratory syndrome coronavirus (SARS-CoV), H1N1, Ebola, and Middle East respiratory syndrome coronavirus (MERS-CoV) outbreaks.[1-6] A fully informed, skilled workforce is essential to adapting to a rapidly changing work environment, synthesizing information, making complex decisions, and providing high quality care.[6] This is especially true when faced with a mass casualty event (MCE).[7] MCEs fall into 2 distinct categories: "big bang" single incident, immediate impact events such as an earthquake or bombing, and "rising tide" events that slowly develop and have a prolonged impact, for example, pandemics.[7]

In the course of performing care during pandemics, nurses must make challenging decisions.[8] Known for their compassion and commitment to service, nurses have perished when caring for patients during mass infectious outbreaks.[2,8] Nursing staff are repeatedly exposed to the virus and must have adequate training and equipment to protect their life and safety. Preparedness for pandemics and other disasters is essential to protect nurses and nurses should be part of the discussion.[6,7] However, when frontline nursing staff are besieged and beleaguered as events overwhelm health care institutions, nurse leaders must spearhead efforts to provide a voice and advocate for them.

KEY POINTS

- **Coronaviruses are common in humans, but when zoonotic transmission from animals to humans transpire and result in a new viral strain, deadly pandemics can occur.**
- **The current COVID-19 outbreak is overwhelming health care systems, and nurses are at risk for infection, isolation, fatigue, and burnout.**
- **Nurse leader support is essential to creating a safe workplace in which nursing staff are protected, supported, educated, and empowered.**

COVID-19

A pandemic that began in November 2019 has spread globally in what may be the largest pandemic ever.[9] The disease, named COVID-19 by the World Health Organization (WHO), likely began through contact with animals creating the environment for a zoonotic transmission from animal to human.[9-11] Now recognized as having the ability to disperse quickly through human transmission, scientists realize COVID-19 can be spread via human transmission during the 2- to 10-day incubation period, before a person exhibits symptoms.[10,12] The majority of patients are male and have mild symptoms of dry cough, dyspnea, and fever, which spontaneously resolve.[10] For others, COVID-19 can evolve to include severe pneumonia, septic shock, organ failure, and acute respiratory distress syndrome.[10] Some persons remain asymptomatic, never realizing they have the virus.

Coronaviruses commonly occur in the human population.[9,11,13] They are responsible for up to 30% of annual respiratory infections including the common cold and have been thought to be inconsequential.[9,11,13] Over the past 3 decades, however, zoonotic coronaviruses have led to deadly global epidemic outbreaks in the human population.[14] The outbreak of SARS-CoV in 2002 and MERS-CoV in 2012 put the world on notice that coronaviruses are serious threats to global public health.[9] SARS-CoV and MERS-CoV have largely similar clinical manifestations; However, MERS-CoV has prominent gastrointestinal (GI) symptoms and often acute kidney failure.[13] Of note, coronaviruses are enveloped, single-stranded ribonucleic acid (RNA) viruses that have spike-shaped glycoproteins on the envelope that are responsible for attaching to a host cell.[9] In SARS-CoV, the host is the angiotensin-converting enzyme 2 (ACE2) found primarily in the lower respiratory tract in lung epithelial alveolar cells.[9,11] For MERS-CoV, the host is dipeptidyl peptidase 4 (DPP4) found in the lower airway, gastrointestinal tract, and kidney.[9] COVID-19 (CO—corona, VI—virus, D—disease, 19—2019) is thought to be closely related to the SARS-CoV, so the coronavirus causing COVID-19 is known as the SARS-CoV-2.[11]

Many of the treatment challenges with COVID-19 are the same as for earlier outbreaks of coronaviruses. For those contracting SARS-CoV, 20% to 30% required mechanical ventilation, and 10% perished, whereas 50% to 89% of MERS-CoV patients require ventilation, and 36% die.[13] Patients with COVID-19 who progress to a more critical stage are most often admitted with severe hypoxic respiratory failure.[15] In the United States, the American Hospital Association (AHA) projected in February 2020 that 4.8 million residents could be hospitalized with COVID-19, A total of 1.9 million would be admitted to an intensive care unit (ICU), and 960,000 would require ventilator support.[15] It was feared that the 62,000 full-featured mechanical ventilators and the 99,000 older ventilators that are of questionable use would not be enough.[15] Additionally, hospitals would be overwhelmed with patients while dealing with shortages of beds, equipment, and staff.[15,16] During the SARS-CoV outbreak, 3% of US health care workers developed the disease as part of the 21% worldwide even though barrier precautions were widely implemented.[17] Coronaviruses have been shown to last on metal, glass, or plastic for up to 9 days when not efficiently disinfected.[18]

Protecting Frontline Staff

Recent research conducted among nurses caring for patients experiencing coronaviruses and other contagions suggests that nurses have definite concerns and challenges.[4,5,7] In a qualitative study of nurses working during the MERS-CoV outbreak, 4 major themes were uncovered: experiencing burnout owing to heavy workload; relying on personal protective equipment for safety; being busy with catching up with the new guidelines; and caring for suspected or infected patients with caution.[5] Kang et al.[5] noted that infectious disease outbreaks cause a high level of fear and distress among nurses. Nurses also reported feeling unsupported by uninformed or misinformed peers and family, and lonely when caring for infected persons in isolation.[5] This was further supported by Wilkinson and Matzo[7] who identified a sense of staff unity/teamwork in the face of challenges as a primary resource needed by nurses in a disaster. These authors suggest that outcomes of care under catastrophic events lead to increased problems due to stress, including changes in mood and/or sleep patterns, eating disorders, substance abuse, and avoidance behaviors.[7] Wilkinson and Matzo also report on several research investigations that suggest nurses are less willing and able to respond to infectious disease outbreaks related to a fear of contagion.[7] Obstacles to willingness included personal health problems, fear for family and themselves, childcare/eldercare responsibilities, pet care, availability of protective equipment, medicines, and education and training in disaster preparedness.[7] Several authors cite the need for staff to be fully informed and skilled to perform effectively and feel safe during disasters.[5-7] The already strained resources of hospitals, including chronically overcrowded departments and insufficient staffing, also add to the challenges for nurses.

According to Bhadelia,[12] when learning from previous pandemics, there are 3 decisions to make when faced with a large number of people who need care for a novel disease. These include: how to quickly identify infected people; how to isolate and care for them; and, how to keep health care workers safe.[4] National nurse and physician chief executive officers (CEOs) are leading efforts in these three areas. In early March, the

CEO of the American Nurses Association (ANA), Loressa Cole, reached out to Congress requesting a "definitive statement" on transmission of COVID-19 from the Centers for Disease Control and Prevention (CDC) that was not based on supply chain and manufacturing challenges, but rather based on clear evidence-based protocols to protect the nation's 4 million registered nurses.[19] Nurse leaders from several nursing organizations were also invited to the White House to share their insight on the needs of nurses during the current COVID-19 crisis.[20] Finally, the ANA, American Academy of Colleges of Nursing and several other nursing entities have developed free education for nurses on best practice in caring for patients with the COVID-19 virus.[21,22]

Despite these national efforts, local health care facilities are challenged as COVID-19 spreads. Nurses need assistance from nurse leaders in their own place of work. Nurses need to feel supported and empowered. They need an advocate. A case study follows in which a chief nursing officer (CNO) council at 1 health system collaborated with the chief medical officer, chief quality officer, infection prevention, and human resources to create a model of success for empowering and safeguarding nurses.

CASE STUDY

Creating Command Central

In late December 2019, long before Rochester Regional Health (RRH) had its first encounter with a possible COVID-19–infected patient, executive leaders began proactively monitoring and preparing for COVID-19. An emergency incident command structure, command central, was set up to operationalize CDC guidance as the virus began appearing in Rochester, New York. The purpose of the command center is to work collaboratively to make operational decisions, support patients and staff, and impart daily briefings to staff. The command center works under the following tenets: Identify, Isolate and Inform. Decisions are made to help staff in the 3 areas. For example, updated screening questions were included as part of the registration process in the electronic medical record to identify patients with COVID-19. For employee identification, a hotline was set up for those who had recently traveled to be cleared for return to work. Specific units were set up for COVID-19 patients, and communication trees were developed for the chain to follow to inform leaders of potential COVID-19 patients.

The Chief Nursing Officer Council

The CNO council is composed of 7 CNOs who provide leadership to all areas of the health system including the 5 hospitals, ambulatory surgery centers and medical groups, long-term care facilities, and nursing education that make up RRH. The CNO council collaborated, as members of the command central team and through long-established collegial efforts, to formulate and operationalize a plan to support nurses and the health system during the local COVID-19 outbreak. Each CNO was responsible for certain processes in their work environment. For example, each hospital CNO was charged with identifying specific units to take COVID patients; create an algorithm of critical care surge locations in nontraditional areas throughout the hospital; and formulate a surge plan for staffing when New York's governor requested that each hospital set up surge locations. The CNO for the surgery centers and medical group was responsible for instituting telemedicine for patient appointments while the chief nursing education officer (CNEO) needed to establish course offerings online for the nursing program and employee orientation. The CNOs reported on their progress daily at the command central meetings. They also met weekly during CNO council meetings to discuss strategy. Throughout the entire process, the focus of the CNO council was on support of nursing staff and quality patient care. There were many joint initiatives employed but also area-focused initiatives, given the different work environments involved (i.e., hospital, ambulatory, long-term care, education).

Joint Initiatives

Staffing. As the system realized that its facilities could face an unprecedented infectious disease outbreak, the CNO council strategized to ensure that staffing levels would be calculated wisely based on patient needs, staff skill level, and anticipated facility changes. Similar to many health systems around the globe, RRH was already dealing with a nursing shortage. The current climate left nurse leaders working to mitigate the augmented human resource shortage that an increase in patients would create. A computer-based algorithm was created to match facility needs with the skills and education of all redeployable staff including nursing staff at every level. Staff were moved to areas of greatest need based on their work experience. For example, Unity Hospital had a pool of 60 nurses, including perioperative nurses trained in critical care and endoscopy nurses with ICU experience, that could be redeployed to take care of critical patients. Surgical technicians were trained as a "turn team" to prevent pressure injuries in COVID patients.

There were additional issues affecting staff redeployment. First was the "stay at home" statewide order. Many nurses and nursing staff had outside-of-work responsibilities including children, elders, and pets. When the long-term care (LTC) facilities encountered a problem with certified nursing assistants staffing based on these outside responsibilities, the CNEO

deployed staff to fill this and other gaps. Human resources (HR) was tasked with providing guidance on absences and time off. Staff were provided with up to 7 nonconsecutive paid days off for childcare or family needs, with the approval of their manager. RRH continued to hire staff, but interviews were conducted via phone or videoconference, and new employee orientation was changed to webinar with the hiring unit taking responsibility for the hands-on skills. Finally, the CNEO developed a transition orientation education plan for redeployed staff. This orientation was conducted via a 2-hour 1-on-1 orientation session for each staff member and specific training was conducted on the unit.

Supplies. A critical element of protecting staff is ensuring that personal protective equipment (PPE) is available. Given the global emergency and the scale of the New York state outbreak, RRH supplies were at critical levels. The CNO council worked to ensure that staff were well-equipped. For example, a PPE command room was set up at each hospital under supervision to foster appropriate distribution and safekeeping. Staffed with 24-hour accessibility, leaders could request PPE for employees based on need and burn rate. Staff were directed to re-use eyewear, and a policy was developed on this practice. An ongoing team of nurses with 24-hour coverage performed "fit tests" to ensure N95 masks fit correctly based upon vendor directives. Surgical masks were used for extended periods, and leaders contemplated decontaminating them for re-use until more become available. The director of sustainability at RRH was asked to search for best evidence in regard to decontamination methods for N95 and surgical masks and resultant structural integrity. Volunteers from the general public were asked to sew masks for health care workers and were provided with patterns and directions.

Employee support. Two-way communication with nursing staff is imperative during times of upheaval to foster employee support. This includes formal structures such as websites and e-mails to all staff, and more in-the-moment opportunities such as facility leadership meetings, daily safety huddles, and staff huddles. The command center began a daily outreach via email for up-to-date information to all employees on system-wide COVID-19 efforts. Nursing leaders augmented their work schedules to increase visibility and support. For example, directors and other nursing leaders are working full weekends for additional coverage. Every nursing leader has an open-door policy to provide staff with an opportunity to voice concerns, put forth ideas, or express thoughts.

Communication is also essential to ensure staff safety. Nurses are at risk when they do not have clear guidelines for care including a clear directive for use of PPE. An employee webpage was created and is continually updated with guidelines and information from the CDC and others in an effort to increase staff knowledge and safety. A COVID-19 toolkit was developed in tandem with the local and state departments of health to provide employees with helpful tools and resources, including guidelines, screening tools, testing workflow and guidelines, treatment management tools, signage, etc. Additionally, a hotline with updates including signs and symptoms, exposure protocols, facts, and prevention was developed.

Other methods of employee support were instituted. The CNO council ensured that team members were supported through additional flexibility in scheduling, and 7 additional days off were added to help in difficult circumstances. Links to videos were provided for stress reduction techniques including exercise and meditation. Private sleeping rooms were established throughout the hospital for employees to sleep, shower, rest, or separate from family to prevent exposure to COVID-19. Hospitals created a grocery store in the closed cafeteria for all employees to shop for staples and to order to-go meals. "Superhero" staff members were recognized and showcased for "going above and beyond." Finally, a special thank you link was set up that includes messages from the community thanking frontline staff for their care.

Focused Efforts

Testing. The CNO of the Primary Care and Ambulatory Surgical Institute (PCASI) was charged with setting up new work streams to enhance efficiency of COVID-19 testing efforts. Nurses were needed for a 24/7 triage line, care tents, COVID result calls, monitoring and self-isolation calls, exposure calls, screening stations, and supply chain efforts. RN staff from PCASI were centralized and cross-trained so that they were fully prepared and additional FTEs were not needed when staff requirements fluctuated. A plan was also needed to transition nurses back to practice areas as care practices reopened.

Telemedicine. Another outcome of the COVID-19 pandemic was the need to alter how patients received outpatient care. Face-to-face visits were no longer possible under state mandates. There was a history of reluctance among many providers in the health system to institute telemedicine as a routine option for patient visits. When the decision was made to begin virtual visits, the CNO for PCASI developed an implementation strategy and education for staff. Nursing functions were centralized to support telehealth transitions. Any work that could be completed outside of the practice was centralized in an effort to maximize efficiency. All "touch" and "no touch" nursing functions were identified to determine what could be removed from nursing's centralized care agenda and delegated elsewhere.

Table 1. CNO Initiatives

Redeploy staff from nonessential closed work areas to ease staffing needs
Continue hiring of staff using phone or online interviews
Centralize and cross-train deployable staff
Provide orientation for redeployed and new staff online with hands-on at the unit
Create personal protective equipment command room with 24-hour staffing
Create ongoing team of nurses to provide "fit testing" for masks
Operationalize telemedicine platform with staff

Long-term care. The CNO of the 6 LTC facilities was tasked with keeping residents and nursing staff safe. She worked with the administrators and nurse directors of the individual facilities to be the first to institute health screening for staff at the door including symptoms and temperature check; ensure that a strict no visitor policy was enacted and patients only left the facility if absolutely necessary; and to require PPE and masks for staff. Additionally, all LTC patients and residents were educated on COVID-19 and the needed social distancing and infection prevention procedures. Virtual visits were arranged for family members. Large group gatherings were limited, and small unit-based activities were developed instead. Residents meals occurred at a social distance. These efforts are meant to safeguard patients and staff.

Education. The Isabella Graham Hart School of Practical Nursing is affiliated with RRH. RRH facilities serve as clinical placement sites for students and graduates often find permanent positions within RRH facilities. The school has 2 class cohorts: day and evening. The CNEO had to suspend classes when New York's governor required academic institutions to close. She worked with school instructors to develop online courses that met the state and accreditation requirements of the program. This was a major endeavor because content and processes had to be developed, technical issues for students without internet access and/or computers solved, and software for virtual test taking acquired. Virtual experiences were developed for clinical requirements in which the student would be responsible for developing and instituting the care for three or more patients. New evaluation techniques had to be implemented to ensure that students were acquiring hands-on clinical skills and achieving school graduation criteria.

Table 2. Employee Support

Create educational initiatives for fully informed staff
Create private sleep rooms throughout the hospitals for employees
Create on-site grocery store in cafeteria for employees to shop and order to-go meals
Increase leader visibility on units
Provide mental health resources including behavioral, spiritual, and stress relief
Provide scheduling flexibility and additional days off for at-home responsibilities

CONCLUSION

WHO proclaimed 2020 the International Year of the Nurse and Midwife to highlight the need to make nursing a priority around the world. This pandemic emphasizes the importance of nursing care globally. Care in the workplace has shifted, and nurses have had to visualize and operationalize new processes rapidly. Nurses are rising to the occasion and exhibiting amazing fortitude through tumultuous times, and continue to put their lives on the line while they care for others. Nurses need nurse leaders to advocate for their work conditions, safety, and welfare while they provide care under difficult conditions. Through the efforts of the CNO council, nurses at RRH were informed and protected in their work environment. As the pandemic continues, we will continue to support our staff through the challenges we all encounter while caring for those in need.

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