THE NATURE OF CARING BY NURSE LEADERS IN THE EARLY COVID-19 PANDEMIC

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ABSTRACT

The Nature of Caring by Nurse Leaders in the Early COVID-19 Pandemic

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In early March 2020, the rapid outbreak of COVID-19 in New Jersey caused hundreds of people to become gravely ill. They filled hospital emergency rooms and ICUs. They lined up on stretchers in hallways and offices. Because there were no known medications or treatments, many died. Soon there were severe shortages of personnel, PPE, supplies, and equipment. Despite the risks, all hospital employees were expected to work every day. The majority were anxious, frightened and confused. Their nurse leaders (NLs) continued managing despite being stressed and exhausted. They seemed to have little time to for caring as they ran from one crisis to another. While caring is said to be essential to professional nursing practice, there is no single definition of caring in nursing. Caring takes time, compassion, and understanding to provide comfort, support, and appropriate interventions. The aim of this qualitative study was to explore the nature of caring by NLs in the early COVID-19 pandemic. The hermeneutic phenomenological approach of van Manen informed this investigation. Six NLs participated in confidential, audio-recorded interviews. They responded to open-ended questions about their lived experiences of caring in the early pandemic. The recordings were transcribed verbatim and analyzed through reading, deep reflection, writing ideas, and repeating until five themes emerged: (a) on the cusp, (b) protecting, (c) caring for, (d) going in blind, and (e) appreciation. Each theme has three subthemes that clarify and contribute to the overall

meaning. An expressive narrative thematic text was created to introduce readers to the world of caring by NLs in the early COVID-19 pandemic. Although results of phenomenological studies are not generalizable, they provide valuable information. Disasters, infectious diseases, and violence are increasing everywhere. Hospitals and NLs must be ready to safely treat and care for people in need. Related recommendations include better and ongoing crisis leadership training, rapid training programs for nurses temporarily deployed to other specialties, relationship building for nurses and physicians, several related research topics, and importantly, assuring mental health support for NLs during and after traumatic events.

DEDICATION

To my husband John for being my rock, my friend, and my love through all the ups and downs of this long and often interrupted journey. Thank you for sacrificing so much for me to achieve my dissertation dream. I look forward to enjoying many new adventures with you!

To my children Scott and Sharon and my grandchildren Larisa, Jake, and Bennet for supporting and encouraging me. I have been in school for most of your lives. Yet, you have taught me more than any formal education could. You are smart, insightful, and kind. The world is a much better place with each of you in it. I love you all so much!

To the memory of my mother who always encouraged me to continue my joy of life-long learning. If only she could be here to celebrate with me! Mom, you are in my heart now and always. I miss you.

To the memory of my Nana and my Grandma who both loved to tell humorous and interesting stories about their life experiences.

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CHAPTER 1

Introduction

> It is always a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence. (Max van Manen, 1997, p. 31)

COVID-19: An Emerging Pandemic

In December 2019, scientists identified a new virus in humans that caused a severe influenza-like disease. No one expected the highly contagious virus to spread far or last long. But it multiplied quickly, spreading from person to person, town to town throughout much of the world. Tragically, it seemed no one was immune to the new virus. By mid-February, the World Health Organization (WHO) named it SARS-CoV-2 virus, or COVID-19, and declared a pandemic (WHO, 2020, February 11; WHO, 2020, March 12). The worst symptoms were respiratory, but there were others, like stomach pains and migraine headaches. The elderly and others with chronic conditions tended to become the sickest. Because there were no available treatments, many became severely ill and died. During the earliest months of the pandemic, nobody was sure how to prevent COVID-19. And nobody knew of a cure.

The rapid spread of COVID-19 in the United States (U.S.) caused significant institutional, professional, and ethical challenges. By the second week of March 2020, most New Jersey (NJ) hospitals reported admitting severely ill patients infected with COVID-19. Soon there were severe shortages of emergency department (ED) and intensive care unit (ICU) beds, life-saving equipment such as ventilators and IV pumps, other patient care technologies, crucial medications, personal protective equipment (PPE), and personnel. Hospitals overflowed with dying and frightened patients. Some

were treated on stretchers in crowded hallways. Others were turned away when corridors became full. Nurses soon became family surrogates for deteriorating patients. When those patients died, they were quickly replaced by others. So many patients died that refrigerated trucks were used as makeshift morgues because hospital morgues and funeral homes were crowded beyond capacity. All elective procedures were cancelled. Staff were asked to work extra shifts. Administrators appealed to local and regional facilities for resources, but all were in similar situations and could provide little assistance.

My Own Lived Experience

As a registered nurse (RN) for over 45 years, I have held many leadership positions, including project coordinator, nurse manager, clinic director, and administrative coordinator. My final role before retirement in November 2019 was the Magnet program coordinator (MPC)/nurse educator for twelve years at HomeTown Medical Center (HTMC: See definitions) in New Jersey. After I officially retired, I continued to work per diem through the second week of January 2020 to orient my successor. I was excited about transitioning to retirement. I would finally have time to enjoy my family, travel, and write my dissertation. I looked forward to new adventures and experiences!

Everything changed by the second week of March when COVID-19 arrived, and the entire state was on mandatory lockdown. While I was confined to my home, I wondered what would happen next. Would we all get sick and die? Would a cure be found? How could any NL (see definitions) leave the relative safety of home and go to work every day when resources were missing, patients were dying, and staff were terrified? I couldn’t stop thinking about my work colleagues. As the MPC, I was

acquainted with all the NLs at HTMC. We attended meetings and education programs together and met individually to discuss their department's progress toward fulfilling requirements for Magnet redesignation. I was aware of their departments' triumphs and struggles. I knew and liked many of their employees.

At first, I tried calling several of the NLs, but they were so busy that they had no time to chat. One told me that PPE, especially masks, were in short supply. I also learned that N95 masks, the ones that we were fit-tested for wearing in isolation rooms, were needed. Only clinical staff could get N95 masks. Other staff had to wear cloth or paper masks. Everyone was afraid. Some were angry. I thought about all the NLs who were dealing with this chaos. I wondered, What are they going through? How did their workdays change? Then, what was it like to lead clinical nurses and other staff during deadly contagion? What does it mean for them? What drives them? Do any of them have any time to care about patients, the staff, each other?

HomeTown Medical Center was already a Magnet designated organization when I was hired as the program coordinator. The Magnet Recognition Program (Magnet) requires participating nursing departments to select a nursing theorist and theory to support a culture of professionalism. I learned that the HTMC nurses had selected the caring science theory of Jean Watson (2008). I was familiar and agreed with her values on caring because I applied them to my master's degree thesis. While more of a philosophy than theory, the caring aspect appeals to many nurses who believe nursing is grounded in caring and that caring separates nurses from being technicians. The NLs and I spent hours going over caring practices for our nursing professional practice model. I wondered if the turmoil caused by COVID-19 would affect their ability to care.

I thought about some of my own leadership practices. The years that I spent as a nurse manger and director were some of the most challenging and rewarding of my career. I enjoyed the ups and downs of running a patient care area. I loved advocating for patients, staff, and my profession. Sometimes my leadership experiences were difficult and frustrating. I recalled how hard it was to care for patients and each other during uncertain times. I wondered what it would be like to lead staff during a new pandemic. Could I do it? Could I be a caring leader in this crisis? What did it mean for NLs to care during the early COVID-19 pandemic?

Significance of the Problem

Despite the risks, nurses and other hospital employees went to work daily without knowing how to protect themselves, their families, and others. Nearly all described fear, stress, and exhaustion. Although many nurses were called heroes, some reported feeling like failures (Chipps et al., 2022). They questioned their ability to continue nursing under such dire circumstances. They turned to their immediate NLs for direction, advice, and reassurance (Shuman & Costa, 2020). But none of the leaders had ever experienced a crisis like this. Their COVID patients were critically ill, supplies and PPE were nearly gone, and staff were sick at home, or taking care of family members. The NLs were unsure what they could do to help. The stress was overwhelming for them, as well (Branden, 2020; Prestia, 2020; Middaugh, 2020). The NLs had to be disciplined enough to advocate for their staff's physical and psychological welfare while providing care under difficult conditions (Cathcart, 2020; Stamps et al., 2021). "Too often, the foundational functions of management are forgotten during a crisis and our systems may produce more chaos than was already present" (Middaugh, 2020, p. 211). Was it possible

for NLs to care for and nurture caring by others while experiencing the devastating conditions of the early COVID-19 pandemic?

Phenomenon of Interest

Nurse leaders are visible and available in nearly every healthcare facility. "Across the entire patient experience, and wherever there is someone in need of care, nurses work tirelessly to identify and protect the needs of the individual" (ANA, 2020, para. 1). Under typical circumstances, healthcare administrators acknowledge the NL position as one of the most highly complex and stressful roles in their facilities (Chipps et al., 2022, 345). Nurse leaders are responsible to ensure safe, healthy environments for nurses and other members of the healthcare team to care for patients, individuals, and communities served by their organizations (AONE/AONL, 2015). The pandemic caused chaos in most hospitals. I wondered if NLs were able to promote caring in settings where nurses were tasked with administering unproven, sometimes risky interventions while trying to save COVID-19 patients' lives.

Nurse leaders who value caring influence the nursing staff to embrace caring in their approach to patients and others in the practice setting (Turkel, 2003). Many NLs work in organizations where a nursing theory or practice model that is centered on nurse caring has been adopted. The goal is for caring to become enculturated throughout the nursing department and eventually the entire organization. But the influence of COVID-19 on caring by NLs is yet to be determined. As a central theme of professional nursing, caring has been researched and studied by many nurse scholars (Adams, 2016; Watson 2008). Most agree that caring is a vital component of contemporary nursing. Still, despite decades of research, there is no consensus on the definition or meaning of nurse caring.

Aim of the Study

"Nurse leaders have a pivotal role in balancing the care of their staff with the care of the patients they serve" (Prestia, 2020, p. 326). Yet, there are few studies that examine the meaning of caring by NLs in general, and more specifically, during the early COVID-19 pandemic in the United States. The aim of this hermeneutic phenomenological study was to explore the lived experience of caring by NLs during the early COVID-19 pandemic in New Jersey.

Research Question

What is the nature of caring by nurse leaders who worked full time in an independent medical center in New Jersey during the early months of the COVID-19 pandemic?

Research Perspective

How could NLs leave the safety of their homes and go to work in a hospital every day during a pandemic when resources were missing, patients were dying, and staff were terrified? What was it like? What did it mean to them? I decided that a hermeneutic phenomenology approach would be the best for me to explore, write, and provide interpretive analyses of audio-recorded interviews of NLs employed in an acute care hospital during the early months of the COVID-19 pandemic.

Phenomenology is a qualitative research approach that asks participants what is it like to be …? Phenomenology gives voice to people, using their own voices. Phenomenological research explores the essence or meaning of a phenomenon by focusing on what and how it was experienced from the viewpoint of those who experienced it (Neubauer et al., 2019). This is most often done by interviewing

individuals who have lived or experienced the phenomenon without evaluating, critiquing it, or justifying how they experienced it. “Instead, participants are asked to voice the experience---in all its confusing, personal, social, physical, incongruencies and its silences” (Ajjawi et al., 2024, p. 1053).

The two main approaches to phenomenological research are descriptive phenomenology and interpretive phenomenology. Edmund Husserl is often called the father of phenomenology. He identified the concept of lived experience; the everyday life we live and experience pre-reflectively, or without critically contemplating the experience. He searched for the essence, the essential nature, of a lived experience. Husserl believed everyone having the same lived experience would describe common features about the experience. When they are interviewed about the experience a definition of its universal essence, or the one true nature, would be revealed (Ajjawi et al., 2024; Lopez and Willis, 2004; van Manen, 1997). Husserl was not interested in the physical characteristics of an object or thing or event that appears in consciousness. The universal essence is transcendental instead, because it is always the way we imagine it to be and not the actual thing itself (van Manen, 2014, p. 91). Descriptive phenomenology requires the researcher to “bracket” or put aside all preconceived beliefs, ideas, or attitudes about the experience in order grasp the other’s lived experience (Ajjawi et al., 2024; de Chesnay, 2015).

Martin Heidegger was a student and follower of Husserl. In time, he abandoned the idea that the essence of experience was something that people consciously know. Instead, he believed that meanings can be obtained from their narratives about the experience. Heidegger rejected bracketing because, “hermeneutic phenomenology is

deeply interpretive, highlighting that individuals (both researchers and participants) can never escape their prejudices as a product of culture, gender, race and class, providing access to the world" (Ajjawi et al., 2024, p. 1053). Hermeneutic research is a search for Dasein, or "being-in-the-world," referring to the way people exist, act, or are involved in their everyday lifeworld (Ajjawi et al., 2024; van Manen, 1997). Four lifeworlds make up the situated context of lived experience. *Lived space* is the space around people and the way it makes them feel. *Lived body* is the way people think about their bodies, their body parts and sensations, including disease and emotions. *Lived time* is related to the passage of time, including day, month, and time of year. It also includes the feelings of the passage of time, such as speeding up or slowing down. *Lived human relations* are the person's experiences of self in relation to others, such as how they are connected, the kind of relationships they have, and their formal or informal interactions. The lifeworlds combine to make up the participants lived experience (Ajjawi et al., 2024, Lopez and Willis, 2004; Munhall, 2012; van Manen, 1997).

Max van Manen is a leading hermeneutic phenomenological researcher. This investigation is based on his approach. He provided and detailed six practical approaches that can provide a methodical structure for hermeneutic phenomenological research. They are: (a) turning to the nature of lived experience, (b) investigating experience as we live it, (c) reflecting on essential themes, (d) the art of writing and rewriting, (e) maintaining a strong and orientated relationship, and (f) balancing the research context by considering the parts and whole. These research activities serve as a guide to conducting a hermeneutic phenomenological investigation. More than one can be done at a time. The alphabetical list does not imply that there is a specific order to follow (van Manen, 1997).

Explicating Assumptions and Pre-understandings

Munhall (2012) asked, “How can one understand what kind of meaning an experience has for a person unless one suspends one’s own preconceptions?” (p. 131) She reminded us that we cannot “unknow” what is already known. In other words, we should not influence our investigation with our past experiences and preconceived ideas about the phenomenon of interest. In descriptive phenomenology the researcher “brackets” thoughts and beliefs about the phenomenon of interest to avoid introducing personal ideas during interviews and afterwards when finding meaning in a lived experience of interest (Munhall, 1994). The phenomenologist, Edmund Husserl, was also a mathematician. He adopted the mathematical term “bracketing” to describe how a researcher sets aside subjective beliefs about the scientific theories, knowledge, and explanations of the natural world to study the essential structures of the world (Dahlberg, 2006; Neubauer et al., 2019; van Manen, 1997). Put another way, “Bracketing means parenthesizing, putting into brackets the various assumptions that might stand in the way from opening up access to the originary or the living meaning of a phenomenon” (van Manen, 2014, p. 215). Moreover, in hermeneutic phenomenology, humans are embedded in their world. A researcher should not discard their prior history and beliefs about the subject under study (Reiners, 2012). Therefore, hermeneutic researchers should examine and contemplate their own beliefs, feelings, and experiences with that phenomenon so that they can better interpret the participants’ narratives (van Manen, 1997; 2014). And yet, with my personal history and lived experience, it was difficult not to put myself in the place of the NLs in this research.

Significance of the Study

Currently, COVID-19 remains a threat to the general population, an outbreak of avian flu is spreading, and polio virus has been identified in human waste management facilities in New York City. Infectious diseases, natural disasters, and violence are increasing throughout the world. Healthcare and nursing research studies and media stories often focus on the experiences of clinical nurses during catastrophic situations. Instead, this phenomenological investigation seeks a deeper understanding of the lived experience of caring by NLs during the early COVID-19 pandemic. While these NLs' meanings of caring are personal and therefore not generalizable, they may help us gain understanding of their professional and personal experiences during the pandemic. It is my hope that new insights gained through this study will cause hospital-based administrators and nursing leadership to think about NLs within the situated contexts of their organizations. Perhaps they will review the relationships of the NLs with other professionals and employees, or reconsider human resources policies, or have better plans for intervening during crises. There is no way to really know unless we enter the lived experience of these nurse leaders.

Definitions for the Study

The following definitions of nursing titles and roles are meant to help clarify the terms used for nursing leadership in this dissertation. While these titles are not meant to be interchangeable, it is understood that various hospitals and authors may use them differently. This could cause some misreading or misunderstanding of this study.

Nurse Leader (NL) The term nurse leader (NL) was selected for "registered nurses with the accountability and supervision of all registered nurses and other healthcare providers who deliver nursing care in an inpatient or ambulatory setting" (ANCC,

2017. p. 195). These leaders often hold the title nurse manager. However, “it is understood that RNs who function in a nurse manager role in the organization may not be assigned the title of nurse manager” (ANCC, 2017, p. 195). To reduce confusion the term NL will refer to nurse managers, directors of nursing, and other nurses with comparable responsibilities.

Chief Nursing Officer (CNO) “The highest-level nurse with ultimate responsibility for all nursing practice within the organization” (ANCC, 2017, p. 186). May also be called chief executive officer or similar title.

Early COVID-19 Pandemic For the purposes of this study the early COVID-19 pandemic is defined as March 1, 2020, through May 31, 2020. These were the approximate dates that NJ Governor Murphy executed an emergency shutdown of all non-essential businesses throughout the state until more was learned about COVID-19 transmission and prevention and the shutdown was rescinded.

HomeTown Medical Center (HTMC) A pseudonym for the actual medical center where the participants in this research were employed. While complete anonymity is not possible, the name was changed to help preserve confidentiality of the facility and the individuals involved.

Index Family A pseudonym selected for the surname of the large family whose members were among the first people to contract COVID-19 and were the first deaths in New Jersey. The first names of family members were also replaced with pseudonyms. Pseudonyms are meant to preserve confidentiality.

CHAPTER 2

Caring In Nursing

What is Nurse Caring?

Caring is often said to be essential to professional nursing. Yet, there is no one definition of caring in nursing. The American Nurses' Association's First Position Paper on Education for Nursing reported:

> The essential components of professional nursing are care, cure, and coordination. The care aspect is more than "to take care of"; it is "caring for" and "caring about" as well. It is dealing with human beings under stress, frequently over long periods of time. It is providing comfort and support in times of anxiety, loneliness, and helplessness. It is listening, evaluating, and intervening appropriately. (ANA, 1965, p.107)

The terms care, care-giving, care receiving, and nursing care are often used interchangeably or defined differently depending on which nursing scholar or theoretical framework is referenced. Other meanings may be applied to these terms in nursing and other literature, leading to some confusion (Blasdell, 2017, Smith, 1999). One example is ethic of care, a feminist moral theory about care that is included in caring and ethics courses in some nursing programs. The theory identifies four phases of care: *caring about, caring for*, *caregiving*, and *care receiving*. The corresponding elements for each phase of care are attentiveness, responsibility, competence and responsiveness (Tronto, 1998).

Wolf et al. (1994) provided a different definition of nurse caring as,

> an interactive and intersubjective process, occurring during moments of shared vulnerability between nurse and patient, which is self and other directed. Caring is directed toward the welfare of the patient and takes place when nurses respond to patients in a caring situation. (p. 107)

When a nurse is in a caring-healing relationship, she preserves human dignity, wholeness, and integrity of the other by deciding how to be in the caring moment (Watson, 2008).

Early Nurse Training and Caring

Modern nursing practice was founded on principles set by Florence Nightingale during the Crimean War in the 19th century. Nightingale's pioneering beliefs were grounded in basic principles of health: cleanliness, nourishment, pure water, fresh air, sufficient drainage, and light. Because Nightingale was a prolific writer, she was able to document the benefits of how these concepts were used to save the lives of scores of wounded and sick soldiers. Her ideas were the foundation of the first schools of modern nursing in the United States (ANA, 1965; Dunphy, 2015; Nightingale, 1992; Reverby, 1987).

Nightingale was very spiritual. She often referred to God but said little about nurses and caring. According to Dunphy (2015), Nightingale believed "all nursing actions were guided by the nurses' *caring*, which was guided by underlying ideas about God" (p. 51). Nightingale viewed all women as caregivers, nurturers, and healers who eventually would be responsible for the health and wellbeing of another person, their families, and even their communities (Dunphy, 2015).

The first official nurse training schools in the United States were based in hospitals. "Trained nursing began as an occupation based on the duty to care" (Reverby,

1987, p. 202). The superintendent of nursing, and perhaps two other RNs, made up the entire employed staff. All patient care was performed by students in an authoritarian, paternalistic atmosphere. There were no specific qualifications for the nursing students, but they were typically young, unmarried, virtuous, and of good character. They worked long, exhausting hours, performing specific tasks and treatments based on the science and medicine of their generation. They quickly learned they were expected to follow doctors' orders and other rules without question. There was little time for appropriate caring in such a hectic environment. Nurses and student nurses had no code of ethics or legal means to articulate the value of caring. Nurse training programs lasted up to three years. After students graduated, most did private duty nursing, living in their patient's home, sometimes for weeks, with little or no time off. A small number remained in hospitals as superintendents or head nurses. For decades, the nursing profession continued without a clear image of how to satisfy the duty to care (Kalisch & Kalisch, 1978; Reverby, 1987).

By the second half of the twentieth century, RN training began to be phased out of hospital diploma schools and basic nursing education was shifting to colleges and universities. In 1965, a position paper by the American Nurses Association recommended basic RN education should be at the collegiate level (ANA, 1965; Kalisch & Kalisch, 1978; Dunphy, 2015). Because there were few available graduate-level nursing programs, nurse scholars who wanted to advance their profession studied in master's and doctoral programs of other fields, such as anthropology, psychology, sociology, medicine, and science. They created theories and models to articulate their views of nursing. Consequently, the foundations of early nursing theories and models were derived from other disciplines. Concepts from these disciplines were applied to and combined with the

existing rules of nursing practice. Examples are Roy's adaptation model, Parson's theory of social system analysis, and Orem's self-care deficit theory of nursing. "Such theories then explain how nursing acts to right the wrong, meet the need, or eliminate or ameliorate the deficit," but do not directly address the essence of nursing (Boykin & Schoenhofer, 1993, pp. 15–16). What then was the essence of nursing? Did it include caring? Over the years, nursing theories and concepts about nursing practice continued to evolve. By the 1980s, the science of nursing became a distinct field of collegiate education that offered graduate degrees and fostered nursing-specific research.

Nursing Theory and Caring

Caring in nursing has been researched by many nurse scholars as a central theme of nursing. Their theories and models of care or caring express the unique, complex relationship between nursing and caring for patients, families, groups, organizations, and communities. Texts, articles, and scholarly papers have been written to summarize and compare established caring theories (McCance et al., 1999). "Each nursing conceptual model or grand theory will have its own definition of caring just as each has its own definitions of health, human beings, or quality of life" (Smith, 1999, p. 18).

From Novice to Expert

In 1984, Patricia Benner published her classic text *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. The book summarizes her extensive qualitative research on skill acquisition and caring in nursing. It is well known for applying the Dreyfus model of skill acquisition to nursing care. "The research was aimed at discovering if there were distinguishing, characteristic differences in the novice's and expert's descriptions of the same clinical incident" (Benner, 1984, p. 14). By using the

Dreyfus model, performance characteristics and general teaching/learning needs for nurses were identified and described at the following levels: novice, advanced beginner, competent, proficient, and expert.

Because much of nursing cannot be quantified or measured, nurses wrote exemplars to express the personal meaning of a specific clinical or caring situation that might otherwise be lost. Analysis of results was accomplished through an interpretive strategy based on Heideggerian phenomenology. Findings from Benner's research have resonated with the nursing community for decades.

The healing power of the nurse-patient relationship was also described in this research. "Nursing without caring is powerful and devastating" (Benner, 1984, p. 216). While detachment, explicit knowledge, and reflective reasoning are significant and highly valued, it is through the role of caring and associated emotions that creative problem solving takes place. Nurses are present during the first and last moments of life. Their attitudes and behaviors can soothe and give hope. The author goes on to say, "if the nurse does not care—the patient's chances for recovery, or for dignity and comfort in dying, are slim" (Benner, 1984, p. 216).

The Primacy of Caring

In 1989, Patricia Benner and Jean Wrubel published *The Primacy of Caring: Stress and Coping in Stress and Illness*. Their book is based on the work begun during Benner's previous research. Exemplars are provided as phenomenological examples of how nursing knowledge growth occurs. The authors state that "caring makes the nurse notice which interventions help, and this concern guides subsequent caregiving. Caring causes the nurse to notice subtle signs of patient improvement or deterioration" (Benner

& Wrubel, 1989, p. 4). They summarized various philosophical beliefs that are foundations for much of western medicine and examined the differences that nursing brings to patients and healthcare. Benner and Wrubel (1989) defined caring practices as:

> organized, specific practices related to caring for and about others. Caring practices are lived out in this culture primarily in parenting, child care [*sic*], nursing, education, counseling, and various forms of community life. An ethic, a way of knowing, and practical knowledge are lived out in specific caring practices so that it is possible to recognize and discuss what counts as caring—or not caring, in specific instances. (p. 408)

Benner and Wrubel also emphasize important issues influencing nurse caring, such as the explosion of technology, the long, arduous work hours, stress, and burnout.

Transcultural Nursing and Culture Care

Madeline Leininger was a nurse anthropologist who wrote extensively about the need for care that is culturally congruent. In the 1950s she began her research that eventually led to culture care theory and the transcultural nursing movement. At that time, international travel and immigration were increasing. As an anthropologist, Leininger researched caring behaviors with a transcultural focus to determine how different cultures and subcultures perceive, know, and experience caring. “The unique focus of Leininger's theory is care which she believes to be inextricably linked with culture” (McCance et al., 1999, p. 1389). She researched the nature of care, including linguistic meanings, descriptive phenomena, values, structural and functional uses, and processes (Leininger, 2012/1977, pp. 57–58). Leininger identified the need for nurses to be culturally competent to care for patients from diverse populations. She used a

qualitative ethnoscience approach to research the nature and processes of caring to determine which caring behaviors and processes are universal and which are non-universal (Tourville & Ingalls, 2003, p. 29).

While Leininger (1977/2012) did not identify a widespread, or transcultural definition of caring, nursing care, or care, she found that the meaning of care and the need to be cared for have considerable cultural and social importance to all cultures. Although not universal, she identified seventeen major principles related to care, caring behaviors, and caring processes:

> 1) comfort, 2) support, 3) compassion, 4) empathy, 5) direct helping behaviors, 6) coping, 7) specific stress alleviation, 8) touching, 9) nurturance, 10) succorance, 11) surveillance, 12), protection, 13) restoration, 14) stimulation, 15) health maintenance, 16) health instruction, and 17) health consultation. (p. 58)

Leininger believed in a holistic, transcultural approach that incorporates educational, political, and religious influences in caring for and preserving the health of people, families, groups, and institutions (Tourville & Ingalls, 2003; Bailey, 2009). The sunrise model was developed by Leininger to provide a visual depiction of her theory. The complex model resembles a rising sun with rays that symbolize the social and cultural dimensions of a world view of culture care. The central portion represents nursing, both generic (emic or indigenous), and professional (etic or outsider) care. The lower level depicts three nursing strategies: preservation of culture, or emic care practices; integrating culture care and professional care practices; and renewing professional care practices with greater sensitivity to the values and belief systems of others (Bailey, 2009, p 22).

Ethic of Care

Although not a nursing theory, nurses are educated about the ethic of care philosophy in some nursing programs. Joan C. Tronto (1998) discussed the ethic of care that takes place in our everyday lives as,

> a species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible. That world includes our bodies, our selves [*sic*], and our environment, all of which we seek to interweave in a complex, life-sustaining web. (p. 16.)

Care takes place everywhere, in households, schools, agencies, institutions, and government. We tend to think of caring as "women's work" or something menial that women do in the privacy of their homes. This is why workers in occupations associated with caring are financially and socially undervalued. If people interested in care can change the public values and priorities of care, the world will be organized quite differently (Tronto, 1998).

There are four phases of caring and its ethical dimensions. They are a way to think about care and how to live a good life. These phases can take place between individuals, groups, and the self. They are also a framework for political change.

1. *Caring about* (attentiveness) is becoming aware of and paying attention to the need for caring. It is done by listening to voiced needs and by recognizing unspoken needs of another and then distinguishing among them to decide which needs to care about. Morally, caring about requires thoughtful attention to the needs of self and others with as little bias or judgment as possible.

2. *Caring for* (responsibility) occurs when someone recognizes a need for care and takes responsibility to meet it. Seeing that caring is needed is not enough. The moral response is to make caring happen by organizing personnel, finances, such as pay, or other resources needed for the work.
3. *Caregiving* (competence) is meeting the need for caring by an individual or organization. Caregiving includes knowledge about how to care for and how to perform the necessary caring tasks. Morally, this requires competence.
4. *Care receiving* (responsiveness) is assessing the response of the thing, person, or group that received the caregiving. There is always a response, whether the caring needs have been met or not. Responsiveness is shared between the thing, person, or group receiving the care; the attention of the ones doing the caring work; and those responsible for the care.

These four phases become a circle of caring. Caregiving may alter the situation even in a small way, thus producing new needs for caring, assessing responsiveness and attentiveness, and so on. Care is an action or practice, not a set of principles or rules. What we think of as good care depends on the way of life, the values, and circumstances of the people involved in the caring practice. The way people care for one another is what makes us human (Tronto, 1998).

Examples of Recent Caring Theories and Models

There are many nurse scholars studying caring. The meaning of nurse caring often depends on the contextual paradigm and personal beliefs of the researcher. That said, “the dynamic essence of nursing is due to caring” (Blasdell, 2017, p. 1). Presented here are a few of the growing number of nurse theories that focus on nurse caring.

Caring Science

In 1985, Jean Watson published her influential text, *Nursing, the Philosophy and Science of Caring* to explain caring science theory. Her theory is a form of humanism with origins in metaphysics; or a philosophy of being and knowing (McCance et al., 1999, p. 1389). She characterized traditional models of health-illness and science as being inadequate for the actual, or lived, experiences of patients. Watson identified and detailed ten features or caritive factors that provide essential aspects of caring in nursing. The first three are mutually dependent and provide a philosophical orientation to the science of caring. The other seven are more scientific and are interrelated for nursing education and practice (Watson, 1985).

Caring science is an evolving discipline. Watson has written many articles and books on nursing and her philosophy of human caring. In 2007, she established the Watson Caring Science Institute, an international, non-profit organization established to advance the philosophies, theories, and practices of human caring. The theory is researched by nurse scholars throughout the world. In 2008, Watson published *Nursing, the Philosophy and Science of Caring, Revised Edition* an entirely new version of her classic text to explain caring science theory. Some sections of the original text are retained with minor updates to "reassert the emerging, evolving wonder at and appreciation for viewing the human-universe as One. The holographic view of caring mirrors the holographic universe: that is, the whole is in each part and each part affects the whole" (Watson, 2008, p. 10). Science alone is unable to provide meaning to complex human experiences, such as joy, love, fear, suffering, and forgiveness. The ten caritive factors became the foundation for ten new caritas processes, a term that evokes love and

caring. Caritive nursing becomes caritas caring science, with the nurse working from a human-to-human connection to merge nursing into an expanded paradigm for the future as both a science and societal mission for humanity (Watson, 2008, pp. 33–34). According to Watson (2008),

> the caring moment-in-the-Now takes place when the nurse connects at a spirit-to spirit level with another, beyond personality, physical appearance, disease, diagnosis, even presenting behavior; the nurse seeks to "see" who this spirit-filled person is as she or he "reads the field" in that instance. (p. 82)

This caritas consciousness/relationship may transcend self, time, and space as the caring moment-in-the-Now connects the consciousness of both the nurse and the other, forever altering their choices for living (Watson, 2008).

The aesthetics, beauty, and spiritual domains of life's journey should be evident to anyone engaged in human caring and healing. Accordingly, it is by studying the various humanities that we can glimpse the human spirit to understand better the beauty of science and of life itself (Watson, 2008, p. 20). The holistic, caring-healing work of nurses is integrated in such diverse areas as "the visual arts, music, sound, aroma, dance, movement, theater, drama, storytelling, design, psycho-architecture/sacred healing architecture, and a variety of tactile-touch and noncontact energetic modalities" (Watson, 2008, p. 21). Thus, nurses are given the language and symbols for a caring perspective that transcends the science of nursing, the arts, the humanities, and the lives of their patients to a caritas consciousness; a system that is wide open for change and surprise.

Theory of Bureaucratic Caring

Marilyn A. Ray researched caring and developed the theory of bureaucratic caring, based on the premise that caring takes place within hospitals and organizations that function on bureaucratic principles. She developed her theory after doing qualitative research using ethnography, phenomenology, and grounded theory approaches. Her analyses also included data related to complex systems (Ray & Turkel, 2015, pp. 461–462). Ray found that caring is transcultural and relational. An organization's cultural and social contexts, including political, legal, and technical factors, greatly influence nurse caring for patients (Baily, 2009; Ray, 2021). The original model of the theory depicted these as co-equal dimensions surrounding and interacting with the central dimension of caring within the complex system of a hospital (Ray, 2021; Ray & Turkel, 2015).

Over the years, through additional research and reflection, the theory of bureaucratic caring evolved from a two-dimensional model to one that is holographic. It incorporates concepts from quantum theory and complexity science, such as change, interconnectedness, wholeness, and emergence (Ray & Turkel, 2015). The central dimension of caring was enhanced to express spiritual-ethical caring. According to the authors, "this holographic model shows overall that spiritual-ethical caring is multidimensional, complex, holistic, and dynamic" (Ray and Turkel, 2015, p. 463). It influences and is influenced by social-cultural, legal, technological, economic, political, educational, and political dimensions (Ray & Turkel, 2015).

As highly complex organizations, hospitals likely will remain bureaucracies to provide structure and predictability for employees and patients. The holographic model demonstrates how nurses and others can remain open to the continuous changes that occur while providing spiritual-ethical care (Ray, 2021; Ray & Turkel, 2015). The

merging of ethics, complexity science, and spirituality reveal "transformation toward relational caring organizations and communities of caring *can* occur in the economic and politically driven atmosphere of today" (Ray & Turkel, 2015, p. 478). Additional research is being done as organizations and the world itself continue to grow in complexity.

Nursing As Caring

Nursing as caring theory was developed by Anne Boykin and Savina Schoenhofer to create a nursing curriculum grounded in nursing theory for Florida Atlantic University. Central to their theory is the idea that all people are caring and are responsible to know both self and other as caring (McCance et al., 1999, p. 1391). "Nursing is expressed in the mutual and simultaneous participation of the nurse and the nursed as caring persons in the moment" (Locsin, 1998, p. 54). The one caring and the one cared for participate by giving and taking and giving again; each living and growing in the nursing situation. "The beauty of nursing is expressed when the nurse, as artist, creates a unique approach to care based on the dreams and goals of the one cared for, the moment comes alive with possibilities" (Boykin & Schoenhofer, 1993, p. 14). Even in highly technical areas, such as critical care units, the nurse that responds to the other with authentic presence and intentionality, lives caring and grows in caring as well (Locsin, 1998, p. 54). By living caring in the moment, "nursing activities are not directed toward healing in the sense of making whole; instead, wholeness is present and unfolding. There is no lack, failure, or inadequacy which is to be corrected through nursing—persons are whole, complete, and caring" (Boykin & Schoenhofer, 1993, p. 12).

The dance of caring persons model was developed to reveal caring by nurse administrators who embrace nursing as caring theory. It represents employees dancing in

a circle to demonstrate connecting with others through personal knowing and caring in various situations. Each person makes unique contributions and is considered equally special and equally caring. Other employees, including those from different professions and departments, are invited to join the circle and dance. Relationships are built as the participants commit to authentically knowing and caring for self and others. An image of the model depicts a circle of people dancing in the moment (Boykin & Schoenhofer, 1993, pp. 36–38).

Summary

These, and other nursing theories and models, emphasize the significance of caring in the nursing profession and professional nursing practice. “Nursing has struggled at length to clarify, accept and articulate the essence of caring in a way that would satisfy all nursing roles and embody all nursing knowledge and practice” (Adams, 2016, p. 1). There is a concern that technological advances, increased workload, higher patient acuity levels, and persistent emphasis on the medical model will diminish the philosophy, ethic, and value of caring by clinical and academic nurses (Adams, 2016). Furthermore, academic nursing programs tend to emphasize different nursing theories depending on the philosophies of their administrators and professors. “Most scholars view [and teach] caring from their own context and therefore, a universal definition is not possible. The complexity of defining caring should be left up to the individual” (Blasdell, p. 5). Nevertheless, caring and nursing remain intertwined for most nurses, scholars, and the lay public. New nursing theories and models, and revisions to existing ones, will continue to emerge reflecting changes in healthcare, technology, organizations, and society.

CHAPTER 3

Nursing Leadership

> Leadership is love. Leadership is the courage to care.
> — Karlene Kerfoot, Leadership–The Courage to Care

A leader is responsible for directing a group of individuals with the common purpose of accomplishing a task, project, or outcome. Leadership is the process that occurs between the leader and the followers. It involves the art of influencing others, or how the leader affects his or her followers to get things done (Knebel et al., 2012; Specchia et al., 2021).

American hospitals were founded and developed in the early twentieth century during the first stages of the industrial revolution. At that time, nurses and physicians were educated in hospital training programs and colleges with separate educational curricula. They were taught to keep their professions distinct with their own lines of authority, practices, and traditions. "The 'nursing leadership' were the educators and supervisors who headed or advised the major professional nursing associations" (Reverby, 1987, p. 5). The first hospital administrators, physicians, and nursing supervisors used an authoritative, paternalistic style of leadership that emphasized following rules and producing outcomes. Hospitals were predominantly staffed by student nurses who were disciplined, self-sacrificing, and obedient. Consequently, models of patient care delivery were rigid and hierarchical (Kalisch & Kalisch, 1978; Reverby, 1987).

Over subsequent decades, and into the twenty-first century, there were extraordinary advances in science, medicine, and technology. Hospital facilities and reimbursement structures were revised many times. These rapid developments required

major adjustments to the composition and conduct of hospital administration. Nursing leadership styles also changed throughout the years to meet existing healthcare priorities and beliefs (Specchia et al., 2021). Today, the authoritarian, paternalistic, leadership style remains relevant in predictable situations that require oversight, but it is no longer deemed the best way to manage departments, professionals, and other healthcare workers (Curtain, 2011).

Styles of Nursing Leadership

Leadership styles develop according to existing social norms and business practices. In 2020, nurses in the United States were more racially diverse, better educated, and older than at any other time (Smiley et al., 2021). Many NLs develop their preferred leadership styles from educational programs, by observation, coaching from mentors, or because they suit their personalities. Some nurse leaders become comfortable with a leadership style and never change it. Others change their leadership approach according to current trends or to one that meets the needs of their organizations, employees, and other followers. There is no "correct" leadership style, but some are preferred more than others. Some leaders vary their leadership approach in different circumstances. The following examples are condensed definitions of leadership styles that NLs and other nurses may have used during the early COVID-19 pandemic. They are arranged alphabetically to simplify locating them but not to imply order of importance or preference.

Authentic style: This leader promotes the open sharing of information and consideration of employees' opinions. The leader's ethical, honest, non-authoritarian approach builds trust and close leader-follower relationships (Specchia et al., 2021).

The *Autocratic style* leader makes decisions efficiently and independently with little input from employees. Excellent at delegation, this leader may be very effective in an emergency (ANA, 2023).

Crisis leadership style: This leader prioritizes communication, caring relationships, and clarity of vision and values throughout all phases of the crisis. The leader makes quick decisions and reassures followers despite their own fear and anxiety. "Effective crisis leadership boils down to responding to the human needs, emotions, and behaviors caused by the crisis" (Knebel et al., 2012, p. 26). Integrative leadership is best in a crisis, but the leader must be flexible enough to revise the leadership style according to the situation (Knebel et al., 2012).

The *great man theory* suggests that some people are born with the essential characteristics that make them effective leaders in any situation (Knebel et al., 2012, p. 23).

Integrative leadership theory is a wholistic approach. Leadership effectiveness is influenced by the leader, follower, and the situation. The leader needs to be aware of how his or her own behavior influences followers. To be effective, the leader must recognize the characteristics, motivations, and individual differences of the followers. The leader considers the impact of specific circumstances or other variables on their ability to perform and complete specific tasks. The leader then integrates these to adapt his or her leadership style, as needed (Knebel et al., 2012).

Laissez-faire style: This leader avoids responsibility and involvement unless problems become serious. When the leader is absent, the followers feel free to make their own decisions. This passive "absence of leadership" style reduces trust and is ineffective

unless the followers are experienced teams or self-directed nurses (ANA, 2023; Merrill, 2015; Specchia et al., 2021).

Passive-avoidant style: This leader avoids confrontation and personal responsibility. Even when serious problems occur, this leader may be slow to react or avoid making any decisions. Without clear directives, employees feel they lack control over their environment. This style of leadership leads to low employee retention and high staff turnover (Specchia et al., 2021).

Quantum style: This leader focuses on innovation, promotes interaction, and facilitates followers' self-direction, rather than giving direction. The leader utilizes data from technology, information systems, and elsewhere to bring employees and departments together. The leader also strives to build honest, ethical, and transparent relationships. This leader articulates visions, models values, and is willing to work with the uncertainty of complex environments (Curtain, 2011; Porter-O'Grady, 1999; Stanton, 2011).

Resonant style: This leader uses emotional intelligence to coach, develop, inspire, and include others. The leader builds trust and creates optimism by managing their own emotions and empathizing with others. They create an environment where others are engaged and eager to fully participate (Specchia et al., 2021).

Servant leadership. This people-centered approach focuses on employee development and individual needs. The servant leader (SL) strives for humility and tries to help employees achieve goals and overcome challenges through effective communication, commitment, and building a community. The SL puts personal advancement and rewards aside and is willing to learn from others. This method works

well in performance planning, day-to-day coaching, and goal-driven environments (ANA, 2023; Specchia et al., 2021).

Situational leadership expanded on trait theory. This style was developed in the 1950s. The situational leader varies the style of leadership as circumstances change. The leader evaluates the follower's motivation and competence to perform an assigned task. Based on the follower's ability to complete the assignment and the organization's needs, the leader determines the best style to help the follower accomplish the goal (ANA, 2023; Knebel et al., 2012, p. 24).

The *trait theory* is like the great man theory but differs by taking the position that leadership qualities are not innate. They can be identified and taught. This theory was popular in the 1940s (Knebel et al., 2012, p. 23).

Transactional style: This is a task-oriented style that focuses on short term goals with tight deadlines. Employees work independently; there is no teamwork or cooperation. The leader is not concerned with building trust or taking an ethical or moral stance, but instead, depends on employees being motivated by personal or other outside interests. The leader provides rewards or punishes and takes corrective actions based on how the employees perform the tasks assigned to them. The transactional leader's goals are efficiency and performance to reduce errors. This style does not inspire followers' long-term commitment (ANA, 2023; Merrill, 2015; Specchia et al., 2021).

Transformational leadership style is popular in today's changing healthcare environment. Establishing and maintaining personal and organizational trust through open communication, valued relationships, and individualized consideration are the fundamental strategies. The leader and the follower motivate one another to higher levels

of performance to promote and achieve team and organizational goals. As employee morale increases, productivity is enhanced, and job satisfaction improves (Knebel et al., 2012; Specchia et al., 2021; Stanton, 2011). Similarly, Turkel (2014) stated "contemporary transformational leadership focuses on authentic leadership styles, relational caring, meaningful recognition, creativity, building trust, relationships, participative decision- making [*sic*], dialogue with time for reflection, and innovation" (p. 172). Transformational leaders stimulate creativity in others, instill pride in performance, and are future oriented (Merrill, 2015).

These styles of leadership may have been used by NLs and others in leadership roles during the early COVID-19 pandemic. Leaders often change their approach according to the circumstances or needs of the followers. For example, a newly licensed nurse may need a more direct approach than a nurse with years of experience. And a proficient nurse that transfers to a new specialty may need more direction and validation than nurses who are veterans in the field. The NLs in the early pandemic needed to adopt a crisis leadership style and they also had the challenge of meeting the leadership needs of each of their employees.

Today's Nurse Manager/Leader

The National Nursing Workforce Survey is conducted every two years by the National Council of State Boards of Nursing and the National Forum of State Nursing Workforce Centers. The purpose is "to provide data critical to planning for enough adequately prepared nurses and ensuring a safe, diverse, and effective healthcare system" (Smiley et al., 2021, p. S4). In 2020, the survey was sent to a randomized sample of RNs and LPNs with active licenses to practice in the United States. The data were collected

during the first six months of the COVID-19 pandemic. Analysis of registered NL (nurse manager) data identified an estimated population value of 267,067 actively employed RNs that gave the title of nurse manager as their primary position in nursing. The majority of these NLs reported nearly thirty or more years of nursing experience. The survey did not indicate their specialties or areas of practice, but the greatest number of total RNs surveyed were employed in hospital settings (Smiley et al., 2021).

NLs (nurse managers) are registered nurses with clinical and administrative responsibility for an inpatient or ambulatory patient care unit, or units, during all hours of operation. They manage interdisciplinary teams of registered nurses, healthcare providers, and employees, assuring safe, evidence-based, collaborative care for a wide variety of patients. NLs typically report to senior level nursing leadership, making them an essential link between the administration, the healthcare team, and patients (AONE/AONL, 2015; AONL, 2023; Deyo et al., 2016).

Many NLs are appointed because of their clinical expertise, charisma, or other subjective data (Deyo et al., 2016; Fennimore & Wolf, 2011). Yet, the current role of NL requires much more than clinical competence. The apprenticeship and on the job training models are insufficient to adequately prepare nurses for management positions today. Leadership experience, formal education, and continuing education programs are needed to achieve the competencies required for NLs to address the rapid changes that occur in complex healthcare systems (Begley et al., 2020; Deyo et al., 2016; Fennimore & Wolf, 2011).

Some organizations require NLs to maintain enough clinical knowledge to discuss patients' clinical conditions during daily rounds with physicians and other healthcare

professionals. NLs in other organizations use clinical knowledge to safely delegate daily rounding to the RN(s) providing clinical patient care (Begley et al., 2020).

NLs require sufficient ability to identify, understand, discuss, and contribute to the business, financial, human resources, and technological requirements of their areas of responsibility. Some must prepare and defend budgetary requests; interview, hire, develop, evaluate, and retain various levels of personnel; comply with regulatory and accreditation requirements; and support their organization's strategic plan and other initiatives (ANA, 2023; AONE/AONL, 2015; Fennimore & Wolf, 2011).

The successful NL cultivates a positive, professional work environment as a role model while leading and mentoring the staff. Strong communication and leadership skills are needed to build a culture of interprofessional teamwork, accountability, and trust. The NL embraces change, manages priorities, and advocates for patients, families, and employees. And in some cases, the nursing staff depend on their NL to help them with patient care duties, when needed (ANA, 2023; AONE/AONL, 2015; Deyo et al., 2016).

Nurse Managers/Leaders and Caring

Studies have been done to identify the influence of caring by NLs on specific outcomes, such as patient safety, staff engagement, staff wellbeing, and staff intent to leave the organization. These studies investigated the meaning of NL caring from the perspectives of patients, nurses, and other staff. Yet, few studies have been done in the United States to explore the meaning or essence of caring *by* NLs themselves.

One qualitative study by Turkel (2003) explored the meaning of caring as experienced by NLs during interactions with staff nurses. Six NLs from two different not-for-profit hospitals were interviewed. Each NL was responsible for a medical, surgical,

or telemetry unit of 30–50 beds. Ray's phenomenological methodology was utilized to analyze the interview transcripts. Essential (descriptive) themes, variant themes, and interpretive themes were revealed.

The researcher identified essential themes by deeply reflecting on the NLs' own words about caring with nursing staff. The themes were growth, listening, support, intuition, receiving gifts, and frustration. The essential themes were universally expressed by all participants. Variant themes were not unanimous but were expressed by one or more NLs. They contributed meaning to the phenomena of NLs' experiences with caring. The variant themes were touch, humor, flexibility, counseling, limitations, and competency. "Interpretive themes are the result of how the researcher interprets the data and are stated in the researcher's own words" (Turkel, 2003, p. 22). The interpretive themes that emerged were nurses' way of being, reciprocal caring, and caring moment as transcendence. Nurses' way of being was supported by three attributes, or subthemes: authentic presence. instillation of values, and spirituality. Reciprocal caring attributes were mutuality, oneness and connectedness, increased self-worth, and the feeling of being cared for. Caring moment as transcendence was supported by the subthemes of change and energy exchange. Through continued deep reflection, and analysis of the data, the researcher created a poetic expression using the NLs' own words to reflect the unity of meaning of caring by NLs.

The author called the results of this study an invitation to reexamine nursing administrative practices. "The concept of caring needs to be enhanced in all relationships within the organization" (Turkel, 2003, p. 26). The caring NL is a role model who creates a culture of caring within the unit and supports staff nurses to integrate caring into their

own practices. If NLs become more caring and humanistic in their practice, then staff nurses will do the same. The researcher suggested additional caring research is needed to create a unified caring model for nursing administrative practices (Turkel, 2003).

The Magnet Recognition Program

In 2020, the nurses and other employees at HTMC were preparing for a site visit by appraisers from Magnet for the fourth time. NLs throughout the organization were excited, and a little nervous, to demonstrate enculturation of the program and its values. The Magnet application and corresponding documentation had been submitted and deemed satisfactory to warrant a site visit. Expert Magnet appraisers would visit to verify, clarify, and amplify information offered in the Magnet application documents. The value to a healthcare organization of pursuing Magnet designation cannot be underestimated. "The objective is not only merely attaining Magnet recognition but also, and more importantly, creating and sustaining a culture that drives nursing excellence in all care settings" (Lal, 2017, p. 588).

In the early 1980s, there was a serious nursing shortage throughout the United States. Most hospitals were able to hire nurses, but few stayed for any length of time. Concerned nurse researchers studied 163 hospitals to learn what was different about the work environment where nurses stayed and were satisfied. The researchers identified 41 "magnet hospitals" that attracted and retained competent, satisfied nurses who provided quality patient care. The study also revealed 14 characteristics called "Forces of Magnetism (FOM)," that distinguished these hospitals from others. While defining the FOM is outside the purposes of this study, they are named here: (a) quality of nursing leadership, (b) organizational structure, (c) management style, (d) personnel policies and

programs, (e) professional models of care, (f) quality of care, (g) quality improvement, (h) consultation and resources, (i) autonomy, (j) community and the hospital, (k) nurses as teacher, (l) image of nursing, (m) interdisciplinary relationships, and (n) professional development (ANCC, 2017; Graystone, 2018; Kramer & Schmalenberg, 2005).

Within a few years, the American Nurses Credentialing Center (ANCC) was incorporated as the credentialing body of the ANA. The ANCC used the FOM and findings from multiple studies of magnet hospitals by Kramer & Schmalenberg and other researchers as the foundation for the new magnet hospital recognition program. The program was revised and strengthened to require participating hospitals to demonstrate adherence to the ANA scope and standards for nurse administrators. As the program grew, it expanded to include long term care facilities and organizations outside the United States (ANCC, 2017; Kramer & Schmalenberg, 2005).

During the next decade, the program name was officially changed to the Magnet recognition program. To participate, hospitals (now called organizations) had to apply or reapply by demonstrating adherence to the FOM. According to Kramer & Schmalenberg (2005), a statistical analysis of site visit scores associated with the *2005 Magnet Application Manual* identified the need to clarify some key concepts used in the application. Some FOMs regarding organizational and professional practices were outdated and others needed to be expanded. Although the earlier Magnet requirements focused on structures and processes, it is the related outcomes that are essential for a culture of excellence and innovation. They aimed for organizations to demonstrate a total Magnet environment with nurses taking the lead in a collaboration between hospital administration, professionals, and communities for the benefit of patients.

In 2008, ANCC introduced the model for magnet to eliminate redundancy, update documentation, and have a greater focus on outcomes. The 14 FOM were still essential but were embedded within five key model components: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovations, & improvements; and empirical outcomes (Lal, 2017).

For the next 15 years, Magnet continued revisions to reflect clinical, professional, and healthcare advances. “In 2014, standards again were revised to reflect 50% outcomes and 50% structure and process” (Graystone, 2018, p. 415). An organization’s Magnet documents had to include graphic displays of outcomes over time, while structures and processes would mostly be presented as narratives. By 2019, requirements expanded again to require additional outcomes graphs, nursing and patient satisfaction survey results, and a greater emphasis on ambulatory/outpatient care. (ANCC, 2017; Graystone, 2018; Lal, 2017). “Nurses in ambulatory care settings are vital to patients through the continuum of care and need equal access to leaders, resources, innovative practices, peer feedback, and shared decision-making” (Lal, 2017, p. 588). As healthcare moves increasingly to outpatient settings for primary and specialty care and procedures, it is important that ambulatory care nurses are held to the same standards as inpatient nurses.

Components of the ANCC Model for Magnet

Transformational Leadership. In Magnet organizations, the CNO is joined by the nursing leadership team to develop and communicate the nursing vision, philosophy, strategic, and quality plans. The organization’s executive leadership team creates and revises their vision for future success in a competitive and turbulent healthcare environment. This may require significant changes to structures, systems, and personnel.

It is often said that the transformational CNO is challenged to lead nurses to where they need to go and not necessarily where they want to be. This requires open, honest, transparent communication, respectfully asking for feedback, and responding to concerns. The Magnet transformational CNO uses influence, clinical knowledge, and expertise in professional nursing practice and leadership to develop new nurse leaders and advocate for all nurses, staff, and patients. In Magnet organizations, a BSN or graduate degree in nursing is required for all nurse administrators and NLs of departments where clinical nurses practice (ANCC, 2017).

Structural Empowerment. In Magnet organizations, the CNO serves on organizational councils and committees to promote nursing in safe, efficient, and effective inpatient and ambulatory hospital operations. Nursing leadership develops structures and processes to create an environment where strong professional nursing practice thrives. Shared governance is a structure that leads to professional accountability and shared decision-making. Shared governance participants are empowered to establish evidence-based standards of practice, address areas of clinical concern, and seek innovative solutions to issues. Nurses at all levels serve on nursing and interprofessional committees, councils, and task forces at unit-based and organizational levels. They are encouraged to participate in local, state, national, and international professional organizations. Nursing professional development is promoted with funding for tuition reimbursement, continuing education programs, and nursing specialty certification. Nurses have opportunities for advancement beyond their immediate job description. A transition to practice program is in place to orient newly graduated nurses, experienced nurses who are just hired by the organization, and nurses already employed by the

organization who transfer to new specialties. Nurses are recognized for community involvement. They are also internally and externally recognized for professional nursing accomplishments (ANCC, 2017; Kramer et al., 2010; Lal, 2017).

Exemplary Professional Practice. At Magnet organizations, a culture of exemplary professional practice means seeking and demonstrating excellence in many professional and clinical categories. Inpatient and ambulatory care nurses review nursing theories and select one that best represents their department of nursing practice. Selection is often done at department-wide or unit-specific practice councils. The nurses then create a nursing professional practice model that represents how the theory is incorporated in all areas of their practice. The model signifies how nurses practice, collaborate, communicate, and develop professionally at the organization. It communicates the way nurses provide quality patient-focused care to patients, families, and communities (ANCC, 2017).

Each nursing unit and patient care area has a scope of care that describes the specialty, how care is provided, the number and levels of staff, and competencies needed for effective care. Clinical nurses are involved with staffing and patient care assignments, but final decisions are based on ANA principles of nurse staffing, standards of nursing specialty organizations, and state-mandated requirements. Nurses coordinate and collaborate with other disciplines and support staff to assure that patient care is respectfully planned in cooperation with patients and their families. Nurses make autonomous, evidence-based clinical decisions for safe, effective, and ethical outcomes. Nurses use the ANA Code of Ethics for Nurses and collaborate with bioethics committee

members and other resources for satisfactory ethical outcomes. Nurses participate in safety initiatives that incorporate national best practices.

Magnet nurses submit inpatient and ambulatory quarterly data to quality databases to benchmark their performance in nurse-sensitive quality indicators, patient and nurse satisfaction, and unit or department-specific performance improvement indicators. Action plans for improvement are developed by nurses and put in place when needed (ANCC, 2017).

New Knowledge, Innovations, & Improvements. At Magnet organizations, nurses have the professional and ethical responsibility to contribute to improving patient care, the organization, and the nursing profession. “For Magnet purposes, nursing research may encompass studies of work environment, professional development, organizational supports, and other factors that influence nursing outcomes” (ANCC, 2017, p. 197). Published research studies are systematically evaluated and used to improve practice, but it is not the same as the nurses doing the nursing research to generate new knowledge. In contrast, evidence-based practice is the use of critical thinking to combine research-based evidence (science of nursing) with practice-based evidence (art of nursing) while being respectful of patient values and preferences. Both nursing research and evidence-based practice studies are done, and the results are integrated into clinical and operational processes (ANCC, 2017). Nurses are involved in structures and processes to advance nursing research, such as a nursing research committee. At least one nurse is a voting member of the organization’s institutional review board (IRB). There must be evidence that nurses are involved in doing research and distributing information about it to internal and external audiences. Innovations by

nurses are encouraged. Examples are workflow and environmental improvements to streamline practice and the design and application of technology to enhance the patients' experience (ANCC, 2017).

Empirical Outcomes. When the new Magnet model included the empirical outcomes category, not many national benchmarks with data were available to make comparisons with best practices. Since then, the world has become more data driven. National and international vendors collect, analyze, and benchmark huge volumes of data. There are now benchmarked data reports related to clinical, financial, technical, and satisfaction outcomes. They are compared internally and externally for quality improvement and financial reimbursement purposes. Organizations applying for Magnet status are required to submit their data associated with nursing-sensitive patient, nursing, workforce, organizational, and consumer outcomes that have been analyzed by Magnet-approved vendors. Depending on the indicator, outcomes may be reported at a unit, department, organizational, or population level. Magnet organizations must demonstrate that their data outperform the mean for each selected benchmark. And so, Magnet nurses must constantly strive for exceptional empirical outcomes (ANCC, 2017). As the saying goes, Magnet organizations lead the way in terms of outcomes!

The Magnet recognition program first began in 1990. Research has been done to compare various aspects of Magnet organizations with non-Magnet organizations. But it is impossible to compare what a current Magnet organization would be like if it had never applied for Magnet designation. By 2020, HTMC had been a Magnet organization for nearly 15 years. At first, the NLs worked to acculturate the 14 FOM throughout the nursing departments. Then the five components of the Magnet model were enculturated

throughout inpatient and ambulatory nursing and other departments of the organization. The NLs aspire to be transformational leaders. The HTMC nurses selected Jean Watson's philosophy and science of caring to highlight the importance of caring in their practice. Their clinical practice was represented by the nursing practice model that they created. While they focused on preparing for their redesignation site visit, COVID-19 began to spread throughout New Jersey.

CHAPTER 4

A New Disease Emerges

COVID-19: A Global Pandemic

In January 2020, the world learned of a new disease in humans that was first identified in Wuhan City, China in early December 2019. It was initially called Wuhan pneumonia because of the city where it was discovered and the symptoms of fever, malaise, dry cough, and dyspnea. Once genome sequencing was done, the causative agent was identified as a novel, or new, coronavirus (Liu et al., 2020, p. 328). Although the symptoms were thought to be relatively mild at first, the rapid spread of a disease with no known means of prevention or cure led international leaders, public health organizations, and scientists to pay close attention.

Within weeks, the virus spread rapidly, first to Thailand, and then throughout Germany, Italy, France, and other European countries. By the end of January, there were thousands of cases in China and a global health emergency was officially declared by (WHO). (WHO, 2020, February 11). In the United States, the Trump administration suspended entry of all foreign nationals who had traveled to China within the previous 14 days except for family members of American citizens or permanent residents (Taylor, 2020, Jan. 31). On February 5th, a cruise ship with 3,600 passengers was quarantined in Japan after many travelers reported symptoms of the coronavirus. The number of shipboard infections increased from 218 to more than 600 between February 13 and February 19 when passengers were finally permitted to leave the ship (Taylor, 2020, Feb. 5). In the US, the novel coronavirus was first identified in Washington State in February (CDC, 2020, February; Taylor, 2020, Feb. 29).

The Centers for Disease Control and Prevention (CDC) monitored reports from around the world about the rapidly changing situation. It began publishing online updated summaries, guidance for public health officials and the general population, and details to dispel some of the myths and rumors that were circulating (CDC, 2020, March).

The WHO began holding daily coronavirus press briefings. February 11 was the first day of the 2019 novel coronavirus global research and innovation forum. At the daily briefing, the WHO director-general, announced the official name of the new coronavirus disease is COVID-19. “CO” stands for corona; “VI” stands for virus; “D” for disease. The number 19 is the year that the disease was first identified. The year was included as part of the authorized name because it would be helpful if another coronavirus were identified in the future. In addition, some scientists were calling the virus SARS-CoV-2, so a standardized name would provide common terminology that everyone would recognize when holding discussions, searching literature, or comparing data. It would also avoid confusion and prevent calling the disease by an improper or stigmatizing name. Audio and written transcripts of the conference would be made available (CDC, 2020, March; WHO, 2020, February 11).

Although the President of the United States continued to call it the Wuhan virus, most health professionals appreciated that the name COVID-19 was more culturally appropriate. “The name makes no reference to any of the people, places, or animals associated with the coronavirus, given the goal to avoid stigma” (Taylor, 2020, Feb. 11).

As the nation watched news accounts of COVID-19 on the west coast, groups of cases began cropping up in northern Italy and other European countries. The Italian government “locked down” the northern provinces to prevent spread throughout the

country. The restrictions seemed extreme, but were insufficient, and clusters of COVID-19 were identified in communities throughout Europe (Taylor, 2020, Feb 23).

COVID-19 Arrives on the U.S. West Coast

Holshue et al. (2020) described the first confirmed case of novel coronavirus disease in the United States. On January 19, 2020, a 35-year-old man went to an urgent care clinic with a history of cough and unconfirmed fever. Symptoms began around the time he returned to Washington State after a four-day visit to Wuhan, China. He sought medical attention after seeing a health alert from the CDC that described symptoms and risk factors for the emerging coronavirus. At the clinic, the man was tested for influenza and other known respiratory pathogens. Serum, nasopharyngeal, and oropharyngeal samples were collected for analysis. The clinic staff notified and consulted local, state, and CDC health authorities. At their advice, the patient was also tested for the novel coronavirus. Because his symptoms were not severe, the patient was discharged to isolate at home with monitoring by the local health department. The next day, the CDC confirmed that the patient's swabs were positive for the new coronavirus. He was then admitted to Providence Regional Medical Center for observation and placed on contact, droplet, and airborne precautions with eye protection (Holshue, 2020, pp. 929–930). During hospitalization, the patient's respiratory status deteriorated to pneumonia. He also experienced periods of nausea, vomiting, and diarrhea. Because the disease was so new, his daily clinical progress was detailed along with related diagnostic tests and treatments. By January 30, the patient remained hospitalized, but his condition was greatly improved. No additional information was provided about this patient.

On February 29, there were more than 87,000 COVID-19 cases world-wide, and the Trump administration issued a warning for U.S. citizens not to travel to Italy or South Korea because of the high number of cases there (Taylor, 2020, Feb. 29). The CDC and Washington State announced that three patients were hospitalized with presumptive cases of COVID-19. Two were from a long-term care (LTC) facility; one was a health care employee, and the other was a resident. The third person, a man in his 50s, did not reside in a LTC facility. He was the first known COVID-19 related death in the United States. Twenty-two other people, in Oregon and California, were diagnosed with COVID-19. At that point, it was believed that most people were not at risk of exposure, but of course, that would depend on their contact with people infected with the disease (CDC, 2020, February).

On March 11, the WHO director-general declared that "COVID-19 could be characterized as a pandemic due to the rapid increase in the number of cases outside China over the past two weeks that affected a growing number of countries" (CDC, 2020, March 17 update). On the following day, the WHO Regional Office for Europe announced more than 20,000 confirmed COVID-19 cases and nearly 1,000 deaths had occurred in the European Region (WHO, 2020, March 12, para 2).

Despite the change to pandemic status, European countries were advised that there was no "one-size-fits-all" prevention strategy. Each country should do daily assessments, remain flexible, and continue prevention behaviors like closing schools, and urging businesses to have employees work at home when possible. Individuals were advised to protect themselves with good hand washing, social distancing, and contacting health providers when not feeling well. "For all countries, the final aim is the same: stop

transmission and prevent the spread of the virus in order to save lives" (WHO, 2020, March 12, para 19). Interestingly, there was no mention of wearing a mask.

COVID-19 Arrives on the U.S. East Coast

Although preparations were made on the west coast to prevent transmission of COVID-19 from China, few public health officials predicted that the virus would arrive quickly and lethally to New York, New Jersey, and other east coast states. The federal government began restricting travel from the coronavirus hotspot countries of China, Iran, Europe, the United Kingdom, and Ireland. Despite the constraints, the first case of COVID-19 was identified in New York City on February 29. The genetic diversity of the virus made it possible to identify where the various strains originated. Genome sequencing on biologic samples that were collected from current and retroactive COVID-19 patients made it possible to identify modes of viral transmission in the NY metropolitan areas. Analyses demonstrated that most cases were introduced by travelers from Europe or within the US. Two clusters that totaled 21 cases suggested community spread from person-to-person. There was little value to restricting travel in areas where community spread of COVID-19 was already taking place (Gonzalez-Reiche et al., 2020).

Governor Andrew Cuomo, New York, monitored and reported on cases of COVID-19 during his daily media briefings. On March 7, the governor declared a state of emergency for New York to more quickly and effectively contain the spread of the virus. The emergency will also allow for:

> expedited procurement of cleaning supplies, hand sanitizer and other essential resources; allowing qualified professionals other than doctors and

> nurses to conduct testing; expedited procurement of testing supplies and equipment; expedited personnel onboarding; expedited leasing of lab space; allowing EMS personnel to transport patients to quarantine locations other than just hospitals; providing clear basis for price gouging and enforcement investigation. (Official Website, State of New York, 2020, March 7, para 4)

By March 12, Governor Cuomo announced all events attended by 500 or more individuals must be cancelled or postponed. All events, mass gatherings, and businesses with fewer than 500 people were required to reduce the number of people attending by 50 percent. These restrictions did not include schools, hospitals, public buildings, mass transit, grocery stores, and retail stores where people did not come into close contact with one another. All theaters had to close by 5 p.m. the following evening. Daily health screenings and wearing surgical masks would be required for all nursing home personnel. Nonessential personnel and visitors would be restricted from entering nursing homes (Official Website, NY, 2020, March 12, paras 1–2). Governor Cuomo continued issuing executive orders and making daily public health announcements throughout the first months of the virus.

COVID-19 Arrives in New Jersey

New Jersey is the most densely populated state per square mile in the United States (NJHA, 2021). The proximity to New York City makes it convenient for NJ residents to commute daily by car, bus, or train to work in “the city.” Others travel there to enjoy the diverse entertainment opportunities. Between January 30 and February 2, 2020, WHO, CDC, and the U.S. Department of Homeland Security made announcements

about the severity of the spread of the novel coronavirus through human-to-human contact. Extreme measures were required, such as quarantining, medical monitoring, decreasing community engagement, and curtailing travel from China via U.S. airports, including Newark Liberty International in NJ and John F. Kennedy International in NY (Governor of New Jersey, 2020, Exec. Order No. 102).

On February 3, Governor Phil Murphy signed Executive Order (EO) No. 102 to establish a coronavirus task force headed by Judith Persichilli, RN, Commissioner of the New Jersey Department of Health (NJDH). Members of the coronavirus task force would include heads of other executive branches. The focus would be to interact and coordinate public health activities with state, regional, and local governments in matters related to the coronavirus (Governor of New Jersey, 2020, Exec. Order No. 102, p. 5). To do so, and to inform the public, the governor and Commissioner Persichilli aired daily coronavirus updates through NJ news media.

On February 10, the CDC reported 12 people in the United States were confirmed to have the new coronavirus, but there were no fatalities; and none of the sick people were in New Jersey. Commissioner Persichilli, Federal Senator Robert Menendez, Federal Representative Albio Sires, and other officials held a news conference to reassure residents and dispel fears about contracting the novel coronavirus. They mainly focused on concerns related to the safety of international travel by airline and cruise ships. They explained new safety measures being implemented, including quarantine and travel restrictions. To help allay fears, a coronavirus hotline was set up and staffed by the state poison control center at Rutgers New Jersey Medical School. The center had already received over 400 calls about the safety of traveling on cruise ships, how people could

protect themselves on airplanes, and whether wearing a mask was necessary. Commissioner Persichilli explained that travel to and from China was being restricted. Because so many NJ residents had loved ones living in China, she cautioned everyone to help prevent stigma by calling the disease a virus without naming a segment of the population (Flanagan, 2020, February 10).

By March, it was clear that the virus was spreading throughout the United States and people were dying. During the next few weeks, Governor Murphy issued more EOs to contain and mitigate the effects of COVID-19. On March 9, EO No. 103 declared a Public Health Emergency and State of Emergency and gave the governor the right to utilize and employ government resources for the protection of NJ residents (Governor of New Jersey, 2020, Exec. Order No. 103).

Executive Order No. 104 was issued on March 16 to establish state-wide mitigation strategies to combat COVID-19. To reduce person-to-person contact, the order limited the scope, services, and hours of operation of certain retail establishments and restaurants. It also deemed "a subset of businesses as 'essential,' including grocery/food stores, pharmacies, medical supply stores, gas stations, healthcare facilities, and ancillary stores within healthcare facilities" (Governor of New Jersey, 2020, Exec. Order No. 104, p. 7). The order stated that the best way for NJ residents to stay safe from the COVID-19 outbreak would be to remain at home as much as possible. On the previous day, the CDC recommended postponing or canceling gatherings of more than 50 people for the next eight weeks.

On March 19, Governor Murphy suspended all directives from EO No. 104 and issued EO No. 107 to expand some of the previous restrictions. The virus was spreading!

At that time, there were "… at least 890 positive cases of COVID-19 in New Jersey, with at least 11 of those cases having resulted in death…" (Governor of New Jersey, 2020, Exec. Order No. 107, p. 2). The governor mandated all NJ residents to stay at home to limit person-to-person contact. They should work from home, if possible. The order provided specific details about who could leave their residences, where they were permitted to go, for what purpose, and how they should move about. It required businesses, such as personal care services and places of public amusement and entertainment, to partially or completely close. Restaurants and other retail businesses could remain open only for takeout or delivery. Theaters, casinos, racetracks, amusement parks, bowling alleys, and other recreational establishments had to close. The order listed businesses that were considered essential and could remain open. It gave examples of essential employees that had to be physically present at their worksites. Public, parochial, and private schools, as well as institutions of higher education, were to remain closed while the order was in effect. Distance learning should be considered and used, if feasible. Other orders were included in this detailed EO that drastically altered how NJ residents would live for the following months (Governor of New Jersey, 2020, Exec. Order No. 107).

The number of COVID-19 cases and related deaths accelerated. Governor Murphy issued EO No. 109 (Governor of New Jersey, 2020, Exec. Order No. 109) to require suspension of all medical and dental elective surgeries and invasive procedures that were scheduled at inpatient and ambulatory facilities by Friday, March 27. These restrictions were based on guidelines issued by the CDC and a statement by the U.S. Surgeon General. All health businesses and non-hospital facilities were required to

submit inventories of their ventilators, anesthesia equipment, and PPE to enhance the state's ability to allocate resources to fight the pandemic. This EO also expanded professional licensure and scope of practice during the state of emergency, authorizing the director of the NJ licensing body, the Division of Consumer Affairs,

> to waive any restriction on the entry or reentry into practice (or any restriction on the prescription of controlled dangerous substances or on access to the prescription monitoring program) of any person who has received training for employment in a healthcare profession or who has retired from practice. (Governor of New Jersey, 2020, Exec. Order No. 109, p. 6)

Executive Order 111 reported 8,825 COVID-19 cases that resulted in 108 deaths in NJ by March 27. This was a tenfold increase in identified cases in less than two weeks. (Governor of New Jersey, 2020, Exec. Order No. 111, p. 1). The governor assured the public that four modular field treatment facilities were already being constructed with the Army Corps of Engineers to provide 1,000 new hospital beds. Because the actual number of available beds remained unknown, EO 111 required all acute-care hospitals, long term care facilities, hospital systems (including specialty hospitals), and emergency field units or similar treatment sites to report their bed capacity and supplies, including ventilators and PPE, by 10 a.m. daily (Governor of New Jersey, 2020, Exec. Order No. 111, p. 3). This order would help the state identify organizations that were in dire need, as well as those that were available to take patients or deliver vital supplies to others.

CHAPTER 5

Literature Review

Overview

Most NLs, like other nurses, are compassionate and will ensure nurse caring even when their own safety and well-being are at risk. In qualitative research, the literature review is often done after the results of the study are analyzed (de Chesnay, 2015, p. 184). The literature review for this research was done after the data analysis.

My phenomenological study explored the lived experience of caring by nurse leaders during the early COVID-19 pandemic. The concepts of nurse caring, nursing leadership, and the early COVID-19 pandemic have been discussed in previous chapters. For the literature review I searched for research about the experiences of caring by nurse leaders during the early months of the pandemic. I searched for investigations that took place from January 2020 through July 2024. Initially, I read reports of studies concerning hospital nurse managers and COVID-19 in China, Turkey, Sweden, Poland, Egypt, and Finland. I found the societal, cultural, health care, nursing, medical, and technological differences made it impractical, if not impossible, for me to connect meanings of lived experiences of the nurse managers in other countries with those of nurse leaders from the United States. Therefore, I did not include them in this review.

I narrowed my search to investigations of the experiences of nurse leaders in U.S. hospitals during the early COVID-19 pandemic. Most of the literature consisted of editorials and articles by nurse executives or administrators that were published in the form of advice and guidelines to support nurse managers and other nurse leaders during the chaos of the early pandemic. Some nurse executives described their personal COVID

leadership experiences. Some reported their observations of managers and staff at work during the pandemic. Others shared crisis leadership recommendations from professional organizations. Only a few articles were written by nurse managers.

I also found a limited number of research reports about NLs in the early COVID-19 period. After reviewing them I realized that some were not actually research, but instead were anecdotal telephone surveys or trials of specific research tools. In the end, I reviewed seven research studies. Some were solely about NLs, some about nurse administrators, and others included both NLs and administrators as participants.

Infectious Disease Outbreaks

In 2018, nurses marked the 100th anniversary of the Spanish Flu pandemic and celebrated the tireless work and sacrifices of nurses who cared for desperate patients, families, and communities at that time. A century later, the COVID-19 outbreak spread rapidly throughout the world and was declared a pandemic (Robinson, 1990; Cipriano, 2018). Today's nursing leadership immediately researched, shared opinions, and gave advice about their administrative and managerial experiences in the early COVID-19 pandemic.

Middaugh (2020) reported that disasters are customarily classified as natural, such as floods, and earthquakes or man-made, like explosions, chemical spills, and mass casualty events. Infectious diseases that spread quickly and last for days or weeks are also classified as disasters. Recently, cyberattacks were named a new disaster category (p. 211).

Infectious disease outbreaks and epidemics such as HIV/AIDS in the 1980s, SARS in 2003, Ebola in 2015, and Zika virus in 2016 overwhelmed hospitals due to their

unpredictability, the collapse of supply chains, and the impact on human resources. But the COVID-19 pandemic was the worst infectious disease to affect NLs in the United States since the Spanish Flu. Instead of dying out, it continued to spread and is still infecting people around the world (Cipriano, 2018; Middaugh, 2020; Prestia, 2020).

COVID-19 in United States Hospitals

In 2020, most hospitals in the United States were underprepared for the rapid emergence of the COVID-19 pandemic. There were unprecedented institutional, professional, and ethical challenges as hundreds of sick people needed treatment. Hospital and nurse administrators, NLs, and others struggled to maintain control of resources as supply chains were exhausted. Soon, inventories of crucial supplies, medications, equipment, hospital beds, and employees were depleted and could not be immediately replaced (Hand, 2020; Middaugh, 2020; Rosa et al., 2021; Shuman & Costa, 2020). Although hospitals received information and began making physical preparations, the COVID-19 pandemic caused sudden, unpredictable, and disruptive changes that undoubtedly will transform the healthcare system beyond the foreseeable future (Sherman, 2020a; Trepanier, 2020).

Nurse Leaders in the COVID-19 Pandemic

While disasters such as flooding, hurricanes, and terrorist attacks have trajectories that can be predicted, the intensity and length of the COVID-19 pandemic was unknown. Nursing staff were often anxious and overwhelmed (Doucette, 2020). Support and guidance from their NLs and other leaders was desperately needed.

Communication Issues

In the early pandemic, federal, state, and local government and healthcare agencies disseminated COVID-19 mandates and guidelines about quarantine, medications, and treatments that were updated daily, and more often, as needed (Caroselli, 2020; Prestia, 2020). Everyone was confused by misinformation from various media sources. Nurse leaders wanted timely information about the disease and how to protect their staff, their patients, and themselves (Mezzina et al., 2021; Prestia, 2020). Many healthcare organizations designated a centralized incident command center for administrators or selected a COVID-19 team to meet daily to gather and assess the data and decide what to share with leadership, clinicians, and staff (Caroselli, 2020; Mezzina et al., 2021).

Hospital administrators or their designees usually held a brief safety huddle every morning with department heads and other leaders. The daily huddle was a 10–15 min interdisciplinary meeting for participants to identify actual or potential safety concerns that would require follow-up during that day. The purpose was not to solve issues, but to assign them to the appropriate individual or group for resolution (Shaikh, 2020). Many NLs received pertinent information during the daily huddle (Mezzina et al. 2020; Shingler-Nace, 2020). The NLs also held unit-based huddles at the beginning of shifts to update and support their clinical staff and help them to focus on getting their patients and themselves safely through the shift (Cathcart, 2020). Because everyone was confused and frightened, NLs were cautioned to remain calm when sharing information (Prestia, 2020).

Administrators soon realized that in-person meetings put everyone at risk for contracting COVID-19, even when wearing masks. All face-to-face meetings were canceled. They were replaced with large distribution emails, conference calls. written

updates from the command center, and daily leadership rounding (Caroselli, 2020; Mezzina et al., 2021; Shingler-Nace, 2020). For example, photographs of revised PPE requirements were included with email briefings for visual clarification (Caroselli, 2020). Because it is better to share too much information than not enough, NLs were advised to be open, honest, direct, and transparent about COVID cases and other information (Doucette, 2021; Mezzina et al., 2021)

Caroselli (2020) described a computer-based bed management system (BMS) that was essential for communicating and managing bed capacity, patient flow, and staff deployment among multiple campuses of the VA throughout New York. The BMS allowed for rapid assessment and coordination of bed capacity from data entered by clinical and clerical staff. A nurse practitioner "bed czar" was appointed to oversee current and arriving patients throughout the entire system. The BMS was critical for maintaining control over the influx of critically ill and other COVID-19 patients during the early pandemic.

Supply Chain Disruptions

Nurse leaders became concerned when major supply chains disruptions resulted in severe shortages throughout the United States (Shuman & Costa, 2020; Trepanier, 2020). There were not enough supplies, vital equipment (including mechanical ventilators), and PPE (Luis & Vance, 2020). The distribution of limited resources caused ethical dilemmas for NLs (Rosa et al., 2021).

The lack of available PPE was especially alarming. Because nurses spent so much time in face-to-face interaction with infected patients, they were at high risk for contracting COVID-19. Staff needed current information about the location and

availability of PPE. Yet, it immediately became apparent that reserves of PPE were running low (Caroselli, 2020; Rosa et al., 2021; Shuman & Costa, 2020; Trepanier, 2020). Without sufficient PPE, best practices for infection control were reduced to procedures that were barely good enough (Sherman, 2020a).

Trepanier (2020) found it unthinkable, but after everyone started wearing masks many hospitals had to make their own. His healthcare system developed websites with instructions on how to sew masks. He encouraged everyone to organize grassroot movements to make and distribute masks. NLs were cautioned that national manufacturers could not be counted on to donate masks, make hand sanitizers, or manufacture ventilators.

Human Resources and Employment Concerns

Some of the greatest challenges brought about by the COVID-19 pandemic were related to staffing and human resources. Nursing staff were often absent for prolonged periods because they had COVID or were required to quarantine after testing positive for the virus (Cathcart, 2020). Others were needed at home to care for young children or elderly parents. Still others were away to mourn the unexpected death of loved ones and then needed time to grieve and attend to financial matters (Rosa et al., 2021). Senior nurses who feared contracting the deadly disease, were often filled with anxiety, and retired prematurely. The increased staff turnover disrupted cohesive work teams (Sherman, 2022a). Fortunately, many hospitals were able to supplement staffing with agency and travel nurses. Although some retired, other older nurses exceeded expectations by returning to work (Simon, 2021). These nurses all were temporary employees who were never fully committed to the organization, units, and teams

(Caroselli, 2020; Sherman, 2022). In addition, newly licensed nurses that were hired during the pandemic had to work in units with high patient acuity. Some organizations were unable to provide mentors to orient and socialize them into their new professional roles (Sherman, 2022). Yet, other hospitals were able to assign new nurses to experienced unit-based nurses to mentor and support them (Caroselli, 2020). Unfortunately, state-wide lockdowns prevented recently graduated nurses from taking their licensure examinations to practice nursing. In some states, nurse administrators worked with their boards of nursing to temporarily resurrect the old position of "graduate nurse" so that the new grads could be hired to perform many, but not all, of the duties of a registered nurse before passing their licensure exams (Sherman, 2022; Trepanier, 2020).

Quarantine restrictions meant that healthcare systems had to close outpatient departments and cancel all elective surgeries and outpatient procedures. Operating rooms, post-anesthesia care units, and step-down units were often converted to COVID-19 units. The staff and NLs remained there or were deployed to other units with unfamiliar specialties. Everyone had to be oriented and educated to assume their new roles and take on additional responsibilities. Employees who were not assigned to a particular unit were sent to work wherever staff were most needed on a given day. If they did not have a specific patient assignment, they could help by retrieving forgotten supplies and assist in other ways. Some nurses who were not yet assigned would become anxious or feel guilty because they were not providing direct care for COVID patients (Caroselli, 2020; Cathcart, 2020; Rosa et al., 2021; Sherman, 2020b). When nurses deployed outside of their specialty to work in ICUs, some hospitals changed their patient care models to team nursing models so that experienced, competent, ICU nurses were grouped with the less

experienced nurses to form teams that were responsible for ICU patient care (Shuman & Costa, 2020).

Caroselli (2020) explained that nurses from outside her organization required orientation to current policies and practices, essential skills, and clinical computer training. New and returning nurses required frequent and repetitive training on the proper use and disposal of PPE as well as the latest knowledge about the COVID-19 pandemic. Many reassigned nurses needed to acquire critical care competencies and the use of technology for different clinical specialties. A rapid re-education program was developed by nurses in the patient services education department to educate and train clinical nurses as they moved about the system.

Cathcart (2020) informed new NLs, and others about the steps to take when closing a unit and/or opening a COVID-19 unit. Larger organizations often formed special teams to handle these complicated activities. In smaller facilities, the NL usually was the one to contact other departments to request assistance, such as moving beds, ensuring that there were enough computers for communication and documentation, and confirming that medication dispensing equipment was in place. Safety was always paramount! The NL had to verify that the newly formed team was educated to care for COVID-19 patients. It was important for the NL to have an experienced manager to collaborate with and provide support. And finally, when staff became frightened or disruptive, the NL had to stay calm, listen, and acknowledge the person's feelings, so they could continue working with their team (p. 19).

NLs struggled to create and maintain cohesive work teams during the pandemic. Along with frequent staff turnover, and social distancing, everyone had to wear PPE that

made it difficult to read facial expressions. Because staff had trouble recognizing each other, casual conversations were challenging. The restricted use of break rooms and lounges reduced informal team interaction during work hours. Socializing after work, celebrating milestones, and eating together were rituals that typically helped staff get to know one another. Without them, it became more difficult for NLs to build and maintain compatible teams (Sherman, 2022).

Psychosocial Issues

According to Prestia (2020), NLs were responsible to balance the care of their staff with the needs of their patients. It was difficult, but they had to speak up for the frontline staff despite their own fears. Anxiety related to shortages of vital resources caused some staff to experience moral distress, or knowing the right thing to do, but not being able to do it. NLs experienced moral distress too when they could not follow the correct course of action because of an error, lack of judgment, a decision made at a higher level or one that was beyond their control. Leaders had to hold on to their ethical values despite fears of negative consequences. They were morally obliged to be truthful, mindful, and relevant when communicating. Above all, they had to stay strong and do what was right for their patients, their staff, and themselves.

Rosa et al. (2021) discussed the effects of the pandemic on nurses' personal and professional ethical responsibilities. They defined and discussed burnout, moral distress, moral residue, and moral failing, and explained that these could be caused or exacerbated by COVID-19. The pandemic burdened the nursing workforce with sicker patients, missing resources, and absent co-workers. Many were overwhelmed, distressed and suffered from impaired dignity and well-being when they could not do what was needed

because of scarcity or restrictions. They became burned out and tended to have higher rates of job dissatisfaction, depression, and thoughts of suicide. Several recommendations were given to help NLs who become overwhelmed: (a) follow strategies from the National Academy of Medicine to support clinicians' health and well-being, (b) create a COVID-19 task force with a strong nursing presence, (c) make top leadership accessible to clinical nurses, (d) intelligently and safely redeploy unassigned clinical staff to units, (e) create a culture of transparent communication, and (f) foster well-being with planned advocacy. Organizations were advised to consider making a well-defined cultural shift to protect and sustain the nursing workforce during COVID-19 and other traumatic events.

Doucette (2020) advised NLs to care for themselves with love, forgiveness, and compassion during the pandemic. He highlighted the importance of getting enough sleep, rest, nutrition, and sharing thoughts and feelings with supportive colleagues or friends. Taking time for self-care and renewal would allow NLs to keep the situation in perspective and remain fully present with the frontline team. Nurse leaders were invited to celebrate all accomplishments, no matter the size. Social media could be used to thank their team and reassure the public. Staff could be encouraged to collect videos, pictures, and stories that show how they cared for each other. All were reminded that these caring actions would create a movement centered compassion and love (p. 56).

Additional ways were suggested to prevent moral distress and burnout during the COVID-19 pandemic. Cathcart (2020) advised new nurse managers to spend less time on social media and cable news programs and stop having frenzied conversations with friends and co-workers. They should avoid opinions and hunches and focus on facts. If things went wrong, they needed to ask themselves what could have been done to make

them better. It was important to celebrate all victories, no matter how small, to boost morale. Shingler-Nace (2020) cautioned NLs to unwind and relax after handing off to the next shift or they would become burned out. Mezzina et al. (2021) launched a Code Lavender program and provided self-care tools and a designated space in their hospital for staff to rest and renew.

Creativity and Innovations

Middaugh (2021) shared innovations that helped organizations keep healthcare workers and patients safe through the early pandemic. All suggestions were considered, including those made by frontline staff. Some creative ideas included 3D-printed ear guards to ease pain from wearing face masks for extended periods, 3D-printed ventilator valves and face shields, a transparent aerosol box to protect clinicians from secretions during patient intubation, and providing virtual healthcare visits (p. 212). Nurse leaders needed courage to embrace changes, to be open to new ideas, and to mobilize their teams through the extreme personal and professional challenges caused by COVID (Middaugh, 2021).

Intensive care nurses had to learn new regimens for treating COVID patients. Patients that previously had been healthy required intubation and mechanical ventilation. The standard clinical treatments and care for respiratory patients did not work with COVID patients. Consequently, nurses and physicians had to learn what to do and when to do it by trial and error. They had no time to write new policies and protocols. They would have to do that later (Cathcart, 2020). Eventually, a new technique called proning made the difference by placing the patients onto their abdomens. This seemed illogical, but it worked. Proning helped the ventilated patient by facilitating oxygenation. Proning

was challenging because it required additional staff to do it safely (Caroselli, 2020; Middaugh, 2021).

Additional creative solutions reduced staff exposure to the coronavirus. Intravenous pumps, ventilators, and monitoring equipment were connected to long extension cords and moved outside of patient rooms. Hospitals restricted the number of staff permitted to be in a patient room. In some ICUs, “code cards” were used to communicate with staff outside the room during patient resuscitation (Caroselli, 2020; Middaugh, 2021). Visual technology made it possible to hold virtual ICU patient rounding that included family members (Caroselli, 2020).

Most hospitalized patients were confined in isolation rooms during the early pandemic. To make communication with patients easier, Trepanier (2020) suggested using various devices, such as smart phones, tablets, and baby monitors.

The early COVID-19 pandemic caused so much despair. When COVID patients were finally discharged, NLs and their organizations had reason to celebrate. Many hospitals played special music and staff lined the hallways, applauding as recovering COVID patients left the facility. Community members showed appreciation for all the hero nurses by sending snacks and food (Caroselli, 2020; Sherman 2020a).

The COVID pandemic prevented nursing programs from holding celebrations for their new nurse graduates. The pinning ceremony is one important ceremony that symbolizes nurses’ graduation from their basic RN program. Mezzina et al. (2021) reported that their hospital held a unit-based pinning ceremony for two nurses who graduated in April and began working right away. The unit’s entire nursing team solemnly recited the Nightingale Pledge and welcomed them to the nursing profession.

Nursing Crisis Leadership Styles

> "We can use this moment to mold our leadership styles and learn from experience to improve the future." (Shingler-Nace, 2020, p. 203)

According to Middaugh (2020), leaders must act quickly to correct problems during disasters. It is not the time for debate and discussion to reach consensus. An autocratic, directive leadership style is efficient and effective. Nurse leaders are not always comfortable with this approach, but all NLs should develop the ability to be authoritative when necessary.

Boykin et al. (2020) presented a nursing situation involving a man hospitalized with COVID-19 and his daughter, a nurse. The exemplar described how three nurse leaders with different roles were guided in a circle of caring by applying the dance of caring persons model. This caring-focused, relational model is based on the theory of nursing as caring that was described in Chapter 2. The exemplar used the circle of caring leadership to highlight how reflective practices of three NLs fostered compassion and increased knowing self as a caring person during the COVID-19 pandemic. The exemplar illustrated the three levels of caring leadership. *Circle of caring leadership: The clinical nurse coordinator.* This role emphasized being with and listening to the person being nursed, supporting the entire staff to come to know themselves and each other as caring persons, understanding concerns of nurses as they practiced during the pandemic while trying to keep themselves and their families safe, and responding to what mattered most to the patients. *Circle of caring leadership: The nurse director.* This role was described as having presence, courage, listening, and a commitment to caring leadership. Staff were engaged because they were supported by a caring role model. *Circle of caring leadership: The chief nursing officer*. The CNO modeled caring interactions with staff

through storytelling and connections, personally hearing staff anxiety, learning their safety needs, and finding out what mattered most to them. The authors shared the values of dance of caring persons and informed us that the language of nursing is caring. They closed by reminding us that "caring ensures that all nursing activities are focused on maintaining and supporting an environment of care in which nursing leadership at all levels responds to that which matters in the moment" (Boykin et al., 2020, p. 5).

Simon (2020) reviewed some of the issues for nurses employed in acute care hospitals during the COVID-19 pandemic. She summarized important characteristics of servant leadership (SL) and followed with a case example of how the leaders in the medical intensive care unit (MICU) at the Veterans Health Administration adopted SL as the best strategy to serve veterans who sacrificed during war and promoted peace. After nursing services adopted SL, the MICU had exemplary patient satisfaction and professional employee outcomes. The MICU leaders identified and applied the ten tenets of SL in their practice: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to growth of people, and building community (p. 350). It was crucial for the servant leader to listen, understand, and communicate the people's will to conceptualize a vision that they could follow. Through SL, the staff was empowered with values of authenticity, humility, vision, trust, and fairness (Simon, 2020, p. 349).

Mezzina et al. (2021) described how a nursing team at a Magnet designated organization was influenced by Magnet principles to become resilient and achieve positive outcomes during the early COVID-19 pandemic. The nursing department had a caring philosophy supported by shared decision-making and professional practice

models. A medical-surgical telemetry step-down unit became the organization's designated COVID-19 unit to link care between the ED and high acuity critical care units. Despite the pandemic, the shared decision-making and unit practice councils, the night practice council, and the monthly networking council continued meeting by switching to virtual platforms. Multiple lifesaving advanced assessments, treatments, clinical trials, and professional collaborations were developed during the pandemic. The authors presented several ideas and examples of how enculturating components of the Magnet model enabled nurses to support their patients and themselves during the crisis.

An editorial by Sherman (2020a) described the sudden disruption and constant changes produced in the healthcare environment during the COVID-19 pandemic as a classic example of VUCA (volatility, uncertainty, complexity, ambiguity). NLs had to manage countless unfamiliar issues, including accepting some changes that previously had been deemed unacceptable or prohibited. Examples included increased patient acuity and death, resource shortages, changing models of care, and transferring staff to new areas of practice without existing or sufficient levels of training. Computer-based nursing education programs replaced classroom learning. There was a new focus on PPE and other safety supplies.

NLs typically strive for a stable environment. But the pandemic required them to let go of tried-and-true practices and accept that leadership in the chaos of the moment often meant coping with uncertain outcomes. It was impossible for simulation training to prepare leaders for all the unpredictable events caused by the pandemic. NLs were urged to reflect upon and learn from their pandemic experiences as they moved toward the

future with greater insight and capabilities. They were reminded that not everything would work, but they should share what does (Sherman, 2020a).

Brennan (2022) asserted that the VUCA environment of the pandemic gave nursing the opportunity to move away from the traditional transformational leadership style to disruptive leadership. She stated that "vision, understanding, clarity, and agility are characteristics that current and future nursing leaders need to possess to thrive in the VUCA environment" (p. 55). Before the COVID-19 pandemic, some nurse administrators felt that hospital nursing leadership had become routine and somewhat predictable. Their role included assuring regulatory compliance, staffing ratios, quality initiatives, introducing technology, and simply reacting to whatever changes were mandated instead of creating solutions. There had been discussions about state-wide mandatory staffing ratios, the health and safety of employees, and expanding the nurse practitioner role, but they were stalled in legislative processes.

Brennan contended that the pandemic provided an opening, not only to adjust daily leadership styles, but also to revise much of how nursing is taught, legislated, and practiced. Entry to nursing practice should be elevated to the baccalaureate degree only, hospital staffing needs to move away from task-oriented patient ratios to acuity-based interdisciplinary staffing models, and nursing work hours should not be twelve-hour shifts which are too exhausting and stressful. Staff need flexible options. More NLs should be involved in developing electronic medical records. They need to understand and value big data, ensure that algorithms and AI support the work of nurses; and stop reacting to problems and start fixing them. Disruptive leadership is necessary in this

VUCA environment for NLs to avoid traditional, outmoded approaches and to transform nursing and healthcare for the future (Brennan, 2022).

Crisis Management, Nursing Leadership Guidelines

Several authors presented disaster or crisis recommendations and protocols for others to follow during pandemics and other crises. Some were created from personal experience, while others were guidelines from professional organizations.

NLs are involved in many crises, such as natural disasters, terrorism, and infectious diseases. To maintain credibility with staff and the public, frequent, transparent, and honest communication by NLs is essential. In 2017, subcommittees of the AONL and the American Hospital Association met for a day of dialogue to review lessons learned during Hurricane Sandy, the Boston Marathon bombing, and the Ebola outbreak in Africa. Participants identified skills and behaviors necessary for managing staff and running healthcare facilities during crises. They also promoted the need for NLs to be valued members of their organizations' crisis management team. The following AONL guiding principles were identified:

> (a) Nurse leaders are trained in media relations and understand the tenets of good communication; (b) leaders are skilled critical thinkers, collaborative, and able to manage ambiguity; (c) nurse leaders project calm, confidence, and authority in all situations. They are also empathetic to how people react to loss, challenges, and uncertainty; (d) nurse leaders are prepared to review and practice the organization's crisis readiness plan with nursing staff; and (e) the CNO is a member of the senior leadership team, whose role is clearly defined and sought by colleagues, particularly during a crisis (p. 1)

In addition, the following focus areas were listed: communication, basic nursing leadership behaviors, necessary nursing leadership skills, priorities of a crisis readiness plan, and nurse leaders' role. Each focus area was followed by 3–5 bulleted phrases to clarify the intended meanings. Links to web-based resources for managing mass casualty/natural disaster, strikes, infectious diseases, media overreaction, technology outages, and other resources were provided (AONL, 2017).

Middaugh (2020) also reviewed the AONL guiding principles for the role of NLs in disasters (AONL, 2017). There are four stages of emergency management that reduce potential loss: (a) *mitigation* means analyzing risks and vulnerabilities to eliminate or reduce them before a disaster occurs; (b) *preparedness* is to be ready; stock up on food and supplies; train for and hold practice drills; (c) *response* takes place during the actual disaster, rescue and care for survivors, and prevent further damage; (d) *recovery* means returning to pre-disaster state; clean up, secure financial assistance, protect the organization, and return to normal (p. 211).

Traditional management functions are easily forgotten in the chaotic environment of a crisis like the COVID-19 pandemic. The functions of management must be reviewed and applied: (a) *planning* is for the future and must include disasters; (b) *organizing* during disaster includes establishing a chain of command, understanding potential hazards, and knowing that unnecessary chaos follows without planning and organizing; (c) *directing* all staff clearly with appropriate delegation, planning, and training*;* (d) *coordinating* only takes place with strong, effective leadership and management*,* and (e) *controlling* to make sure staff performs according to plans and standards. Nurse leaders must be models of fairness, participation, and cooperation to influence others. However,

they must also act quickly, remain focused, and use an autocratic, directive leadership style to maintain control, when necessary (Middaugh, 2020).

Shuman and Costa (2020) summarized the AONL recommendations for disaster preparedness that included developing skills in three key areas: communication, business, and leadership. *Communication.* Communication in (the organization) involves informing staff about planning, preparations, and updates. Communicating with staff builds trust and demonstrates empathy and understanding. Leaders should be comfortable communicating in person, by email, by telephone, and videoconferencing. Communication up (to leaders and managers) promotes the needs of the units or departments, or hospitals to the executives. Leaders must communicate and advocate for both staff and executives with equal intention. Communicating out (to policy makers and communities) is a skill that nurses must learn and develop to be effective. *Business*. During the COVID-19 pandemic and other disasters nurse leaders, especially unit leaders, require the ability to analyze, interpret, and use data. Financial competency is needed to manage budgetary requirements. Strategic planning is needed for disaster preparedness, to identify an incident command center, and to assure staff receive disaster training with simulation. *Leadership*. Understanding and knowing when to use different leadership styles improves workflow, employee engagement, and occupational health and well-being. It was important for NLs to recognize the toll that the stress of pandemic took on them and know when to ask for help.

Caroselli (2020) described how the Veterans Affairs (VA) New York Harbor Healthcare System (NYHHCS) followed the four phases of the VA Comprehensive Emergency Management Plan to mobilize resources in the early pandemic. (a)

Prevention/Mitigation was accomplished by utilizing the BMS (described earlier) and an incident command center to safely prepare for an influx of COVID-19 patients (b) *Preparedness* was carried out with information from the national VA headquarters and surrounding communities. The chief physician and chief nurse, the bed czar, infection control personnel, nurse managers, and additional physicians held telephone conferences daily and as often as needed to assess capacity management and bed flow issues. Calls were also held with biomedical engineering and groups responsible for managing vital supplies and resources. (c) *Response* meant that the pandemic was a reality. This was a time for slowing, stopping, or reversing any damage caused by the emergency. Some standard hospital operations were modified including ICU modifications, patient cohorting, and severely limiting entrance to the facilities. (d) *Restoration* occurred when fully functioning, pre-pandemic capabilities returned. Some pandemic improvements continued, such as adopting new treatments and procedures for COVID-19 patients. Staff were more flexible and able to adapt to constant changes. Social distancing and telemedicine appointments became standard (Caroselli, 2020).

Shingler-Nace (2020) expressed concern for all nurses, but especially for NLs during the challenges produced by the COVID pandemic. As front-line leaders, they were responsible to support basic day-to-day operations, including quality, safety, service, finance, research, and education. Nurse administrators were advised to mentor and guide NLs to be as successful as possible during uncertain times by establishing trust and a healthier work environment and by role modeling desired behaviors for frontline leaders to follow. Nurse administrators were urged to guide others through the pandemic while remaining true to their core values: (a) stay calm, staff watch and will model leader's

behavior; (b) communicate often, be consistent, NLs need to be fully informed; (c) collaborate, lean on each other, take breaks when necessary; (d) coordinate often with physicians, support services, and operational leaders for safer quality environments; and (e) provide support, so that all levels of nursing leadership feel valued and relevant. (Shingler-Nace, 2020, pp. 202–203).

Trepanier (2020) shared leadership experiences from the first three weeks after the COVID-19 pandemic arrived at the west coast of the United States. No amount of experience or training could prepare NLs for the turmoil of the very early pandemic. The author expressed concern, but also hope for the future and said, “I am reminded that hope is not a plan; therefore, now is the time to show up as nurse leaders and make a difference” (Trepanier, 2020, p. 404). Without clear guidelines, nursing leadership realized they would have to depend on informal, “real-time” learning. They knew very little about the contagious nature of COVID-19, the trajectory of the disease, how long the pandemic would last, or its effect on the hospital, the healthcare system, and nearby communities. Until more was known, they depended on three emerging principles: prevent, protect, and control.

Prevent: Infectious disease prevention includes physical and social distancing, handwashing, staying home if sick, no unnecessary travel, and limiting visitors to hospitals and nursing homes. Teleconferencing and virtual consultations help patients avoid the emergency department, the clinics, and hospital.

Protect: Reduce access to the hospital with one designated entrance for caregivers and providers. Everyone else should enter through the main entrance and emergency room. Every person entering the facility must have their temperature taken. Deny access

to anyone with a temperature greater than 100 °F unless they have an appointment. All greeters should wear masks and gowns. Send sick employees home according to policy. Direct everyone sent home to self-quarantine for at least 14 days, practice hand and other hygiene measures, stay calm, and follow-up with their primary provider.

Control: Review organizational policies and confer with local, military, and state representatives. Although it was very early in the pandemic, nurse administrators consulted with colleagues in China who advised cohorting COVID patients to reduce spread of the virus to individuals without COVID.

Caring by Nurse Leaders During COVID-19

This literature review did not identify caring as requisite for the experience of NLs in the COVID-19 pandemic. However, the following quotes show that caring not only existed, but it was also vital for some of the authors:

> This is a time of uncertainty in our world. We must understand things likely will not be normal for a long time. Our current crisis is extremely stressful and pushes people to their limits. Now is a time that calls for leaders and managers to show their human sides as well." (Middaugh, 2020, p. 212)

"Of all the things I miss, being able to hug people is what I miss the most. When the time comes, there will be lots of hugs and I hope this gives you hope for what's to come" (Doucette, 2020, p. 56).

"Love your team. Show warmth. By leading with love, you will inspire others. Love, or true caring, will get us through this" (Trepanier, 2020, p. 406).

"Leadership is hard, and holding a team accountable is not wrong; however, loving them through transition and challenge is ok, too" (Shingler-Nace, 2020, p. 202).

Research of Nurse Leader Experiences in COVID-19

Although quantitative and qualitative studies of the experiences of staff nurses during early COVID-19 were published, research specific to NLs during the pandemic was limited. Of the few studies that were available, most NL responses were mixed with those of administrators and staff nurses. There were no available U.S. studies of NLs and caring.

Hand et al. (2021) shared thoughts that NLs conveyed during the final stage of a three-part Delphi study that started prior to the COVID-19 pandemic. Participants were members of the Association for Leadership Science in Nursing (ALSN), members of AONL, and a group of invited nursing administration and leadership experts. The original aim of the study was to identify and prioritize leadership science research topics. The ALSN members were surveyed in 2019, but the pandemic interrupted the study in early 2020. “The pandemic thoroughly tested the capabilities and capacities of every aspect of the health care delivery system, including supply chains, communication channels, information systems, physical infrastructure, organizations, leaders, and staff” (Hand, 2021, p. 616). When the survey resumed, the researchers had the opportunity to ask the AONL members and the expert leaders an additional open-ended question: “Are there any new areas of research related to nursing leadership and administration that you believe should be explored following the COVID-19 pandemic?” (p. 617) Responses were analyzed, and themes were identified. Four supercategories emerged for creating a body of knowledge to guide nursing leadership in the future: (a) organizational leadership preparedness; (b) adaptive leadership in crisis; (c) innovations in care delivery; (d) health,

well-being, and resiliency. Each category was described and then supported with quotes by participants.

White (2021) conducted a phenomenological investigation of the experiences of a sample of seven NLs and six assistant NLs during early COVID in the United States. Participants reported working for 2–5 months in an ICU or a medical-surgical unit that treated COVID-19 patients during the early pandemic. Major themes identified were (a) being there for everyone; (b) leadership challenges; (c) struggles, support, and coping; and (d) strengthening my role. There were 11 subthemes. The researcher concluded that NLs had the new task of meeting the psycho-emotional needs of front-line nurses while at the same time experiencing stress and exhaustion themselves. They needed strategies to meet those needs. Peer support was recommended for managers as well as taking time off to prevent exhaustion. These findings and recommendations are comparable to those in the non-research literature (Prestia, 2020; Rosa et al., 2021).

Bunch et al. (2024) reported the role of the frontline NL was increasingly difficult during the COVID-19 pandemic. Inadequate staffing, expensive traveling nurses, and PPE shortages affected NLs' job performance and professional quality of life. They conducted an electronic survey of 54 NLs at a large midwestern academic medical center in 2022. The Professional Quality of Life Measure Version 5 was used to measure compassion satisfaction, burnout, and secondary traumatic stress. Participants also responded to six items related to past consideration of or intent to leave their current job or the nursing profession. Findings concluded that most participants had previously considered changing roles or leaving their organization during the COVID-19 pandemic, but fewer reported being likely to do so during the next 6–12 months. Most participants

scored in the moderate ranges for compassion satisfaction, burnout, and secondary traumatic stress. Nurse leaders with higher compassion satisfaction scores were extremely unlikely to leave for an internal non-management role. Those with higher burnout scores had more years of work experience and had already considered, or were likely to consider, leaving for an external non-nursing position. The NLs had higher secondary traumatic stress scores than assistant NLs and likely thought about leaving for an internal non-management role, an external non-nursing position, or considered leaving for an external non-nursing position in the future. Although the sample size was small, the researchers found the NL role was stressful in the best of times and was even more so during a crisis. They concluded it was vital for all healthcare organizations to explore ways to support and retain NLs in a post-pandemic world.

Freysteinson et al. (2021) were concerned that the U.S. health care system lacked adequate supplies, staffing, and ability to deal with the COVID-19 crisis rapidly and efficiently. Despite conflicting reports, little was known about how NLs lived through and managed during the pandemic. The researchers conducted a hermeneutic phenomenological study using Ricoeur's method to understand nursing leaders' lived experiences at a healthcare system consisting of 11 hospitals in a metropolitan city during the pandemic. A purposeful sample of 28 nurse leaders in management and administrative roles was interviewed between July and September 2020. The following themes emerged: (a) *embodied leadership*, the visible, physical results of being a leader; fear that new treatments would not work; the need to keep the organization running and to be strong for the staff. "This motivation was surpassed by the leaders' genuine care and concern for their employees" (p. 1538); (b) *navigating differently*, a different safety priority; to

prevent the spread of the virus, physical rounding stopped and performance improvement projects were put on hold; non-clinical nurses took refresher courses so they could care for patients; to save time, 84 documentation fields were removed from the electronic medical records, but documenting still took too long; financial mistakes were made, i.e. spending thousands of dollars on hazmat suits that could not be cleaned for reuse; (c) *trusting and earning trust*, meant trusting CDC, other experts, administrators, and peers to give the best information, to make the right decisions; schedules were developed to assure physical presence of leadership; face-to-face interactions to reassure staff; transparent communication with patients, employees, families; by working with staff, leaders developed a sense of pride, faith, and trust; (d) *being the calm voice,* because staff were so anxious, everyone heard the same messages differently; leaders met with employees through rounding, huddles, or virtually to reassure employees; messages were conveyed via white boards, email, group messaging apps, and teleconferencing, the usual socializing and team building were not permitted, but some held virtual happy hour get togethers; and (e) *envisioning the future*, the end of the surge; communication was the greatest challenge; barriers were broken as staff and leaders worked together forming cohesive teams; a new normal was beginning. This study strongly supported what was reported by nurse leaders in the non-research literature. Recommendations included utilizing what we have learned in this pandemic and enhancing communication by forming a disaster plan with a designated disaster team to prepare for future crises.

Aydogdu (2021) found that NLs required crisis management education similar to their training in leadership, human resources, and operations management. Two years after the COVID-19 pandemic began, NLs still experienced related physical and

psychological health problems. An integrative literature review was conducted to identify challenges faced by NLs during the COVID-19 pandemic. Twelve primary research articles were analyzed using a qualitative method. Two studies were from the United States. The rest were from various other countries. All articles reported challenges for nurse managers. Four themes were identified: (a) workplace demands, (b) impacts on physical and psychological health, (c) coping measures and resilience, and (d) recommendations to better support nurse managers in times of crisis. The author concluded that organizations should use collaborative, inclusive, and participatory practices for better crisis management. Knowing the experiences of NLs during the pandemic period may help health institutions and policymakers better prepare for emergencies. The findings that led to these themes support similar findings reported in the non-research literature review.

According to Chipps et al. (2022), the NL role was among the most visible and complex leadership positions. Their study explored professional and personal experiences of NLs during the COVID-19 pandemic. The investigators conducted six virtual focus groups of 5–7 NLs each. Participants had at least one year of management experience and were recruited from five different U.S. healthcare systems ranging from 125–1250 beds. The focus group transcripts were analyzed using a qualitative software program. The research team identified themes using a constant comparative method until data saturation was reached. Three major themes with associated subthemes emerged: challenges, feelings and emotions, and coping.

Challenges: *Organizational and leadership challenges*. Staffing was a major issue because so many employees had COVID or were quarantined. Units were closed, staff

were deployed elsewhere, and nurse-patient ratios increased. NLs struggled communicating frequent changes. Despite being short staffed, nursing had to do other departments' work. *Workforce and team challenges*. Staff were afraid and exhausted. NLs felt the need to support the staff, but did not have the requisite counseling skills. *Death and dying challenges*. Nurses were prepared to deal with death, but not in the numbers and frequency brought about by the virus. Many patients died without support from loved ones. Nurses also had to cope with the death of people in their personal lives. *Personal challenges*. There was no work-life balance. There was no way to get away from work to relax. Several NLs began to rethink their career choices. *Ethical challenges*. Several NLs discussed social disparities that affected many Hispanics and people of color. Others voiced disparities in the crisis pay provided to nurses but not to techs and others. The NLs were the means of communicating information even if they were conflicted about it. At least one NL felt it was wrong to ask staff to do tasks they had never done before.

Feelings and Emotions: *Negative feelings and emotions*. NLs despaired about needing to be strong for everyone even when they felt exhausted and burned out. Despite being busy all day, some felt like they got nothing done. Others complained that senior leaders were not visible and stayed in their offices or worked from home. *Positive feelings and emotions*. Although there were more negative feelings expressed, some NLs voiced pride in their teams and the nursing profession.

Coping: *Self-Care*. Taking care of self was difficult during the pandemic. Most organizations offered mental health tools and services, but the NLs said they had no time for them. Some rested in their office for 15 minutes. Others needed a "mindful moment"

and stepped away for a short period. The constant stress led some NLs to have new or worsened health problems.

Resilience: Some NLs drew on their years in nursing and longevity in their organizations for strength, while others remembered the onset of the AIDS epidemic and other past emergencies.

Support: Many NLs received support from talking with others who were in the same role with similar experiences. Others drew support from their directors.

McAndrew et al. (2023) reported that nurses were traumatized after watching patients suffer from extreme hypoxemic respiratory failure without any successful treatments. So many patients died during the early COVID-19 pandemic. With heavy workloads, short staffing, and exhaustion, nurses risked mental health symptoms of depression, anxiety, burnout, and moral distress. In January and February 2021, the study team convened focus groups for a phenomenological study of the lived experience of nursing staff and nurse leaders working in intensive care or medical units devoted to COVID-19. The study was done after the first COVID-19 surge, but before vaccines were available.

A sample of 44 nursing staff (nurses, nursing assistants, nurse technicians) and NLs (managers, assistant nurse managers, clinical nurse specialists, nurse educators) was recruited from a midwestern academic medical center in the United States. Participants in 10 in-person focus groups and five one-on-one interviews were asked to describe their (a) experiences as nursing professionals, (b) coping strategies, and (c) perspectives about supportive resources. Their responses were analyzed using a Giorgi-style phenomenology method and Meaning Making, a conceptual framework often used for work with

bereavement and loss. The Moral Distress Thermometer Tool was used with participants' self-reported data to determine their levels of moral distress.

Seven themes emerged: (a) the reality of COVID-19: we are sprinting in a marathon; (b) acute/critical care nurse leaders experience unique burdens; (c) acute/critical care staff nurses experience unique burdens; (d) meaning of our lived experience; (e) what helped us during the pandemic; (f) what hurt us during the pandemic; and (g) we are not okay. In general, participants reported moderate levels of moral distress.

This research confirmed findings from other studies that nurse leaders faced many of the same challenges as their staff. The NLs' personal trauma was increased by listening to and absorbing staff suffering while implementing frequent top-down directives. They emphasized that peer support was preferred over support offered by the healthcare organization. The researchers concluded that their findings affirmed the need for trauma-informed care and grief support for nurses, peer support programs, pandemic preparation, ethics improvements such as a moral distress consultation service, and continued team building activities.

CHAPTER 6

Methodology

Quantitative or Qualitative Research

Scholars of the natural and physical sciences and medicine use the scientific method and other quantitative approaches to study and define the world. “These methods are characterized by deductive reasoning, objectivity, quasi-experiments, statistical techniques, and control” (Munhall, 2012, p. 83). Quantitative methods are valuable for analyzing empirical data to make predictions that are generalizable to larger populations. However, they are not concerned with or offer insights about human experiences or what it means to be human (van Manen, 1997; Watson, 2008).

Qualitative research takes a different approach. Qualitative methods are often preferred by health researchers because they use text as data and focus on meanings and interpretations (Sloan & Bowe, 2013, p. 1293). “Qualitative research is known for giving voice to people, to hearing people’s own personal narrative and using the *language of our participants* in research” (Munhall, 2012, p. 4). Qualitative methods include phenomenology, ethnography, historical, case study, discourse analysis, and narrative inquiry. Each technique requires a slightly different approach (Astroth & Chung, 2018; Munhall, 2012; van Manen, 2014) and for some studies, more than one method is used, depending on the desired philosophical emphasis (Munhall, 2012). A specific qualitative method is selected according to the event, context, access to participants, and the personality and perspectives of the researcher.

Phenomenology

Phenomenology is both a philosophy and a research method that concerns itself with human experience. It is concerned with the fundamental nature of a phenomenon that is not fully understood (Munhall, 2012). As a method of inquiry, the researcher seeks the essence, or meaning, of an experience, what was experienced, and how it was experienced, from the perspective of the persons who lived it (Neubauer et al., 2019, p. 91). The persons, or research participants, are the only reliable sources of information about the phenomenon because they are the ones who lived it. Their lived experiences cannot be directly observed, so we can only investigate what they choose to disclose. Their memories, feelings, thoughts, and dreams about the phenomenon must be identified by indirect methods such as interviews or questions and thus require interpretation and understanding (Chinn & Kramer, 1995). The phenomenological method of inquiry fits well with nursing's philosophy of understanding unique individuals and their meanings within their own cultural and social contexts (Lopez & Willis, 2004).

There are several approaches to phenomenological research: descriptive which is based on the work of Edmund Husserl; interpretive which is guided by the work of Martin Heidegger and Hans-Georg Gadamer; the Dutch School (combining descriptive and interpretive, guided by work of Max van Manen and others); and newer approaches, such as life world research described by Ashworth and Dahlberg, post-intentional phenomenology of Vagle, and interpretative phenomenological analysis (IPA) of Smith. All approaches are concerned with lived experience; and all originate from philosophical views of either Husserl or Heidegger (Dowling & Cooney, 2012; Neubauer et al., 2019).

Descriptive Phenomenology

Edmund Husserl is considered the founder or father of the philosophy and research methods of phenomenology (Converse, 2012; Rentmeester, 2018). He was interested in the essences of the "lifeworld" or "lived experiences." He assumed this reality could only be observed through people's thoughts or as they appear in consciousness, so there can be no real existence outside the mind (Dowling & Cooney, 2012). "Husserl contended that a lived experience of a phenomenon had unique features that were universally perceived by individuals who had experienced that phenomenon. These common features—or universal essences—can be identified to develop a generalizable description" (Neubauer et al, 2019). His research aimed to discover and describe the universal essence, or true nature, of a phenomenon in the world without explaining, interpreting, or theorizing about it. (Bynum & Varpio, 2018; Dowling & Cooney, 2012; Neubauer et al., 2019; van Manen, 2014). Husserl's phenomenology is sometimes called transcendental because it is not interested in the external appearance of an actual object, thing, or experience, but in the way it transcends the physical characteristics to appear in our consciousness (van Manen, 2014). It is always the way we imagine it to be and not the thing itself. Husserl developed this philosophy in response to, or in reaction to generalizations of the positivist empirical approach of the natural sciences (Munhall, 2012, p. 127). Husserl coined the term bracketing, or epoché, for a necessary step to help the researcher remain objective during analysis. "With bracketing, the researcher's preconceptions, attitudes, values, and beliefs are held in abeyance [throughout the investigation] to ensure that they do not prejudice the description of the phenomenon" (de Chesnay, 2015, p. 4). He believed this would be akin to scientific rigor

during analysis of descriptive research (Lopez & Willis, 2004). Descriptive phenomenology is straightforward. After the phenomenon of interest has been identified and analyzed, the work of the researcher is done. Anything that is done after the analysis is a departure from descriptive phenomenology (Sloan & Bowe, 2013, p. 1295). As a research method, descriptive phenomenology is often used and appreciated by nurse researchers.

Interpretive or Hermeneutic Phenomenology

Martin Heidegger was a philosophy student of Edmund Husserl. Heidegger initially aligned with Husserl's work, but eventually thought that describing others' experiences was not enough. He believed that meaning is based on understanding what people experience, and not what they consciously know. Lopez and Willis (2004) stated:

> The hermeneutic phenomenologist, rather than seeking purely descriptive categories of the real, perceived world in the narratives of the participants, will focus on describing the meanings of the individuals' being-in-the world and how these meanings influence the choices they make. (p. 729)

Instead of describing or knowing the world, Heidegger used the German term Dasein, or "being-in-the-world," to refer to the way people exist, act, or are involved in their everyday lifeworld (Ajjawi et al., 2024; Reiners, 2012; van Manen, 1997). He also used the term "lifeworld" to refer to the idea that individuals' realities are always influenced by the world in which they live (Lopez and Willis, 2004). Each person experiences the same phenomenon differently depending on the "situated context" of their lifeworld including the lived time, lived space, lived body, and lived relations. A person's situated

context influences the choices that they make as they navigate the lifeworld (Ajjawi et al., 2024; Connelly, 2015; Munhall, 2012; van Manen, 1997).

Lived Time (temporality)

Lived time is not the objective time that we measure with a clock or calendar. And yet, the time of day, the day of the week, the season of the year influence our being in the world. Lived time is the perception of the passage of time as voiced with expressions such as, “time flies” or “losing track of time,” or “time seems endless” (i.e. Are we there yet?). Time seems to slow down when we are bored or anxious and speeds up when we are engaged in an enjoyable activity. Lived time can include being a “night owl” or feelings of “wasting time” when things do not get done. The temporal dimensions of past, present, and future are perceived differently according to a person’s stage of life. The historical period we live in also influences our behavior, attitude, and beliefs about the life world (Connelly, 2015; Munhall, 2012; van Manen, 1997).

Fictional Lived Time: Early COVID-19 in the Hospital Lobby. It is March and the gray chilly days seem endless. It is early in the COVID-19 pandemic and many of us feel like time is standing still. At the hospital, the doors are locked. Only employees and patients are permitted to enter. The code team, wearing masks and scrubs, race through the nearly empty lobby toward an emergency. They hope they make it in time to save a life. Workers at the information desk also wear masks. They glance at the code team, murmur something, and continue stapling forms and other paperwork to help departments without clerical support. They keep looking at the wall clock or their watches and wonder why the past fifteen minutes felt like an hour. Sometimes they reminisce about the previous year before so many people got sick and died. They wonder what the future will

be like, if they get there. Most of them imagine relaxing outside without masks on warm, sunny spring days.

Lived Space (Spatiality)

"We become the space we are in" (van Manen, 1997, p. 102). We usually don't reflect on the meaning of our lived space. It is where we live our daily lives, or where we work, or where we find ourselves as we go about our day. It can be as big as a city or as little as a room in a house. Our lived space takes on different meanings with different experiences. We may feel tiny in an enormous cathedral or huge while seated in a cramped office cubicle. Bodily changes also lead us to think another way about our lived space. For instance, being newly confined to a wheelchair alters how we look at our home environment. In warmer weather, our lived space can expand outdoors to patios, gardens, and beaches and it can be limited to indoors huddled under a comforter in colder weather. The number of daylight hours also influences some peoples' response to their lived space. (Connelly, 2015; Munhall, 2012; van Manen, 1997).

Fictional Lived Space: Early COVID-19 in the Hospital Lobby. It is the early COVID-19 pandemic. The hospital parking lots are vacant except for some spaces designated for employees. Security guards in masks and gloves stand watch. No one is permitted to enter the building unless they have a pre-approved purpose. Those that do must wear masks. They must stop at the information desk to have their temperature taken and answer questions about recent travel and illness. The workers are nervous and unprotected without the plexiglass windows that will be installed later. The lobby appears vast and lonely. The floor is stenciled with footprints six feet apart to show people where to stand. But there are no lines. No one is there. Like the lobby, the elevator floors are

stenciled with images of footprints, one in each corner, indicating where people must stand. Only four are permitted to ride at one time, but no one is waiting. No one is there. The gift shops and coffee shops are locked and dark. They are closed as if it were late at night. The occasional sounds of footsteps, squeaky wheels, or brief conversations are magnified. Overhead soft music drones on, but no one lingers to hear it. Voices are silent, except for the occasional anguished cries that signify someone just learned their loved one has died alone of COVID-19.

Lived Body (Corporeality)

We are always bodily in the world, meaning we experience life through sensations and feelings that originate within our body. When we first meet someone in person, it is through our bodies. Facial expressions, posture, and distance influence our meeting. Our physical presence reveals something about ourselves and conceals something at the same time (sometimes in spite of ourselves). The way we feel about our body influences how we respond to the critical gaze of others. Hair styles, piercings, tattoos, other bodily adornment and clothing choices tell others about who we are. Changes within our body lead us to think about life differently, such as when a life-threatening illness alters a person's self-image and mental health. Other important aspects of lived body include race, gender identity, nationality, and physique (Connelly, 2015; Munhall, 2012; van Manen, 1997).

Fictional Lived Body: Early COVID-19 in the Hospital Lobby. It is early in the COVID-19 pandemic and people in the hospital lobby look different. No one can enter the building unless they wear a mask. Some masks are paper, some are cloth in different colors. Men especially like to wear neckerchiefs pulled up over their noses like

stagecoach bandits from old cowboy movies. It is cold outside. People who wear eyeglasses deal with foggy lenses as they enter the warm building. Many people wear long sleeved jackets, gloves, and scarves. In the lobby, they slather their hands and exposed arms with hand sanitizer. Everyone must stand at least six feet apart on footprints stenciled on the floor. Anxious hospital personnel go about their business, heading through the lobby without looking around. No one wears business clothes or dress shoes. Some wear lab coats over street clothes, but most wear scrubs. They may cover their hair with OR caps or scarves. It is hard to identify them because, like everyone else, they wear masks and glasses or face shields. Most wear disposable gloves and still hesitate to touch anything. They may wear disposable shoe coverings to protect their personal footwear. People seem stiff and uncomfortable. They look down as they speak as if the virus could spread through eye contact. No one hugs or touches the people they recognize, although a few bump elbows instead. There is no laughter. They ignore the soft music playing overhead.

Lived Other (Relationality)

Relationality is the lived social relationships we have with other human beings in the space(s) we share with them. Relationships are important to understanding a person's life and experiences. Humans search for experiences of the other in the group, the social situation. Informal interactions with others allow for personal growth as we seek solidarity through a common purpose in life, meaningfulness, or grounds for living. People relate to others through family, religion, politics, professions, income, social class, educational levels, and community (Connelly, 2015; Munhall, 2012; van Manen, 1997).

Fictional Lived Relations: Early COVID-19 in the Hospital Lobby. It is early in the COVID-19 pandemic and relationships are different in the hospital lobby. Some people appear shell shocked as they arrive alone. The guards look suspiciously at everyone as if they are carrying vials of coronavirus in their pockets. At the information desk, masked people stand in line, six or more feet apart, hands at their sides or folded over their chests. But no one is there, so there is no line. No families arrive to visit friends or relatives. No groups of professionals arrive to attend meetings at the conference center. The local school does not send the senior chorus to cheer patients by singing in the hallways. No community members meet for coffee and a game of cards at the coffee shop. The coffee shop is empty; it is closed. So is the gift shop. Most local churches, schools, and restaurants are closed, too. All social gatherings are banned. We are on lockdown. It is too quiet, scary, and very lonely.

Although each lifeworld and fictional representation are presented individually here, they are not separate. Together they merge to encompass a person's existential reality, their situated context. With that in mind, it is essential to include the participants' lifeworlds in addition to their thoughts and feelings when considering the meaning of their experiences (Ajjawi, et al., 2024; Lopez and Willis, 2004; Munhall, 2012; van Manen, 1997).

Unlike Husserl, Heidegger believed the researcher cannot remain neutral or detached during the process of essence investigation (Sloan & Bowe, 2014). Unless the researcher has an interest in a phenomenon, there would be no reason to investigate it. It is impossible to completely set aside, or bracket, past and current experiences, biases, and expertise when collecting and analyzing information from participants (Bynum & Varpio,

2018). “With an interpretive approach, the intentions and understandings of the participants are taken into consideration and are seen as dependent on a shared world of meanings” (Benner, 1984, p. 40). The researcher who has had similar knowledge and experiences, as well as anyone else with a similar background, should be able to understand the meanings of a particular situation.

Hermeneutic Phenomenology and Max Van Manen

The hermeneutic phenomenological research approach of Max van Manen combines both descriptive (phenomenological) and interpretive (hermeneutic) methodologies. It is a phenomenological approach because it seeks to describe and enrich a lived experience by extracting its meaning. And it is interpretive because it is the study of the expressions and texts of lived experience to determine the meanings embodied in them. This research method is fundamentally a reflective writing activity. It involves deeply thoughtful, almost meditative, writing that transforms all extraneous descriptions and explanations of a lived experience to a textual expression of its “essence.” The essence is the spirit, or the nature, the meaning of a phenomenon (van Manen, 1997).

Unlike quantitative and some forms of qualitative research, sorting, counting, and systematic coding is not the aim of van Manen’s approach. “The best materials for conducting phenomenological analysis are direct descriptions of the experience, rather than accounts *about* the experience” (van Manen, 2014, p. 299). In other words, this resembles the advice given to writers to *show, don’t tell,* an experience so that the reader can “visualize” or relate to the situation.

Van Manen (1997) provided and detailed six practical approaches that can provide a methodical structure for hermeneutic phenomenological research. They are: (a) turning

to the nature of lived experience, (b) investigating experience as we live it, (c) reflecting on essential themes, (d) the art of writing and rewriting, (e) maintaining a strong and orientated relationship, and (f) balancing the research context by considering the parts and whole. These research activities serve as guides to conducting a hermeneutic phenomenological investigation. The alphabetical list does not imply that there is an exact order to be followed. The researcher often moves back and forth between the activities throughout the investigation and can also work on several at the same time. Through additional hermeneutic processes of epoché (bracketing) and reduction (removal of information extraneous to the phenomenological question), reading, re-reading, writing, and rewriting over and over, themes will be revealed and insights to the nature, or essence, of the lived experiences of nurse caring by nurse leaders in the early COVID-19 pandemic will take place.

CHAPTER 7

Data Collection

Research Setting

When COVID-19 first appeared and spread rapidly throughout New Jersey, the origin of the disease was unknown, the routes of transmission were unclear, and there were no known treatments or cures. Soon hospitals became crowded with sick and dying patients. Of necessity, the early COVID-19 pandemic led to immediate, drastic changes in the way hospitals operated. Elective procedures were cancelled. All departments that were not essential for the care of acutely ill patients were closed. Their employees were relocated to work in units and departments that remained open. Cafeterias and gift shops were closed. When possible, personnel from non-clinical departments started working from home by telephone and computer. Family members and visitors were not permitted to enter hospitals to visit critically ill and dying patients. Although hospital administrators were ultimately responsible for these and other organizational changes, it was the NLs who were accountable to accomplish frequent policy revisions, support clinical and other staff, and assure safe, appropriate care of acutely ill patients. Consequently, this phenomenological research invited the unique perspectives of caring by NLs during the early COVID-19 pandemic.

The specific setting selected for this study was HTMC, a NJ hospital during the early COVID-19 pandemic. At the time of the study, the hospital had fewer than 350 licensed beds and was not closely connected to a university or other healthcare organization. It was a Magnet redesignated organization; one that promotes, strives for, and supports nursing excellence.

As a reminder, the early COVID-19 pandemic is defined as March 1, 2020, through May 31, 2020. The term nurse leader refers to nurse managers, directors of nursing, and other nurses with comparable responsibilities. These NLs differ from clinical nurses and nurse administrators that have broader organizational responsibilities and titles such as executive director, assistant vice president, and chief nurse officer/executive.

Inclusion and Exclusion Criteria

I selected HTMC as the location to seek volunteers for this phenomenological study because I was employed there as the Magnet program coordinator until November 2019 and was familiar with the organizational culture and environment. The target population for this research consisted of all NLs employed in an inpatient or ambulatory setting at HTMC during the early COVID-19 pandemic. I invited all NLs who were employed at HTMC in an inpatient or ambulatory setting during early COVID-19 pandemic to participate if they met the following criteria: (a) licensed as RN before March 2017, (b) employed in a NL role at HTMC for two or more years before March 1, 2020, (c) employed in a NL role, from March 1 through May 31, 2020. Nurse leaders were excluded from the study if they (a) became a licensed RN after March 2017, (b) were a NL for fewer than two years on March 1, 2020, (c) first employed in a NL role at HTMC after March 2018, (d) were not in a NL role from March 1 through May 31, 2020. The CNO, all other administrators and administrative directors, administrative coordinators (supervisors), clinical and other nurses, and employees did not meet the criteria for inclusion. They were excluded from participation.

Participant Recruitment

Unlike quantitative research, phenomenological investigation does not aim to create results that are generalizable from a sample to a larger population. Hermeneutic phenomenological research is always about the meaning of lived experience. “And so, it does not make much sense to ask how large the sample of interviewees, participants, or subjects should be, or how a sample should be composed and proportioned in terms of gender, ethnicity, or other selective considerations” (van Manen, 2014, p. 353). Some researchers recommend a minimum of ten participants (Sloan & Bowe, 2013, p. 1298). Others suggest at least three to more than a dozen participants. Still others state that the phenomenological question and goals of the study should determine the number of people to interview (de Chesnay, 2015, p. 19). Nevertheless, van Manen recommends the number of people interviewed should provide sufficient compelling examples of the lived experience to create a scholarly and reflective text (van Manen, 2014, p. 353).

I was dismayed to learn that several NLs at HTMC resigned during or just after the dates of the early COVID-19 pandemic. I wondered if anyone would be available and willing to participate in this research. Despite my concerns, I met with the manager of clinical and nursing research, a nurse administrator, and a clinical NL to describe my study, answer questions, and enlist their support. We reviewed the aim of the study, the proposed methodology, access to participants, issues related to confidentiality, and follow-up requirements. Unfortunately, I was not permitted to attend the Nursing Research Committee meeting to explain the study due to COVID-19 restrictions. Instead, it was presented at the meeting by the manager of clinical and nursing research and was

granted approval. Soon after, I received a formal letter of support to move forward with the study (see Appendix A).

The chair of the Nursing Research Committee distributed flyers inviting the remaining NLs to take part in the study (see Appendix B). Potential participants could also learn about the study from co-workers. The flyer asked for volunteers to take part in a private, audio-recorded, confidential interview about their experiences of caring as a NL in the early months of the COVID-19 pandemic. It listed my definitions for NL and early COVID-19 and included the expected length of the interview of about 60 minutes, the criteria for inclusion and exclusion, that the audio-recorded interview would be typed verbatim, and gave my contact information as well as the email address of my academic advisor. All interested NLs were asked to email or call me for additional details. The flyer also stated that a phone call would take place in 2–3 weeks to further explain the study and that we would meet again in 3–4 months to summarize the experience. To avoid coercion, the names of participants would not be divulged to nurse administrators, other NLs, or other hospital employees. Participants would be assured that they could withdraw from the study at any time without penalty. Although payment would not be offered, a small store gift card would be provided as thanks for participating. I hoped to recruit a minimum of five NLs who had been responsible for or broadly affected clinical nursing at HTMC during the early COVID-19 pandemic.

Protection of Human Research Subjects

Prior to conducting any research involving humans, potential ethical issues must be addressed to protect participants. According to van Manen (1997) pedagogical [or

nursing] researchers minimally need to consider and understand the following challenges before beginning:

> (a) the people involved may feel a wide range of emotions, such as anxiety, guilt, hope, and insight; (b) institutions where the research is conducted may be effected positively or negatively; (c) the research method may lead to lingering effects from intense conversational interviews in the participants that are positive, i.e. new levels of self-awareness and possible lifestyle changes, or if done poorly the person may feel anger, disgust, intolerance, and more; and (d) the researcher may also experience effects, such as deep learning leading to transformation of consciousness heightened perceptiveness, increased thoughtfulness, and tact. (pp. 162–163)

The ANA (2015) encourages all nurses to advance their profession through research and scholarly inquiry. *The Code of Ethics for Nurses with Interpretive Statements* advises soundly constructed, worthwhile research that protects all persons involved by conforming to national and international ethical standards, including review by an IRB prior to beginning the study (p. 22).

In addition, Drew University expects students to complete The Responsible Conduct of Research (RCR)–Basic Course, Parts 1 and 2, prior to conducting any research activities involving humans. The Collaborative Institutional Training Initiative (CITI) course meets the requirements of the U.S. National Institutes of Health, National Science Foundation, and U.S. Department of Agriculture to assure principles, regulations, and rules are practiced before, during, and after research.

After completing the RCR basic course, I submitted a set of documents for review as required by the Drew University IRB along with a request to move forward with the study. The letter of support and cooperation from the manager of clinical and nursing research at HTMC was attached. In addition to the Letter of Support and Cooperation (see Appendix A) and the Invitation to Participate (see Appendix B), the completed IRB documents included the Human Participants Research Review Form (see Appendix C), Informed Consent for the Nature of Nurse Caring In The Early Covid-19 Pandemic (see Appendix D), Demographics Form (see Appendix E), and Debriefing Form (see Appendix F). After all documents were submitted with minor amendments, a letter to proceed with the research was received from the IRB chair at Drew University (see Appendix G).

Participants in a research study must be free from coercion and undue influence through an informed consent process (ANA, 2015, p. 44). The informed consent for this research assures participants that they can withdraw from taking part in the study at any time. If they do, their information and data will be removed, and there will be no penalties from HTMC or Drew University. The Code of Ethics for Nurses with Interpretive Statements (ANA, 2015) concurs and clearly delineates what is to be included in an informed consent:

> Information needed for informed consent includes the nature of participation; potential risks and benefits; available alternatives to taking part in the study; disclosure of incidental findings; return of research results; and an explanation of how data will be used, managed, and protected. (p. 10)

These and other ethical concerns, such as bias and confidentiality, are serious and can lead to long-term problems for researchers and participants.

To address privacy concerns, each participant will be assigned a confidential code to be used on the demographic form, transcripts of recordings, and related documents. When quoting or describing comments made by specific participants, the code or a pseudonym will be used. Typed transcripts and the list of names with corresponding codes and pseudonyms will be maintained in a locked location in the investigator's home. At the end of the study, the audio-recordings will be destroyed. The typed transcripts will be retained for three additional years.

Any participant that exhibits anxiety, stress, or other emotions during or after the interview, will be offered the options to continue, postpone the remainder of the interview, or opt out of the study at any time without penalty. Information about the HTMC confidential Employee Assistant Program (EAP) will be provided. Additional information will be offered about accessing supportive measures from the ANA and other professional nursing organizations for nurses undergoing stress associated with the COVID-19 pandemic. All participants will be given the research study Debriefing Form for their future reference (see Appendix F).

During the following weeks, six NLs called me to express interest in taking part in the study. The information from the invitation flyer was discussed and the informed consent was explained. Each assured me that they met the criteria for participation. The NLs were told they would be called one or two weeks after the interview to see if they had questions or anything else to share or explain. In another 4–6 months, we would meet briefly to go over a summary of their responses. After reviewing the summary, the NL

would be asked if they would like anything to be added or deleted. All NLs remained interested and volunteered to participate.

Determining Quality

Rigor (Validity and Reliability)

Scientific, physical, and biomedical researchers employ quantitative methods that require detached, objective, value-free observation; controlled experimental design; and mathematical measurement. They follow precise rules to seek facts-based explanations, make predictions, and generalize results to larger groups or populations not in the study. The rigor of quantitative studies is evaluated post hoc according to strict research standards for validity and reliability that include independent and dependent variables, sampling techniques, and the appropriate statistical methods used for data analysis (van Manen, 2014; van Wijngaarden et al., 2017). “Validity is the degree to which a scientific study measures what it intends to measure. Reliability means that when the same study is repeated, under like circumstances, it will produce the same measurement” (van Wijngaarden et al., p. 1741). Thus, a quality quantitative study produces valid and reliable, trusted outcomes.

Qualitative researchers have been working for decades to identify specific criteria for evaluating qualitative research. In 1986, Lincoln and Guba developed trustworthiness criteria that include credibility, transferability, dependability, and confirmability (de Chesnay, 2015, p. 14–15). According to Morris (2015), the trustworthiness criteria “are respectively equivalent to quantitative criteria of internal validity, external validity, reliability, and objectivity” (p. 1212). In hermeneutic phenomenology, the participants’ interview responses are the text for analysis. Assuring, adhering to, and verifying the

rigor and merit of phenomenological research is vital, but there is no consensus on a specific strategy to follow. Therefore, the terms validity and reliability should be used because they are synonymous with quality or rigor in scientific or quantitative research. Without using the same terminology, qualitative research has been viewed as lacking rigor and unscientific. For this reason, some qualitative studies have been ignored by policy makers and practitioners, causing qualitative researchers to have difficulties with securing funding or becoming published (Morse et al., 2002). The trustworthiness criteria can also be problematic when qualitative researchers use them solely to evaluate their finished research because attention to rigor should be ongoing from the beginning until the end of a study (Morris, 2015; van Mannen, 2014). Morse (2015) cautioned researchers to be judicious when selecting strategies to accomplish rigor in qualitative research. A qualitative researcher's arbitrary use of techniques designed for specific qualitative methods may be harmful to achieving validity and reliability in other qualitative approaches.

Despite the above, as a novice researcher and doctoral student, I will support and explain my research evaluation selections by using a combination of Lincoln and Guba's method for trustworthiness plus other evaluation criteria for phenomenological research.

Credibility (Internal Validity)

Credibility means that the truth of the data or participant views are verifiable and trustworthy. Credibility is often demonstrated by prolonged engagement, observation, triangulation, peer debriefing, audit trails, and member-checking. The selected qualitative method and the amount of data collected must be suitable to the research method (Amankwaa, 2016, pp. 121–122; Cope, 2014, p. 89; Stenfors et al., 2020, p. 598).

Prolonged Engagement. Prolonged engagement is the process of spending adequate time with the participants to build trust and rapport, understand their culture, and identify and clarify any misinformation. The more time the researcher spends getting to know the participants and collecting their data, the richer, more detailed the descriptions will be. The extent and depth of the study increases as the researcher has time to focus on the participants' feelings about their experiences. In unstructured interviews, such as those in hermeneutic phenomenology, it is best for the participant to get to know the researcher before the interview takes place (Cope, 2014; de Chesnay, 2015; Morris, 2015).

Before I began this research, I had the advantage of working at HTMC for nearly 15 years as the MPC. I understood that the organizational goals and culture aligned well with the Magnet program requirements, and I felt comfortable with the hospital administrators and employees. I worked often with all the NLs and hoped to enroll some of them as participants in my research. Although I knew each of them by name and spoke with them often, I wondered how my retirement plus the COVID-19 pandemic would affect our relationships. I took the time to reconnect with each NL by telephone, during the initial visit, and again immediately before each interview. This helped us to relax and gain trust with each other, especially as they shared their personal experiences of caring during the early months of the COVID-19 pandemic.

Triangulation. Triangulation enhances the depth and scope of a research study and is another way to establish validity. There are four approaches: data, investigator, methods, and theory. It is preferable to use at least two sets of data (interview texts) or at least two approaches to accomplish triangulation (Morris, 2015). *Data triangulation*, or

source triangulation, looks to the perspectives shared during the interview of one participant at different times during the same study, or of several participants with differing opinions, or of participants from different demographics or backgrounds. *Investigator triangulation*, or analyst triangulation, means that more than one investigator, such as members of the research team, review findings to identify potential bias or missed information in an interpretive analysis. In *methods triangulation*, the researcher uses various resources throughout the research to gain additional information about the phenomenon and to check for consistency. Methods include interviews, document analyses, literature reviews, and reflexive journaling. *Theory triangulation* means the investigator examines and interprets the data through multiple theoretical perspectives (Amankwaa, 2016; Cope, 2014; de Chesnay, 2015; Morse, 2015).

I accomplished data triangulation by interviewing six NL participants. Their professional differences, plus their personal lifeworld experiences, were the bases of their varied perceptions of caring during the early COVID-19 pandemic. The hermeneutic circle, or the going back and forth between the themes and the original transcripts, was another method to check and recheck my interpretations against the participants' descriptions explanations.

To accomplish investigator triangulation, I met routinely with my dissertation readers to explain my analyses, answer questions, and discuss sources of possible bias or missed information. During the interviews, I was cautious not to introduce unintentional bias to the interviews through my facial expressions, body language, and comments. And because the NLs already knew me, I realized they might gear their responses toward what they thought I would want to hear instead of openly sharing their experiences.

Methods triangulation was performed by ongoing reading and viewing the COVID-19 experiences of NLs in printed news stories, television, social media, memoirs, books, and professional websites.

Theory triangulation was not done for this hermeneutic research.

Peer Debriefing. Peer Debriefing, or review, is a method that helps with internal validity. The investigator recruits a trusted peer to meet routinely to review the study as it progresses. At the meetings, the researcher and peer discuss and collaborate about thoughts, feelings, and concerns with the research processes. Entries in the researcher's reflexive journal may also be reviewed. The meetings help the researcher identify gaps in the data, synthesize concepts, and discover possible biases (Amankwaa, 2016; de Chesnay, 2015; Morris, 2015).

While I did not participate in debriefing meetings with any peers during this research, debriefing activities were fulfilled by my dissertation readers. See investigator triangulation.

Member Checking. Member checking occurs when the investigator meets with participants at intervals, such as after completing the interviews, after theme creation, and after data analysis. Terminal member checking may take place after completing the final data analysis. Participants are asked to read portions of the analyses to verify whether the text is an accurate representation of the interview, make changes, or give additional information. Sometimes issues related to member checking can cause dilemmas for researchers. For example, there are no distinct justifications why any participant should be able to revise the text. A participant may not even recognize his or her own story in a text that is an abstraction of multiple interviews (Morris, 2015; Sandelowski, 1993). Also,

recollections often change over time. A participant may no longer recall the events of a specific moment described in the text. Stories that were told with emotion may have been forgotten or have lost relevance to the participant. The participant may even disagree with the investigator's analysis. This could cause an ethical dilemma regarding whether to retain accurately transcribed information or remove it and then extensively revise an entire portion of the analysis. And finally, there are no recommendations about what to do if a participant wants any or all the text changed or discarded (Sandelowski, 1993).

I began member checking at the onset of this research. When I enrolled NLs for my study, they were informed that we would be meeting individually at least four times. The first time the NLs were interviewed was the fall of 2022. They were reminded that they could withdraw from the study at any time and their data would be removed. I met for the second time with each NL approximately three months after their first interview. These individual meetings took place over a period of 2–3 weeks in the spring of 2023. COVID-19 restrictions were loosening, making it easier to find private locations to talk. During the second meeting, the NL was asked to read a draft of Theme I and share opinions. I noticed that two participants nodded while reading various sections of the theme. This is the "phenomenological nod" that indicates the interpretation of the text resonates at least partially with the participant's meaning of the experience (Munhall, 2012; van Manen, 1997). Another NL asked me to change one sentence for clarification about who was speaking. There were no questions or negative comments in these meetings. All NLs were satisfied with the content and encouraged me to continue writing. We agreed to meet again in three months.

The third meetings were all scheduled to take place at the end of June 2023 as we agreed. However, three weeks before the first scheduled June meeting, I suffered a traumatic injury when I tripped, fell, and fractured both ankles. One was a simple break, but the other was a compound fracture that required emergency surgery. I was hospitalized for two days after surgery and spent the following two weeks in an acute rehabilitation facility. I was in considerable pain, confined to a wheelchair, and not permitted to stand at all. I was able to email each NL and cancel our meetings while I was in the rehab facility. Before I could be discharged, I had to learn to use a walker to transfer to and from bed and pull myself into and out of a car without standing on either leg. The following three months were a blur of pain, struggling to do even the most basic daily activities. Physical and occupational therapy sessions took place at home three times a week. Eventually, I progressed to outpatient physical therapy three times a week . I required a family member to drive me to and from appointments and continued to use a wheelchair most of the time until I was discharged from outpatient care in October.

I was finally able to schedule individual NL meetings beginning in September. I was starting to use a cane, but I could only walk short distances. Fortunately, we were able to meet in locations on the first floor of the medical center, which made it easier for me to use the wheelchair. I think these meetings went well. I shared potential titles and summarized the themes. Each NL asked a few questions, but there were no disagreements. I asked two NLs to read what I wrote about them in portions of the text. I was concerned about confidentiality with one, because the name of the NL's department was revealed. I had a similar concern about the other NL and also was concerned that the information revealed in another section might be considered too personal. I did not want

to write about it without permission. Both NLs gave approval and asked me to continue with no revisions. All NLs agreed to a final meeting in another three months.

Meanwhile, I continued writing. It was slow going at first. I continued having difficulty concentrating until about six months after my injury and surgery. I met for the last time with each NL in December 2023, approximately one year after our original interviews. Happily, I was able to walk without casts, walkers, or canes. It was good to be on both feet again! At each meeting I went over the purpose of the research and described some of the analyses. I distributed and explained the Drew University debriefing form. I had already shared much of the debriefing information informally with them at previous meetings or by email. In closing, I thanked each for their trust and honesty. I gave them a thank you card with my telephone number and email address. It also contained a gift card as promised in the invitation to participate. As with our initial meetings, some NLs chatted with me for a while and others immediately returned to work.

Dependability (Reliability)

In both quantitative and qualitative research, dependability, or reliability, means the ability to obtain the same results if the study were to be repeated in precisely the same way. In qualitative research, reliability also means that the processes of data collection, interpretation, and analysis are dependable, consistent, and can be replicated, although conclusions will likely be different (Amankwaa, 2016; Morris, 2015; Stenfors et al., 2020).

Audit Trail or Audit Inquiry. An audit trail, also known as audit inquiry, consists of documents saved from the beginning of the study until the end to establish reliability or dependability. Unlike the peer debriefing which reviews internal validity, the

audit trail establishes external reliability by examining the step-by-step activities taken to learn what was done (or not) and how decisions were made throughout the research process. The researcher meets routinely with a different researcher who is not involved with the study to investigate the processes and outcomes of the research for accuracy. Documents are evaluated for authenticity and consistency to determine whether the data supports the findings, interpretations, and conclusions. Constructive feedback is provided by the auditor. Audit trail results are written up in a journal and retained for future review (Amankwaa, 2016). Despite the above, Morse (2015) asserts that external audits provide limited value for validity, and none for reliability. They are usually done by external auditors at the end of the study, making it too late to address any problems.

Because this research is in progress, it is unknown whether sufficient steps were taken to repeat the study, but as described earlier, the steps were reviewed by others throughout the research processes. A specific audit trail was not planned for this phenomenological research.

Transferability or Generalizability. Transferability means that conclusions based on the study of specific individuals, settings, times, or institutions can be generalized, or applied, to similar contexts. Readers of a research report require rich, thick descriptions to envision the results in their own settings. Individuals or groups not involved in the study will still find meaning in the study results (Amankwaa, 2016; Cope, 2014; Morris, 2015). Generalizations in the empirical or quantitative sense are factual and cannot be drawn from phenomenological inquiry. Nevertheless, existential and singular generalizations are two kinds of phenomenological generalizations. An existential generalization is one that makes it possible to recognize recurring aspects of the meaning

of the phenomenon. A singular generalization makes it possible to recognize what is universal about a phenomenon (van Manen, 2014, p. 352).

Thick Description. A thick description is provided by the researcher to reproduce the essence of the phenomenon being studied as clearly and as detailed as possible. “Rich descriptions that explore the meaning structures beyond what is immediately experienced gain a dimension of depth” (van Manen, 2014). One-word descriptors and short sentences do not constitute a thick description. Instead, the text should be rich, vivid, and artful so that the reader can visualize the phenomenon of interest. In interview studies, internal validity can be presumed when there are sufficient examples from multiple participants describing similar experiences, even though they are not exactly the same (Amankwaa, 2016; Cope, 2014; Morris, 2015).

The NL participants shared many rich, thick descriptions about their experiences of caring in the early COVID-19 pandemic. When responding to the open-ended interview questions, participants were encouraged to say as much (or as little) about their experiences as they wished. Each NL gave in-depth, vivid descriptions about various caring occurrences. Often more than one NL spoke about the same phenomenon, yet each perspective was uniquely based on their situated context within the medical center and their personal and professional lifeworld experiences. During each interview, and later as I listened to their recordings, and re-read the transcribed interviews, I felt like I was transported to HTMC. It was as if I were following each NL, thinking their thoughts, seeing their surroundings, and feeling their emotions as they cared for patients, staff, and themselves.

CHAPTER 8

Data Analysis

> Themes are the stars that make up the universes of meaning we live through. By the light of these themes we can navigate and explore such universes. (van Manen, 1997, p. 90)

Reflecting on Essential Themes

I looked forward to analyzing the experiences that were shared by each nurse leader. I began each interview by attempting to bracket out (the epoché) my own preconceptions, familiarity, experiences, and memories of HTMC and the NL participants. "The aim [of the epoché-reduction] is to connect directly and immediately with the world as we experience it–as opposed to thinking about it. Here judgments and theories are temporarily suspended to see the world afresh" (Finlay, 2009, p. 476). Although van Manen (2014) describes many different approaches to epoché-reduction, it is most important to realize that the reduction is meant to give meaning and significance to the prereflective (unconscious) lifeworld, through the experience of reflective writing (p. 220).

I started the analysis by listening to each audio-recording twice. I was surprised that the interviews were only 25–48 minutes long. Although they were shorter than the 60 minutes that I anticipated, they were filled with rich descriptions. I then listened to the recordings again and typed each transcript verbatim into six separate files on my personal computer. I named each document with the numerical code that the NL was assigned during our interview. After typing, I had six manuscripts that ranged from 6–11 single spaced pages. I also reviewed my personal journal and the notes that I made during the interviews for additional insight.

Creating Themes

I was ready to begin creating themes for analysis. But how does one create themes from phenomenological reflection? I knew about computer software programs that code and classify texts and other data sources for qualitative thematic analysis. But van Manen points out that phenomenological theme analysis is not simply making use of frequency counts or coding selected terms found in transcripts of texts. Instead of being restricted by precise rules, the researcher ponders the texts to find meaning in participants' lived experiences. Through insightful processes of invention, discovery, and disclosure, the themes are revealed (van Manen, 1997; 2014). The researcher examines the text and reflects on the content until something "telling," something "meaningful," something "thematic" is revealed (Sloan & Bowe, 2014, p. 1292). Although creating themes for analysis can be tedious and challenging, I looked forward to delving into the NLs' narrative descriptions. After listening to, transcribing, and reading the six different narratives, it was time to identify themes that would help me to bring meaning to their lived experiences.

van Manen (1997) calls themes the structures of experience that give control and order to our research through written interpretations of lived experience (p. 79). This was complicated! There were so many experiences to consider. Over and over, I reflected on my original question: What is the nature, or lived experience, of caring by nurse leaders during the early COVID-19 pandemic? I wondered how to create themes that would capture the meaning. I recalled that the researcher becomes an active participant in the data analysis or interpretation by using empathy or relevant past experiences (Sloan & Bowe, 2014). I had no nursing experience during a highly contagious respiratory disease

outbreak like COVID-19, but I cared for patients and led staff during the onset of the AIDS pandemic. We didn't know the mode of transmission then either. There was no known cure. Everyone was confused and afraid.

According to van Manen (1997), themes can be looked at as tools that help us get to the meaning of an experience. By creating themes, we give form or expression to endless thoughts and examples shared by participants. A good theme touches the very core of the experience that we try to understand. Despite good theme(s), no thematic interpretation can completely open us to the deep, mysterious, inexplicable aspects of the experience (p. 88). The hermeneutic circle, or the going back and forth between the themes and the original transcripts, was another method to check and recheck my interpretations against the participants' descriptions.

There are three major approaches to uncover themes that van Manen describes. In the *wholistic reading approach*, the researcher reads the entire text searching for the main significance, and then formulates a phrase that captures the essence of the entire text. In the *selective reading approach*, the researcher listens to or reads through a text several times searching for and highlighting statements or phrases that are essential or meaningful to the phenomenon or experience. The highlighted meanings are captured in thematic expressions or longer reflective descriptive-interpretive paragraphs, then copied and saved as possible theoretical "gems" for developing and writing the phenomenological text. In the *detailed reading approach*, every single sentence or sentence cluster is reviewed to identify and capture thematic expressions, phrases, or narrative paragraphs that reveal meaning in the text. If the entire account is powerful, it may be lifted out as an exemplary story or anecdote (van Manen, 1997; 2014).

I admit I tried each approach with varying success. When I tried the wholistic approach, I felt overwhelmed by trying to identify the one phrase that would exemplify the meanings of the memories shared by the nurse leaders. I did not feel it was the best way for me to find meaning. I started over, using the second approach. I highlighted all meaningful sentences and phrases related to the nature of caring by the NLs during the early COVID-19 period. I used a different color for each possible theme. I repeated this process, using the same colors for matching themes in each transcript. The selective highlighting approach was helpful for organizing the potential themes. Next, I created a table with columns for each color-coded theme. I inserted the highlighted phrases into the columns of themes with corresponding colors. This process was followed using all six transcripts. It worked well because I could move phrases back and forth between the different categories as I reflected on the interviews. The table was copied into a new folder for additional analysis. I was still uncertain, so I tried the line-by-line approach. I created a spreadsheet using the same color-coded themes for categories and pasted the color-coded sentences or phrases into the thematic category that seemed most appropriate. This method was also helpful but seemed too fragmented for me to make anything meaningful from the phrases. I needed to do something else to help me to access meanings in the text.

Once again, I returned to the original transcripts. I realized I had transcribed too many unnecessary comments, murmurs, and phrases. I had included some phrases to encourage the participants, like “go on,” and “uh huh.” I deleted them. I reviewed all NL expressions that were unnecessary, such as “um,” you know,” “like,” “everything like that,” and “it’s just.” I eliminated these phrases and other words that were repeated by

speakers while thinking about what to say. By removing some of the extraneous comments that are often used in day-to-day conversation, the text was easier to read. I started the process again and was more open to reflection on the meanings as given.

This was the hermeneutic circle. By going back and forth repeatedly between the textual data and the phenomenon of interest, by reflecting deeply and considering the NL expressions and their situated context, the nature of caring by NLs during the early COVID-19 pandemic was revealed (Neubauer et al., 2019). The process was lengthy, but ultimately, I found my own way.

As I reflected deeply on the interviews, five themes emerged: (a) on the cusp, (b) protecting, (c) caring for, (d) going in blind, and (e) appreciation. Each theme had three subthemes that clarified and contributed to the overall meaning of the theme.

CHAPTER 9

The Lived Experience of Caring by Nurse Leaders in the Early Covid-19 Pandemic

> Today if there was an influenza epidemic similar to the one that occurred in 1918–1919, would we as nurses be prepared to handle it? (Robinson, 1990, p. 25)

Prologue

On Tuesday, March 10, 2020, Governor Phil Murphy announced that a 69-year-old man from Bergen County was the first NJ resident to die from the new coronavirus, later known as COVID-19. Before he retired, the man had been a horse trainer with connections throughout harness racing communities in the region. A week earlier, the man had received antibiotics from his primary physician for a fever and cough, but his condition deteriorated. Medically, he had a history of several chronic health conditions, including emphysema, diabetes, and hypertension. He was hospitalized on Friday, March 6, went into cardiac arrest and was resuscitated, but he arrested again and died four days later (Davis, 2020, March 20; Herbst, 2020, March 19).

By Thursday, March 12, there were four known cases of the novel coronavirus in New Jersey. To protect the public, patients, employees, and administrators, HTMC collaborated with other NJ hospitals to control transmission of the virus. But the disease was already spreading throughout the state. The following day, a woman who was hospitalized for treatment at HTMC became the second NJ person to die from the novel coronavirus. Prior to her death, lab samples were obtained and sent to the NJDH and the CDC. The COVID-19 diagnosis was verified a few days later. Health Commissioner Persichilli announced that the woman, who was in her 50s, was one of several people who tested positive for the coronavirus after attending a large family gathering. The man

who died in Bergan County was a close friend of the woman's brother (Herbst, 2020, March 19; Tully, 2020, March 18).

The deceased woman was from a family of well-known horse trainers and harness race drivers in the region. Originally from Italy, her parents settled in NJ in 1975 and raced at regional tracks for decades. The family eventually grew to 11 children, 27 grandchildren, and three great-grandchildren. On weekends, many of the children brought their own families to enjoy dinners at the home where they grew up. Although widowed in 2017, the family matriarch continued to enjoy going to church and cooking Sunday meals for her family. Many of them met for Sunday dinner on March 3, 2020. That gathering is thought to be the source of the coronavirus outbreak that caused multiple tragedies for the family. Eight family members rapidly contracted the coronavirus. Five, including the matriarch, died within two weeks and three others were hospitalized at the same time. Sadly, twenty members of the extended family were left to grieve alone and unable to comfort each other because they were quarantined as they awaited their own test results (Herbst, 2020, March 19; Sheridan, 2020, March 19; Tully, 2020, March 18).

Many articles were published about the family. They illustrated the magnitude and the contagious nature of COVID-19 in the early spring of 2020. Every day the NJ governor and the commissioner of health announced more cases and more deaths. Soon, the number of people who would become ill and die from the coronavirus was extensive.

NJ Advance Media began publishing and updating NJ state and county-by-county lists of confirmed and presumptive coronavirus cases. On March 20, two days after the family matriarch passed away, there were 890 confirmed or presumptive cases of coronavirus and 11 deaths in New Jersey. By April 1st, just three weeks later, there were

22,255 confirmed or presumptive cases of coronavirus and 355 deaths in New Jersey (Goldman, 2020, April 2). Clearly, the rapid increase in the number of cases and deaths was unprecedented. The sheer number of sick people made data collection difficult, presumably because people with mild cases were not tested. Some cases would not be identified and reported until months later when antibody testing became readily available.

As many more NJ residents rapidly developed symptoms of COVID-19, hospitals throughout the state became overcrowded with sick and dying patients. Nurses working in hospital EDs were not prepared for the numbers of people who began to arrive in early March 2020. The situation was dire.

Theme I. On the Cusp: COVID-19 Arrives

During the first quarter of 2020, NLs at HTMC were focused on preparing for a Magnet appraiser site visit in March or April. This was to be the hospital's fourth Magnet designation; an honor achieved by nurses in just 2% of healthcare organizations at that time. The NLs were busy ensuring that their policies and procedures were up to date, staff meeting minutes and outcomes for nurse sensitive quality improvement indicators were available, and nurses and support staff were ready to meet and converse with the Magnet appraisal team.

We Didn't Know What was Happening

Most of the NLs felt that COVID-19 was worrisome but not an immediate threat. The virus was miles and miles away. No one thought that HTMC would be among the first hospitals on the east coast to admit and treat COVID-infected patients. Although some nurse leaders claimed it was earlier (1010, 1014), the first patients sick with COVID-19 arrived at HTMC in March 2020. "The beginning for us started when that

family came into the ED. That was the beginning" (1020). One NL explained how unprepared they were. "When we got our first COVID patients, they came from our community. They came to us, walking in, and died within two hours. We didn't know what was happening!" (1010) Another NL was amazed when COVID patients were admitted to HTMC and said, "You would think as a health professional I would be more mentally prepared or expectant of where we ended up in March. But it's not real until it hits home" (1014). This NL continued, "You wait until it's knocking at your door to make a response. Not that it wasn't real, but it wasn't reactive real until it was here. And I said, oh shit! Now what? And then suddenly it just skyrocketed" (1014).

Another NL said, "I'm a nurse for over 30 years. I went through HIV. I went through Y2K when all the computers were supposed to crash. I went through anthrax [scares] and other things. But I've never gone through anything like this. Ever" (1010). The unexpected nature of the situation was confirmed by a NL who explained how the entire hospital was unprepared, "Everything else was stopped in order to get the minimum amount that we needed to get these patients on board. So… [pause] in March we did not know what we were doing. Nobody knew" (1016).

Am I Gonna Get Sick? Am I Gonna Die?

When the first COVID-19 patients arrived at HTMC, no one imagined how deadly the disease would be. Nurses and other staff immediately acted to relieve their patients' suffering and save their lives. Tragically, there were no known COVID treatments at the time and many patients died within a few hours. The NLs all described the early weeks of the pandemic as a very scary time. The Index (I) family's tragedy affected everyone. One NL did not directly care for them, but said:

> I heard that Momma came in and said, 'I don't feel good, Jenny doesn't feel good, Nick doesn't feel good, Lenny doesn't feel good, Angela doesn't feel good.' As they were talking to them, they were deteriorating right in front of you. (1016)

Another NL explained what it was like for nurses and other staff to care for the first COVID patients. They knew the danger was real and no one was sure what to expect. "I think there was a time period of feeling that you're running into a building and it's 9/11! That's what it was like for people" (1018). A different NL described how an experienced clinical nurse on her staff reacted with stunned frustration and grief when she couldn't save the patients in her care. "And she cried after the first patient came in and died. Then the second patient came in and died. And she's strong. She's a very, very strong woman" (1010). And another NL said, "A family came in with COVID-19 and five of the six people all died. It just broke me. Because one day everything's fine, you have a party, and then in a week everybody's on their death bed!" (1014)

It wasn't long before the same experienced nurses who were crying because their patients were dying, wondered if they, too, were at risk. Should they have been wearing additional PPE? Their NL expressed their anxiety. "All of a sudden, we have to garb all this stuff on, and we didn't in the beginning. 'Am I gonna get it? Am I gonna get sick? Am I gonna die?' That's how they felt" (1010).

That led to a new concern. How do you lead and care for staff who are afraid to take care of their patients? As one NL explained, "There was a lot of fear of walking into rooms, spending time in the rooms, and then I thought about who was going into the rooms" (1018). Another NL felt the anguish experienced by staff when they faced the death of the first COVID patient admitted to their unit. "When I came in the next

morning, everybody was just… different. Like there was an aura and a shadow over everyone. They were all just straight eyed, staring at the wall, crying. It was… It was… it was tough [looks off, remembering] (1014).

As the number of COVID patients grew, the level of fear throughout the organization increased. One NL explained, “Those who panic, their panic grew. It wasn’t only nurses. It was patient care technicians, social workers, therapists, physicians” (1020). Another agreed. “Because it’s very scary. A very scary moment. We definitely didn’t know what we were dealing with at the time” (1012). And yet, it wasn’t all uncertainty and fear. One NL said,

> A young surgeon came to me and said, ‘Isn’t this exciting? You can tell your great-grandchildren, or they could read about what you did.’ And it was. There was something about it. We were on the cusp of a world-wide problem.” (1016)

My Manager Brain Kicked in

To protect NJ residents from COVID-19, all schools and non-essential businesses were ordered to close. People were advised to stay at home and avoid contact with others. The NLs had to face their own anxieties about the highly contagious disease and decide whether they should continue working. Most of those who remained either consciously or unconsciously revised their leadership style from a participative or transformational style to become more directive. In fact, some NLs used the following terms when describing their role: “I needed to care for my troops” (1010); “I am a leader of the unit. I am the captain of the ship” (1012); and “Let’s face it, being a manager, they’re kind of like your kids to a degree” (1014). One NL explained the leadership obligation of caring for the nurses and other staff. “I needed to hold my troops together. And that was my biggest,

biggest challenge. I had to care for them" (1010). Another NL shared the self-reflection required to assure care for COVID patients, "As a leader, there were a lot of my own feelings I had to understand. I've never been afraid to take care of patients. I wasn't afraid to take care of the COVID patients, but it was definitely scary" (1014). Still another NL felt responsible not only for the sick patients, but also the staff and said,

> As a leader you have to understand that the caring part of it is not just for the patient. Now you need to care for your team to make sure they come back with you the next day and be there again to repeat the process. (1012)

There were so many unknowns during the early days of the pandemic. One of the newer NLs was concerned about responding appropriately to the staff's emotional needs:

> There's a lot of people that look to you for advice, answers, and venting frustration. You know, being afraid and looking for support. It's hard to support somebody when you don't know what you're supposed to do. It was definitely a challenge. (1014)

Nearly all the NLs at HTMC chose to continue working during the chaotic days of the early pandemic. Despite multiple stressors, they were able to concentrate on their roles within the organization. Most found solidarity and comfort that other nurses were in the same situation:

> So, you found yourself there and you found that other nurses were there, too. And it's not that you really gave it thought of, should I go in to work, should I not go in to work. You just found yourself pulling in to work because this is what you did. (1018)

One NL told of overcoming personal fear and disbelief:

> My manager brain kicked in. What are we doing? Do we have to worry about managing supplies? Do we have to worry about managing resources? Do we have what we need? But at the same time, I had to emotionally support my staff, because my unit's very busy and they're already stressed. And now you're adding this [pandemic] to the mix? (1014)

And finally, another NL expressed the enormous responsibility of remaining a NL during the early days of the pandemic. "It was probably one of the most substantial moments in my own nursing career; that small blip of time of the initiation of the COVID pandemic" (1018).

Theme II. Caring is Protecting

Most NLs have some experience with keeping their departments running smoothly while getting things done under pressure. But managing anxious employees during the first chaotic stages of a pandemic was an entirely different matter. It was flu season, and the staff had been vaccinated, so no one was overly concerned when patients arrived at the hospital with respiratory symptoms. However, when the patients died quickly, everyone realized that they had been exposed to some of the first patients infected with COVID-19 in the country. This was serious!

Communicating Rapid Changes

Administrators at HTMC routinely hold a daily administrative department head meeting, or huddle, to review current goals, share concerns, and discuss recent issues affecting the organization. One of the agenda topics in the administrative huddle is patient safety. When the Index family members were admitted with COVID-19, everyone had to be extra cautious. One NL said:

> [For safety], they would usually announce locations of people with the same names: two Smiths, one's here, one's there; two Browns, one's here, one's there. But there were six people in a row with the Index family's last name in ICU! It was, here's another family member and here's another one. Put this one here, and this one here, and this one here. We had to move quickly. (1016)

Because NLs are the liaison between their staff and administrators, they were always advised to attend and participate in administrative huddles. Early in the pandemic, these meetings were dominated by the latest CDC and New Jersey Hospital Association (NJHA) recommendations related to COVID-19. But the CDC communicated new rules so often that it led to uncertainty. As one NL put it, "You don't know if you're doing things right or doing things wrong. Because at that time the CDC gave new guidelines every day, by the day, if not by the hour, and it caused a lot of confusion" (1012).

It was confusing for many NLs. Every day was something new. Everyone was worried about catching the deadly disease or giving it to someone else. As COVID-19 took hold of the community, it was clear that in-person meetings were dangerous. Teleconferences became the main link between administrators and nurse leaders. Everyone needed to know more about the new disease, how to protect themselves, and how to treat their patients.

Soon, "the medical director began holding additional COVID meetings twice a day on the phone with a core group, called the COVID team, to share anything from the NJHA on how to treat COVID patients" (1010). This was helpful because the COVID team would be available to answer questions about current practices and help with difficult decisions. The COVID team also sent the NLs data about patients admitted to

HTMC with the virus. It was no surprise that the nursing staff wanted to know what was happening. “Are the numbers going up? Are they going down? How many died? How many patients died today?” (1010) The nurses knew that most COVID-infected patients were admitted through the ED, put on ventilators, and sent to critical care. They were anxious to know if any of their patients survived.

Connecting with Nursing Staff

At the beginning of most shifts and when major changes occur, NLs of clinical areas call for a unit-based huddle; a short meeting to update the staff and answer questions. This huddle usually lasts less than ten minutes and is not the same as change of shift report where outgoing nurses provide clinical and other information about their patients to the nurses who will be responsible to assure care during the next shift. The huddle gives employees at all levels an opportunity to learn about the status of their department and what might affect their work.

It was challenging for NLs to keep their staff informed about so many changes. Some had to call staff away from patients and other responsibilities to attend their unit huddles whenever changes were announced (1014; 1018). One NL remembered, “I would call them to the nurses’ station and talk to them three times a day. This is what’s new. We’re gonna do this. This is the best thing we’re gonna do with PPE. Or does everyone know how…” (1018). Another NL voiced frustration about the rapid changes. “So, in March we didn’t know what we were doing. Nobody knew. You need a mask! You don’t need a mask! You should have a mask! Maybe you need a mask! You don’t need the gown!” (1016) It was difficult to remain composed when instructing the staff about frequent changes to PPE requirements. One NL exclaimed,

> There was panic. There was a lot of confusion. Don't wear masks unless you're with patients that have COVID-19. Oh! You have to wear an N95 [mask]. Oh! You don't have to wear this; you should wear this. It was constantly changing. It was very stressful. (1018)

And yet, the NLs understood that their situation was far from ordinary. Most had similar comments as one NL colleague who said:

> I do think, for whatever reason, a lot of decisions were made immediately without a great deal of thought. It was so quick! Monday things were normal. Tuesday, it's everyone wear a mask! But, thinking back, I probably wouldn't have done any better. (1016)

Personal Protective Equipment

Once the latest COVID-related information was shared through the administrative huddle and the daily COVID call, any new or revised recommendations were announced by email. Of course, the staff wanted to know as soon as something new was reported. One NL explained, "Every day we didn't know what to do and I didn't know what to tell them. So, every day you're reading through your emails to see what the change in your PPE is today" (1014).

Although the administration tried to reassure everyone, they couldn't prevent the staff from watching TV and other media at home. News reports emphasized that hospitals in New York and other nearby states were running out of masks, gloves, and other PPE. At their unit-based huddles, the NLs encouraged staff to discuss the latest rumors and tried to reduce their anxiety. As one NL put it, "Watching news where New York City nurses were wearing plastic bags to protect themselves, I wondered, are we gonna get to

that point? And then talking your staff off the ladder from those conversations" (1018). Another NL also worried about the possibility of running out of PPE. "We still have the PPE that we need, but we know what we hear on the news. You know what the director infection control tells you; the limitations of what you have" (1012). The thought of running out of PPE was worrisome. There were so many possible scenarios. One NL said:

> You see young people going into respiratory distress and hear that ventilators are not available and you're having conversations about how to split [share] ventilators. You're having conversations about running out of PPE and how to keep yourself and your staff safe. (1018)

One NL, whose department was closed, assisted a night supervisor by making rounds and helping in any way that she could. On an especially hectic night, the supervisor was attending a code when staff from several patient care units began calling to say they were running out of gloves and gowns. The busy NL was told to get a pass key from the nursing office, open the warehouse doors, call the units, and instruct the staff to go and get what they needed. The NL reported:

> So, they did. And that morning we went to administrative huddle, which was still in person at the time, and the CEO [chief executive officer] was code purple, because they went down and cleaned it out! They took gloves. They took everything. There was nothing left. Even physicians were walking in the hallways with boxes of masks. (1016)

The CEO instructed everyone to return all PPE to the warehouse. "But we never got it all back. 'Cause people took it home. They took it to their office" (1016).

Another NL became upset when the administration started conserving PPE by requiring clinical staff to wear one N95 mask for a full day and said, “Hold On! The CDC just said that you have to wear a *new* mask every time you go into a room! And you’re telling us we have to wear the same one for the whole day?” (1014) It was true. The hospital’s supplies of PPE, including gowns, gloves, goggles, masks, and other important items were running low. It was becoming difficult to follow the CDC and other health department instructions for protecting everyone. One NL frowned and said, “Sometimes I wanted to fire everyone for their complete lack of adherence to policy and protocol. I would say that’s pretty critical! I want to have this wonderful story of all this warmth and kumbaya. No, it wasn’t always kumbaya” (1020). Although other NLs also were worried, they were told not to panic. There was no need to re-use masks or gowns. But one NL strongly disagreed:

> You hear it on the news. We know that the supply chain went down, and the raw materials cannot get to certain places because of COVID-19. Production is cut, so there’s no PPE coming every day. Yet, you have to work with your supply for a certain period of time. (1012)

The hospital PPE supplies continued to dwindle. According to one NL, “And then it turned into, we’re gonna take those masks and sterilize them so you can use them for three days. So, you really started to feel the pressure to keep resources” (1014). Another described how difficult it was to assure some protection for everyone.

> We were at that point that we had to … how do I say this? We sterilized our own mask! We sent it downstairs for decon[tamination] so we could reuse it again,

> because the supply was gone. And then we had to reuse the gowns for an extended period of time, too. (1012)

Another agreed. “The supply concerns and issues were terrifying. We were at the point where we had to reuse our gowns. People were making gowns out of garbage bags in case we ran out (1014). The NLs had to assure that PPE would be available and labeled for the staff to reuse. One NL said, “There were times when we had to reuse PPE, so we created a room with [wall mounted] hooks labeled with people’s names for them to hang their PPE” (1018). The NLs also had to secure their units’ PPE. The same NL explained, “I remember having to lock PPE so that no one would take an abundance to give to people outside the hospital” (1018).

And finally, one NL compared the difficulties of leading during the COVID-19 pandemic to working with frightened staff and very sick patients during the early AIDS epidemic.

> People double-gowned, triple-gloved, triple-gowned. They said, ‘I won’t go into that room. Or, you can’t give me that assignment. Or, I won’t take care of…’. Our knowledge may have grown, but people are people. They say and do the same things now. (1020)

Theme III. Compassion for …

Patients and Families

When the first COVID patient walked into the ED at HTMC and died within two hours, the medical director immediately informed the CDC, the NJDH, and local public health agencies, that people infected with COVID-19 were arriving at the hospital. He asked for an appropriate treatment plan to save their lives. But there was no known

treatment plan! Establishing the medications, procedures, and nursing care that were needed became a priority. One NL explained, “Everything else had to go away so we could figure out, what are we doing here to take care of these people with this virus” (1016). Another lamented, “A lot of the treatments were questionable, so you have to really make sure that your team can provide the care” (1012). Still another said, “It’s the hardest thing for a nurse, when somebody wants your help, and you don’t know what to do” (1010).

This was confirmed when additional members of the Index family were admitted. As one NL explained, “I was sitting there with the medical director who was on a call with the CDC. He said, ‘We don’t know what to do with these people.’ And the CDC said, ‘Supportive care. We don’t know what to do either.” (1016)

That was troublesome. One NL described what it was like to primarily provide supportive care. “Our care included spending more time with the patient. We went back to very basic nursing because you want to maximize the time you spend with the patient although it would still be limited” (1012). Another NL agreed:

> You’re limiting your nursing care to an extent because you don’t want to spread COVID or waste PPE. You’re only going in for necessity, really, so we batched everything. Like, we batched meds with lunch and so many of the other services we needed to provide. (1018)

Supportive care wasn’t very effective, but one NL wasn’t confident in subsequent medical plans either. She explained, “They’re telling us don’t intubate them. Don’t put them on a ventilator. Don’t give them steroids. So, we followed these directions, and we would watch them die” (1010).

COVID treatment plans were often revised several times a day. Eventually, some procedures were successful, although the same NL remained doubtful and said, “After a while, they changed the medical treatment plan for these patients. Give them the steroids. Intubate them early. But if you intubate them too early, they might not come off [the ventilator]” (1010).

The critical care unit was filled with COVID patients who could not be successfully weaned off ventilators. The same NL was relieved when proning the patients was found to be the best approach. “Then we started proning them. Then we thought, *this is the practice*! And we started doing that” (1010). Proning patients who were on ventilators led to a new problem. Turning a ventilated, unresponsive, or very weak patient onto their stomach often required more than two people. Although the patients were in the ICU, it was hard to find enough available personnel to help. One frustrated NL said, “To put these people on their stomachs, to flip them, you need a lot of people. You know, get whoever’s available. The painter? Yeah. It was weird. But we did it. We did do it” (1016).

Not all COVID patients were admitted to the critical care unit. Some ambulatory patients were hospitalized because they tested positive for COVID-19. Others were admitted because they had a high fever and a cough. They were presumed COVID positive because of their symptoms and had to be quarantined until lab results were received. Patients in respiratory distress can become restless, confused, and sometimes combative due to low blood oxygen levels. It was difficult for them to follow instructions. One NL explained, “so, wearing masks was not a top priority for some

patients. They either didn't think it was important, or they just weren't together enough to be able to accomplish things like consistent mask wearing" (1020). Another NL recalled:

> I remember the very first time that I had to enter a COVID room; the feeling of putting all the PPE on; and going in to readjust the patient's [oxygen] mask that he kept ripping off. And I remember my hands shaking just to adjust his mask. (1018)

Empathy and courage were needed to care for sick and dying COVID patients. One NL emphasized, "I got into this work because my heart wanted me to help people. So that's what I always try to do. I always think about that person in that bed and what if it was one of my… [silence]" (1014).

Another NL felt helpless when a young man was admitted to her unit early in the pandemic. The staff took turns watching him from outside the room to see if he needed anything. She became emotional as she said, "As we were monitoring, there were moments that his pulse ox[imitry] would decline. And we were in tears as we watched this young man struggle with a new disease" (1018).

The same NL empathized with COVID-19 patients who were sick and in isolation during the early pandemic. "Think how fearful it must be to be hospitalized in general, and then during the pandemic when you can't even see peoples' faces, you can't read their lips if you're hard of hearing, 'cause they're wearing so much PPE" (1018). The patients weren't the only ones challenged with clinical staff covered in PPE. One NL said, "The codes were just the worst. You couldn't get into the room. You couldn't even tell who the people were because they wore so many layers of PPE" (1016).

One NL reflected, “It was very, very sad to see patients without families there. So, we FaceTimed for them, and they called” (1018). Another NL remembered what it was like. “A lot of sad phone calls. A lot of scared people. A lot of scared patients. We FaceTimed with families, putting patients in front of camera phones so they could talk to their family members” (1014). Interacting with absent family members wasn’t the only reason that video communication was vital for desperately ill COVID patients. Another NL explained, “I cannot tell you how many times nurses held their iPads up for patients with the priest, the rabbi, the imam, the minister giving sacraments on the other end. It was awful, but they got them” (1016).

Nursing Staff

When the first COVID patients arrived at the ED, the staff had no idea what they were dealing with. The NL shared, “You know, everybody was exposed at that time. That’s why, as the pandemic started getting worse, we realized, that we should have been protecting ourselves” (1010). After some staff contracted COVID-19, the NLs realized how vulnerable everyone was. One NL told what it was like to send a nurse or tech into a COVID patient’s room. “You wonder where their motivation comes from. Because the person has little kids at home, or is only 25 years old, or are they even paid enough for what they’re risking” (1018). Another concerned NL said, “I didn’t know what I should or shouldn’t be doing. I wanted to support the staff. I needed to learn how to help us all get through this. I knew it would get worse. It wasn’t going away” (1014). One NL recalled, “I had my strongest, strongest nurses crying. We didn’t know what was happening. Although believe me, I was just as upset as they were, but I couldn’t break

down with them. I had to really care for my nurses" (1010). Another NL gave a personal definition of caring that was especially relevant:

> A lot of people think that caring is providing proper physical care and giving medications to a patient. But it is not just caring for the patient, but also for the nurses. So, to me, there should be an added piece to caring and that is *listening*. (1012)

Listening. There were so many distraught staff. The same NL knew it would be impossible to listen to all of them and said, "You can't be there for every single one of them, but when you see that it's needed, you make time to listen" (1012). Most of the NLs agreed that caring for frightened staff did indeed include listening. One said, "I had to bring the nurses one by one into my office and sit with them and talk them through it. I didn't care if it took them an hour to compose themselves" (1010).

When the ED began to face many COVID deaths, the NL became concerned that the clinical nurses needed additional emotional support. "They were just coming to work, doing their job, and leaving. No matter what I tried to do to get them to talk, they didn't. I even asked the chaplain to come and talk to us" (1010). Eventually, she also consulted with the NL of behavioral health. "I wanted to see if she could do anything because she's excellent in her role. And there were things that she offered. She had her staff come and sit with some of our nurses to talk it out, too" (1010).

All the NLs provided additional opportunities for the staff to talk about their fears. Most of this was done during unit-huddles and other staff meetings. One NL stated, "We would have morning huddles and afternoon huddles with seven or eight people. Everyone would want to know, OK, what's happening? Who's on the unit? What's going on? Do

we have enough PPE? And conversations would develop" (1020). Another NL said, "At huddle, I would say, 'We will get through this.' It was me talking to myself, too, but someone needed to say that to *them*. Someone needed to not back out on them and that was my role" (1018). Still another NL said, "We would have extra meetings and talk about feelings and situations and make sure we kept up to date on what was going on. There were a lot of debriefings when things were hard" (1014).

While talking and listening were vital, there were other ways to care for the staff. One NL donned scrubs and joined the clinical nurses in providing physical patient care during the early pandemic. "At one particular time I worked 21 straight days with my team" (2012). The NL continued, "It's a lot of mental distress. I really have to let my team know I'm there with them. Not just by saying it, but also doing it" (1012). Another NL took a different approach:

> My role may not have been direct care, that was their role. But my role was to help them mentally, physically, and every aspect through that. I can imagine what they went through. Because what I witnessed, I also experienced to a degree. (1018)

Self and Loved Ones

During the early COVID-19 pandemic it was difficult for nurse leaders to assure safe and appropriate patient care by staff who were often scared and confused. One NL explained, "They're falling apart. They're crying, breaking all the time. You wonder when you come the next day if you would have enough team members to take care of the patients" (1012). Despite their own fears, most NLs had to be role models and cheer leaders for their staff. It took courage and was exhausting. As one NL explained, "There

were a lot more questions than answers and a lot of helping staff work through their discomfort and uncertainty" (1020). A different NL said,

> I had to figure out how to protect them. That made me put my emotions in the background. Maybe I harbored more stress than I would have wanted, but I knew that we needed to be on the ball, so nobody got hurt. (1014)

One NL admitted, "Every day there was a different challenge. I was so tired" (1010). Despite being weary, another NL explained, "But did we consider that I can't do it anymore? No. We went on because we knew we were needed" (1012)

How were the NLs able to continue in their role while surrounded by so much anxiety and despair? To help others, the NLs had to reflect on their own fears about working with contagious, very sick, and often dying COVID patients. One of them said, "Obviously, you can't be efficient about helping somebody if you don't know how to handle it or how you feel about it. I put pressure on myself to figure it out; to find my own way" (1014). Another NL explained, "I'm really good at compartmentalizing. When I'm here, I'm here. And when I'm home, I'm home. You have to be able to separate the two" (1020). Another NL said, "I could put my feelings aside and focus on what I needed to focus on. I'm not saying I'm uncaring, I just needed to put my strength in a different place for my staff and it was hard" (1010). And another shared,

> It's OK to feel sad while I'm at work, but I don't take your pain with me. It's very important because I feel that's what burns you out. It's not avoidance. I remember the hurtful times, but I'm also proud of the people that I've helped. (1014)

A different NL was more specific, and said,

> I was able to detach myself by taking a short walk. I would thank the Lord for guidance and take a moment to reflect on what happened during the day. I asked myself, what did I learn that I can apply tomorrow? I told myself; you did a great job, you've done your best. If I could not disengage, I could not continue. (1012)

Not only did the NLs have to look after patients and staff, but they also had to protect themselves and anyone they lived with. They feared bringing COVID home, so they developed personal routines that they hoped would work. One NL said, "You know, it's the little things. Everybody was walking around [the hospital] in scrubs. Nobody wore street clothes because you don't want to wear your real clothes in here" (1016). Another NL spoke of protecting her family. "I was the only one that went in and out every day. I didn't know what to do, so I changed in the garage. I bought the blue light [sanitizer] to clean my mask and my phone every night" (1010). A different NL agreed. "A lot of people changed in their garage. It was March and it was cold outside, so they were freezing. But they didn't want to bring their work clothes inside" (1016). And another NL described this routine before leaving the hospital: "I'd bring clean clothes into the bathroom, wash exposed areas, and literally change everything before I went home. I even changed my shoes in the car" (1014).

One NL described what it was like to work during the early COVID-19 pandemic. "It was monumental. For about two months last year, whenever I thought about it, I got a little teary eyed. I think I had a little PTSD from it. I don't know who in their right mind wouldn't" (1018). Although HTMC provided an EAP for any staff who needed advice, psychological support, or selfcare strategies, the NLs received the most emotional support from their own families. The NL continued,

> The hospital offers help through the EAP, but I didn't think I needed anything. I have a very good family support system. And it's not affecting my daily life. It's just when you really start to peel it back and think about that exact time, it's a little traumatizing. (1018)

Another NL recounted what the extreme stress was like:

> On the way home from work, I began crying while talking to my wife on the phone. I feel like I needed to. It's obvious it was building. She said, 'Oh my God, you never cry!' When I got home, she just hugged me. That was my turning point. I got that out and it changed my focus. (1014)

Yet another NL found comfort from family members and said, "My family in California constantly called to say, 'just be careful, you're doing a great job, you're doing a great thing'. And my two kids always said, 'Are you ok? Do you need anything'? It was as simple as that" (1012). Another NL smiled and said, "I would come home, and my husband and kids were always there. Everyone would be in the house. And one day they wrote in chalk on my driveway, '*My mom is a hero.*' It was so sweet" (1018).

Theme IV. Going in Blind

The early COVID-19 pandemic led to unforeseen clinical, work, and personnel situations. The HTMC administration addressed some of them through changes in roles and policies, but other issues required quick responses to avoid new crises. In every circumstance, the NLs had to lead calmly with patience and flexibility.

One NL described a night when she assisted the usual supervisor. A security guard called to say that the morgue was completely full. He had one deceased patient on a stretcher and there were three more to follow. The regular supervisor was attending a

clinical emergency and could not help. The NL said, “We couldn’t leave the patient in a room or on the morgue floor. Although it was 2 o’clock in the morning, I called the COO [chief operating officer] and said, ‘We need a refrigerator truck. We cannot wait!’ And we got it” (1016). Makeshift morgues in refrigerator trucks were not unusual in many larger cities at that time, but it was unheard of at HTMC. Yet, it was just one of many situations during the early COVID-19 pandemic that required quick-thinking by NLs to assure care of patients, staff, and themselves.

Life Called and They Answered

A major area of concern in the early pandemic was the intensive care unit (ICU). All ICU beds were filled with patients on ventilators. Additional inpatient beds were needed for intubated patients in the ED who were on ventilators, too. The progressive care unit (PCU), formerly called telemetry, was located adjacent to the ICU. That made it the best place to admit additional ventilator patients. The PCU nurses were already trained in advanced cardiovascular life support (ACLS) and many other interventions required by critically ill patients. Because some PCU nurses worked occasionally in the ICU, they were the logical choice to receive rapid, intense training for skills required to care for ventilated patients. The training classes normally took place over many weeks. In the chaos of the early COVID-19 pandemic, the training had to be accelerated. The NL explained, “The ICU was so inundated that there was just no other option. So, who was the next best to help? It was the progressive care nurses who were trained as quickly as possible and expected to take [ventilator] patients” (1014). The critical care beds remained full and more patients on ventilators were admitted to PCU. The NL said, “It was amazing to see how much they [the nurses] grew in that short time, using skills that

they never expected to have, to become competent in ventilator and COVID care. And you know, it was same thing with me" (1014). Pride was evident as the NL continued, "They didn't come here asking to be ICU nurses. They didn't ask to be vent nurses, but life called, and they answered. Just being part of that was awesome!" (1014)

Another NL learned that his unit would become the designated COVID-19 unit. Most of the patients would be in isolation and require frequent observation to detect even the most subtle changes that could indicate the onset of respiratory failure. The NL met with the respiratory therapy supervisor to learn how to identify which COVID patients might eventually require mechanical ventilation. The NL learned it would take about four days from the time a patient entered the ED until a ventilator would be needed. "Because that's how quick and aggressive it is" (1012).

The NL had another cause for concern. COVID-19 patients were admitted to respiratory isolation in rooms with solid doors that had no windows. The doors had to remain closed for quarantine purposes. The NL said, "With the door closed you're going in blind. You don't know if the patient will be alive the next time you open the door" (1012). As a temporary solution, baby monitors were obtained and set up outside the rooms on small tables. A camera was placed in each room and aimed so the patient could be seen on the monitor screen in the hallway. The NL continued, "We taught our techs to look at the monitor whenever they passed. Take a pause. Make sure that it's on and you can see the patient" (1012).

The NL instructed the nurses and techs to look for and recognize subtle signs that could indicate a change in a patient's respiratory status. The NL reviewed this daily with team leaders and staff:

> We know COVID is contagious, so we have less time to spend with patients. So, now care includes more. People could breathe [easily] or they could take a deep breath and there's pain, so when I provide your medication, give your IV antibiotic, or turn and reposition you, I have to pay more attention." (1012)

All clinical staff learned to identify the patient's position in bed, the O2 saturation level, and the ability to take a deep breath without pain. The NL stressed the importance of detecting and reporting any changes and then intervening quickly so the patient could survive. The staff would do this every time they passed by or entered the patient's room and then would report their observations to the team leader. The NL said, "Because you can give your best effort, but unless you intervene quickly, you will still see them fade away in front of you and you won't be able to get them back" (1012).

Thank you for Being Here

During the early COVID-19 pandemic, many experienced nurses and staff became sick, had to quarantine, or resigned. Consequently, many hospitals did not have enough experienced clinical nurses and support staff to care for patients with COVID and other acute illnesses. To keep as many employees working as possible, HTMC administration announced emergency measures. All employees were required to work. One NL explained, "There were changes where no one could take time off and paid time off (PTO) was rescinded" (1018). Another issue was the way that staff were compensated for COVID-related absences. According to one NL, "If you came down with COVID and you got it through the hospital you could use your extended illness benefits (EIB). If you got it from the outside, you had to use your PTO" (1016). This proved frustrating because there was no way to know exactly where a sick employee was exposed to the virus.

Administrators then declared that pregnant women could not work. One NL who was helping in the nursing office became sarcastic when describing the confusion caused by that decision. “Female staff were coming in saying ‘I think I’m pregnant. I might be pregnant. I should be pregnant. I oughta be pregnant. I’m gonna to be pregnant. Everybody in the world’s pregnant!” (1016) But men were employees too, and several said their wives were pregnant. They were still required to work, and the same NL said, “Wait a minute! You want them to catch it from their spouse? That was the dilemma we were in. If it wasn’t so sad it would be comical” (1016). Another NL disclosed, “I had a nurse that was trying to get pregnant. She said I’m not coming back and another nurse on the edge of retirement told me there’s no reason to come back anymore. They resigned. I had multiple people like that” (1018).

Leading was difficult for the NLs when nurses and other staff left. There were vacant positions and no additional staff to fill them. HR did not require, but strongly advised staff to come to work even if they had other responsibilities at home. One NL recalled a long-time nurse who was the sole caregiver for her husband who was very sick at home with COVID-19:

> She was struggling mentally because she worked for so many days. I said, ‘Why don’t you stay home tomorrow? I checked the schedule, and we will be ok.’ And the staff nurse said, ‘How can I? They won’t approve any PTO.’ But I asked a co-worker to work for the staff nurse and she was so thankful. (1018)

The NL chuckled and concluded:

> It wasn’t exactly following the right policy, but you put managers in place to make decisions. Someone needs to take care of their staff and that’s what I did.

> She knows I helped her. I don't think she'll forget that. I feel like we'll always have that moment. (1018)

A different NL said, "They [HR administrators] dug their heels in and it was really bad because you had people saying my life is not worth this job and I'm leaving" (1016). Another said, "There were so many problems, not only from COVID, but also psychological issues, logistics issues, staffing issues, and so many people retired. Anybody who could get out of healthcare at the time, did" (1020). A different NL felt there was resentment between staff that continued working and staff that didn't. She explained, "Some people were at a different point in their life. They might have different illnesses, like autoimmune diseases or they might be a caregiver of an elderly parent. Others didn't make the decision [to leave], so I think there's animosity" (1018).

Because all NJ healthcare facilities were required to cancel elective procedures and close most outpatient departments, HTMC had a shortage of acute care clinical staff and a surplus of employees from various outpatient settings. "So, we were calling other hospitals asking, What are you doing? How are you managing this?" (1016) Based on these phone discussions, an administrative decision was made to send employees from closed departments to temporarily work in understaffed clinical patient care areas. "A lot of our nurses were displaced at the time because of COVID so they were sent to assist frontline nurses and techs and others" (1012). They would not provide clinical care. Instead, they would help in many other ways and so were called *helping hands*. Other hospitals in the region established similar programs. But some nurses were unhappy with the helping hands program. According to one NL,

> Sometimes OR and PACU nurses were assigned to put consents together or make sure drawers were filled with gloves, while ICU nurses were putting their lives on the line. It caused a lot of conflict, but nobody knew what to do. The squeaky wheel gets the grease. Some people were very vocal and got what they wanted; the others did not. (1016)

Many other helping hands staff were anxious because they had to work in departments with specialties that were new to them. They were unfamiliar with the diseases, treatments, and equipment needed for patient care in those areas. One NL explained "It was a huge relief that they were there. But some staff said things like, why do I have to be on a COVID floor? or, I don't know how to do this. I'm not a nurse in this area" (1018). After hearing these complaints, the NL created a list of non-clinical tasks that the helping hands staff could do, such as "cleaning door handles, counter tops, and phones with disinfectant wipes; stocking supplies and PPE; answering call bells or calling into rooms and asking patients if they needed anything to limit the number of times the nurse would go in" (1018).

Another NL expressed the concerns of staff that went to medical units where they did not feel qualified to practice. "They were the 'fetch it' people, getting equipment. Get me this, get me that, find me this, find me that. Sometimes you have to explain what you want me to find. What does it look like? Ok, what is that?" (1020) Another NL was grateful that helping hands staff could make sure that the nurses or techs didn't have to repeatedly go in and out of patients' isolation rooms:

> When you go to the patient, as much as you plan, you end up realizing, oh my goodness, I forgot something. You're not gonna go out, especially with the limited

> PPE at the time. So, if you need to provide care for the patient and you need something, I'm at the door waiting. What do you need? (1012)

Another NL defended the staff who were unhappy with being asked to work in unfamiliar acute care settings. "At the same time, some had tremendous fear about being on a medical unit where there was care of COVID patients, because that was not what they signed up for" (1020). Despite the complaints, one NL explained the approach his staff took. "My staff welcomed them as part of the team. Instead of saying, oh you work there, this is not your thing. It was more like, thank you for being here. I'll see you tomorrow. We'll make it happen again" (1012).

Unpredictable Physicians

In a typical fast-paced, rapidly changing hospital environment, nurses and physicians must develop and maintain collegial relationships to successfully care for their patients. It was a little different during the COVID-19 pandemic. The NLs had mixed feelings about the physicians during that time. One NL chuckled and said,

> There was an eye doctor who was gowned up and wearing an HTMC badge. We were curious as to who he was because he put his PPE on all wrong. Finally, we learned he was from an outpatient setting. He said he was an employee and was trying to visit his mom. We had to instruct him on safely wearing PPE. (1018)

Another NL felt there was a lot more camaraderie with the physicians. She recalled a young woman who was in respiratory distress and needed to be intubated, and said:

> A pulmonologist was on duty. You could see he was thinking of his family, and he was afraid. I said, we'll get you garbed up. We're gonna wrap you like a mummy so there's not an inch of skin showing. And we did. And he did it. I think before

> this pandemic we would have said, that's your job. Just do it. But nobody wanted this guy to get sick, just like we don't want to get sick. (1016)

An exasperated NL described a different physician who was fearful of contracting COVID-19:

> She came in dressed like a human condom, covered from head to toe with only her eyes exposed, and stood at the doorway. She frightened the patients so much in this getup that the medical director had to tell her, please take a leave of absence. (1020)

Several NLs were troubled by physicians who would not enter COVID patients' rooms. One of them explained:

> One physician would physically go into the room in a day and the other doctors would just read their notes and look at the patient through a window. So, I always said to them, 'Are you kidding me? My nurses and my techs are in there exposed twenty times and you won't even go into the room?' I was a little resentful of it. (1014)

A different NL confirmed, "Sometimes physicians came, but they didn't go in the room to see the patient. That was upsetting for nursing staff to know that they had to go in, and they would, but sometimes physicians or other disciplines wouldn't" (1018). Another NL, from an area that did not care for COVID patients summarized what others expressed:

> I've seen resentment for people taking bows for things they didn't deserve and no applause for people who did. Imagine what it's like to be the nursing staff who took care of a [COVID] patient. They physically gowned and ungowned thirty times, and scrubbed, and disinfected, and turned that person, held the iPad over

> their face to talk to their loved ones, and talked to their families. And then a group of providers comes by once a day and stands outside the room and looks through a window and has an intellectual debate and leaves. They never once set foot in the COVID patient's room. But they get the applause and take a picture, and the newspapers, and magazines, and newsletters say they're a fabulous team for how well they cared for the person. (1020)

Theme V. Appreciation

Nurses Were Everybody's Hero

In the early months of 2020, very little was known about COVID-19. To help prevent the spread, Governor Murphy ordered all non-essential businesses in New Jersey to shut down until further notice. Yet nurses and other employees went to HTMC every day to care for sick and dying patients despite putting themselves at risk for contracting the virus. Residents of the town and surrounding communities did what they could to show their appreciation. One NL said, "The local Home Depot provided anything we needed. 'You need 30-foot extension cords? Here you go.' We ran out of plastic gowns. They devised bags to make the gowns. They came through for us" (1016). Another NL said, "Members of the community restaurants and stores that had to close would package things up and send them to us as gifts" (1010). She went on to say, "The way they sent in gifts and food at least five times a day, we were inundated with pizza… and pizza… and pizza [she chuckled]. They just constantly sent gifts" (1010). One NL explained, "There were so many times that people gave us money or people gave us gift cards. So, we organized, and I did a lot of food ordering for them [the staff]" (1018). Another NL said, "I think a lot of people came together. The community supported us a lot. People couldn't

stop sending enough food, and treats, and thank yous" (1014). According to one NL, "My own family would say, 'How many staff members do you have? We're sending Panera Bread, or we're sending something.' I always made sure to take care of that. It was one silly thing that I could do" (1018).

Sending gifts and food wasn't the only way that the community supported the healthcare workers. One NL stated, "People came out of the woodwork to do good things" (1016). An example was described by another NL. "The kids in the community drew [thank you] cards for the heroes. All the nurses in the hospital got a card. I took pictures and posted them on social media and gave them to PR, just to thank the community" (1010). Another NL reflected on the generous community support and said, "It's interesting when you look back on it, 'cause all of a sudden the nurses were everybody's hero" (1014).

One NL described a meaningful caring moment that was posted on the HTMC website, Facebook, and Instagram:

> Our EMS drove past the hospital with all sirens blaring. They were first responders too, so we knew they were feeling what we were feeling. We held up signs for them and clapped for them as they clapped for us. Patients watched from their windows. Nurses watched from windows in the front of the hospital. That was really nice. (1010)

We Would Clap as They Left

The initial weeks of the COVID-19 pandemic were dreadful. So many patients were on ventilators. So many patients died. Eventually, some patients improved and became well enough to be discharged. HTMC employees were grateful to be able to see

their patients leave. One NL said, “You know, as time went on, we started to learn how to really care for these patients, then we started to think about them being discharged. It was beautiful” (1010). Another NL said, “A high point was seeing our patients come in sick and eventually walk out. They’re not 100% when they leave, but we know they’ll recover” (1012).

As COVID patients started to be discharged, the hospital began some small rituals that lifted the spirits of staff and patients alike. Each time a baby was born at HTMC, the mother-baby unit initiated a recording of chimes playing a few bars of a lullaby. The bells signified a new life arrived and could be heard by staff, patients, and visitors. One NL described a similar ritual that began as COVID patients were discharged. “One of our nurses suggested we repurpose the chimes that play when babies are born to announce COVID discharges. When we discharged a COVID-19 patient, it would play, so people knew we had another one that made it” (1014). Hearing the discharge chimes gave everyone a feeling of hope that their patients would survive and be discharged, too. The NL continued, “so, as we had more of those happening, I think subconsciously it probably helped. I know I liked hearing it” (1014).

According to another NL, “One of the best moments was when a woman who was on a respirator for months was our first patient discharged. We lined up and clapped for her when she left. We started doing that” (1010). She went on to say, “The whole hospital would come. Critical care nurses, respiratory therapy, the CEO, everybody. You know, we would make an announcement. And everyone would line up at the exit and clap” (1010).

Thinking back, one NL said, “The staff and people, the doctors… your heart goes out. I mean, there were so many people you wish would get better” (1016). But one

patient was particularly memorable to the entire hospital and the community. He was the first, or one of the first patients discharged after being on a ventilator for months. The NL said:

> He was in his fifties, and he looked pretty good, but was just not responding and kept getting worse, and worse, and worse, and worse, and worse! Everybody really felt for this guy. After twenty-something days on a ventilator, call it a miracle, God, good luck, whatever. He came out of it. (1016)

Another NL described the same patient,

> I remember we had a patient who was in the hospital for… God, months. When we finally released him, he was our first COVID recovery discharge. And we all were in the hallway clapping for him. He was in the papers because he was a well-known musician. That was just kind of cool to see that. It helped. (1014)

I Have the Best Staff in the Hospital

The NLs at HTMC quickly learned that caring for and leading any group through a pandemic is not easy. Several of them wished that nursing and hospitals could have planned better to deal with something as chaotic and dramatic as the COVID-19 pandemic. They thought it would have helped to learn what was done in past crises to help them prepare for the pandemic (1010, 1014, 1020). Even so, one NL admitted that there were too many variables to consider, and that each situation is different. The NL summed it up by saying:

> You can’t say what information will be important tomorrow. Things are constantly changing. And everything changes, like technology, knowledge, access to stuff,

changes in personnel, and workload. All these complicated things. You don't really know what's gonna be valuable tomorrow. (1014)

Although the NLs were inexperienced in the challenges brought about by the early pandemic, they were clearly impressed with the way the staff nurses had to deal with so many difficult situations. One NL opined, "Medicine is full of young people. Some don't understand what they're getting into. They may have just started three months ago and never experienced someone dying except for an older family member. The pandemic changed all that" (1014). The NL went on, "You don't realize that one day you're gonna feel like somebody's chasing you around with a shotgun to your back [chuckles], because you can't stop. 'Ok, keep going! Run!' Not everybody's prepared for that level" (1014). Another NL told of a recently graduated nurse who was distraught from all the death and suffering. She was referred to the EAP and took a leave of absence. The NL said, "She didn't learn this at school. She didn't learn about proning or COVID. You're not taught that in school. So that was really difficult" (1010). The new nurse eventually returned to work on a per diem basis.

One NL described several staff members who were afraid to work during the early weeks of the pandemic. She said, "Someone brought in a popular magazine article about the virus. It was confusing. Half of it made sense and half didn't make sense. It left some staff in a panic, so they had trouble focusing on their work" (1020). The NL asked some calmer, more experienced nurses to help their co-workers do a review of scientific literature about COVID-19. She said, "They were selective with the information they were reading and sharing. Participating helped bring down the anxiety of their colleagues who were really frightened. It wasn't just coming from me. It was coming from the

group" (1020). The NL felt that this peer-to-peer activity helped the staff learn more about how COVID-19 was transmitted and what they could do to protect themselves and others.

The pandemic gave many NLs a different perspective about the nurses that they worked with every day. One NL said, "It was very gratifying for me to see the growth of the staff that I work with. I'm not afraid to say it to anybody. I'm not arrogant or egotistical. I have the best staff in the hospital" (1014). When asked to explain, the NL replied, "My staff always pulls through. It doesn't matter what it is. We're the only floor in the hospital that everybody says, oh, they never complain. They're never a problem. They never push back. 'Cause we just do our job" (1014). A different NL had a similar opinion:

> I don't have anything against other nurses or other teams. But I know for a fact, this is the best team to take care of the situation. And I'm proud to say that. I've seen the good, bad, and the ugly with my team. But when they were truly needed, they were there. No one walked away. I didn't lose any team members. They all stayed [teary, wiped eyes]. (1012)

Another NL shared some final thoughts about nurses, their peers, and their character:

> I think it's about why you became a nurse. Are you in it because you get a great bonus? [laughs] In it because you get paid great? Are you in it because they paid for your schooling? Recruited you? Did your parents tell you to go to nursing school? Or did you go into it because you wanted to help people? That, I think, showed the difference between the people you were standing beside [during pandemic]. You don't forget those faces. (1018)

CHAPTER 10

Discussion, Limitations, Recommendations

COVID-19 Arrives in New Jersey

During the first two weeks of March 2020, the NLs at HTMC focused on getting ready for a site visit by Magnet appraisers. This entailed reviewing and updating policies and procedures, assuring minutes and quality data graphs were up to date, and coaching the staff to describe how and why HTMC should be redesignated as a Magnet organization. Nurses at Magnet organizations are required to select a nurse theorist whose ideas reflect their nursing practice. Then they must develop a professional practice model that represents how their practice reflects the theory. The HTMC nurses selected Jean Watson as their theorist. Their model was based on Watson's philosophy and science of caring. The nurses were ready to shine for the Magnet appraisers but were completely unprepared for what happened next.

In the US, COVID-19 arrived suddenly, accelerated swiftly, and caused confusion, sickness, and death. By the second week of March, NJ identified its first COVID case. By March 31, there were 18,696 positive cases and 5,340 hospitalized COVID patients. Just two weeks later, on April 14, the number of COVID-19 hospitalizations in NJ peaked at 8,270, thus greatly reducing available hospital beds, staff, ventilators, medications and personal protective equipment (Governor of New Jersey, 2020. Exec. Order No. 2020-111, p. 3; NJHA, 2021, p. 5).

Meanwhile, I was locked down at home with a few family members. I had recently retired and there was plenty of time for reflection. I was worried about everyone, but especially some of my colleagues who were NLs at HTMC. They were working in

the hospital; an environment that put them at high-risk for developing COVID-19. During my pandemic musings, I wondered what it was like to be a NL in such an unprecedented, stressful time. What did it mean to them? What was their experience? As I mused, I wondered if it was possible to care during chaos or was there only time for the bare minimum managerial tasks? The more I thought about it, the more it spoke to me.

Summary of Study

The aim of my qualitative inquiry was to investigate the lived experience, or nature, of caring by nurse leaders during the early COVID-19 pandemic. After IRB approval, six NLs at HTMC volunteered to participate. The hermeneutic phenomenological approach of Max van Manen was selected. During private, audio-recorded confidential interviews, the following questions were asked:

1. As a leader, what was caring like for you during the early COVID-19 pandemic?
2. What hindered your caring as a nurse leader during the early COVID-19 pandemic?
3. What helped your caring as a nurse leader during the early COVID-19 pandemic?
4. Tell me about an especially critical or meaningful caring moment that you experienced as a nurse leader during those months.
5. Is there anything else about caring as a nurse leader during the early COVID-19 pandemic that you would like to share?

The audio-recorded interviews were transcribed verbatim and analyzed through deep reflection and writing. The process of reflection, writing, and rewriting in a hermeneutic circle, was repeated over and over until themes emerged and a narrative text was created. “Phenomenological research and writing tries to make intelligible the

experiences that we explore in a 'feelingly understanding' manner" (van Manen, 2014, p. 390). Because van Manen does not espouse one format over another for presentation, I elected to introduce caring by NLs in the early COVID-19 pandemic in the form of a text that would not only help the reader *see* the NLs' experiences, but also to *feel* them.

As I reflected deeply on the interviews, five themes emerged: (a) on the cusp, (b) protecting, (c) caring for, (d) going in blind, and (e) appreciation. Each theme has three subthemes that clarify and contribute to the overall meaning of the theme. The following discussion relates findings from each theme with examples.

Discussion: Theme I. On the Cusp

Theme I. On the Cusp signifies the abrupt transition from readying for an on-site Magnet appraisal to the unanticipated crises caused by the arrival of the COVID-19 pandemic.

We didn't know what was happening

When the first COVID-19 patients arrived at HTMC, the NLs were caught by surprise. They may have been prepared for the Magnet appraisers' site visit, but they were totally unprepared for the arrival of COVID-19. They had heard rumors about the disease, but as one NL said, "You wait until its knocking at your door to make a response" (1014). Denial is not unusual when a potential for a catastrophe seems remote.

The literature review revealed little about the beginning of the COVID-19 pandemic. The reports and articles immediately began with general or specific issues that were caused by the pandemic, but clearly, everyone was caught off guard. Hand et al. (2021) stated survey respondents identified a lack of organizational leadership preparedness for the pandemic. Trepanier (2020), a nurse executive, stated, "To some

extent I had my head in the sand" (p. 404). As one of the NLs in this inquiry said, "We never expected this. Ever (1010)."

Am I Gonna Get Sick? Am I Gonna Die?

In this subsection, the NLs began to understand the reality of the pandemic. Their descriptions invite the reader into the enormity of the Index family's tragedy. "It just broke me. Because one day everything's fine, you have a party, and then in a week everybody's on their death bed" (1014).

Some experienced nurses were crying. "Am I gonna get it? Am I gonna die? That's how they felt" (1010). Vivid speech by one NL brings us to the anguish his staff felt when their first COVID-19 patient died. "Everybody was just… different; like there was a shadow over everyone. They were all just straight eyed, staring at the wall, crying... It was… It was… it was tough [looks off, remembering]" (1014). This was still in the very beginning of the pandemic, before anyone knew much about COVID, before the NLs had a chance to comprehend the situation.

An applicable metaphor was shared. "I think there was a time period of feeling that you're running into a building and it's 9/11! That's what it was like for people" (1018). By comparing caring for the first COVID-19 patients to running into a building after the 9/11 terrorist attacks, the reader can imagine or "see" the NLs and their staff experiencing terror while caring for the first patients of the early COVID-19 pandemic.

We might not think caring for dying COVID-19 patients in the early pandemic, before vaccines were available, without any known treatments, would be exciting. And yet, one NL shared the following anecdote:

> A young surgeon came to me and said, 'Isn't this exciting? You can tell your great-grandchildren, or they could read about what you did.' And it was. There was something about it. We were on the cusp of a world-wide problem." (1016)

Like the first responders who run into burning buildings or rappel down cliffs to save lives, some nurses say in emergencies, surgeons "act first and think later." They quickly size up the situation and get to work. As the NL talks with the young surgeon, they seem to understand the historical nature of this 100-year pandemic. Perhaps they feel heroic as they consider that their descendants might learn about their experiences of being on the cusp of the COVID-19 pandemic.

My Manager Brain Kicked In

The NLs had to face their own anxieties about COVID-19 as they struggled to maintain a semblance of order and normalcy in their units. In a Magnet organization, transformational leadership is the preferred style for leading others. Yet the pandemic led some NLs, whether intentionally or not, to adopt a more paternalistic or directive approach. Terms such as "I needed to care for my troops;" I needed to hold my troops together;" and "That was my biggest, biggest challenge. I had to care for them." were used by one. Another spoke of the staff saying, "They're kind of like your kids, to a degree." Still another said, "I am the leader of the unit. I am the captain of the ship."

According to Middaugh (2020), "During a crisis, when leaders must act quickly to correct problems, an autocratic, directive leadership style is efficient and effective. Disasters are not the time for debate and discussion to reach consensus" (Middaugh, 2020, p. 212). In the literature review, research reports and non-research articles addressed leadership styles. Hand et al. identified an adaptive leadership style was

appreciated, but additional research was needed (Hand et al., 2021). A participant in another study used a situational style of leadership in the early pandemic (White, 2021). A non-research article recommended a repertoire of relational, charismatic, transformational, servant, and other leadership styles (Shuman & Costa, 2020). While another suggested that the COVID-19 pandemic was the opportunity to learn from experience and revise accordingly (Shingler-Nace, 2020).

One NL (1012) spoke about caring when COVID-19 arrived, reminding us that leaders don't only care for patients. "Now you need to care for your team to make sure they come back with you the next day to repeat the process again" (1012) .Another was concerned about being able to care for the staff's emotional needs, because "It's hard to support somebody when you don't know what you're supposed to do" (1014).

Eventually the same NL realized that it was time to stop worrying and begin to take control of the situation, saying "my manager brain kicked in" (1014). He began considering his ability to manage supplies and resources. Yet, at the same time, he remained concerned because he felt the need to take time to emotionally support the staff, "because they're already stressed" (1014).

Discussion: Theme II. Protecting

During the early COVID-19 pandemic, the NLs received so many announcements throughout each day that they were often unsure which ones were the most recent. To protect everyone, communication had to be clear and timely. The nursing staff was already alarmed. Their NLs had to be calm and supportive. The most frequent changes were related to PPE, such as what was needed versus what was available. The Magnet model component, transformational leadership, asks the CNO and all nurse leaders to

always use open, honest, transparent communication (ANCC, 2017). Despite the need to be more directive at times during the early pandemic, NLs led their staff with honest, transparent communication about shortages of PPE and other resources and how to protect themselves and others

Communicating Rapid Changes

Nurse leaders attended the daily administrative huddle because they were the liaison between the administrators, the patients, and the staff. At the administrative huddle, all department heads learned the latest CDC and other agency rules and guidelines related to COVID-19. But the rules changed many, many times throughout the day. “You don’t know if you’re doing things right or doing things wrong. Because at that time, the CDC gave new guidelines every day, by the day, if not by the hour, and it caused a lot of confusion” (1012). After HTMC established the COVID team, communication problems eased. The COVID team members were available to answer questions about COVID and the pandemic. The literature review articles described how two organizations established centralized incident command centers to evaluate data and communicate more reliable COVID-19 information (Caroselli, 2020; Mezzina et al. 2021).

Another focus of the daily administrative huddle at HTMC was to identify and discuss any potential safety concerns. An extreme, but important example that occurred in the early pandemic was the admission to the ICU of six adult siblings who were critically ill with COVID. It is unclear how many family members were in the ICU at the same time. However, several were there and had the same last name, so everyone had to be

extra cautious. All departments had to be on the alert because the danger of errors was real. And in this case, the entire hospital was affected by the Index family's plight.

Connecting with Nursing Staff

The frequent revisions to PPE guidelines would have been unimaginable a few months before the pandemic. The NLs usually gave PPE updates and shared other information with their staff by holding unit-based huddles. Most of the huddles in the early weeks were meant to dispel rumors and clarify the latest recommendations about wearing masks and gowns. As one NL (1014) exclaimed, "There was panic. There was a lot of confusion." In hospitals around the country, similar huddles were being held as a means for nursing leadership to be visible, answer questions, and stop rumors (Cathcart, 2020; Mezzina et al., 2020; Shingler-Nace, 2020).

Personal Protective Equipment

Throughout the US, supply chains were disrupted, and availability of PPE and other supplies was unreliable (Luis & Vance, 2020; Shuman & Costa, 2020; Trepanier, 2020). Concerns regarding PPE were mentioned in nearly every research report and non-research article. Whether it was issuing new recommendations, or responding to staff concerns about what they saw or heard in the media, PPE was always at the forefront. At HTMC, one NL was particularly descriptive when she compared her attempts to dispel the latest PPE rumors to "talking your staff of the ladder" (1018). This colorful phrase invokes an image of a person climbing a tall ladder who does not want to or is afraid to come down. In this case, the NL confirmed how rumors are easily believed, but are not so easily dismissed. Other NLs were concerned that the hospital would run out of PPE, and they would not be able to keep their staff safe (1012; 1018).

It was troubling that staff and physicians at HTMC took advantage of an extremely busy night when supervisors were not available. The warehouse doors were unlocked so staff could take what they needed for their units. Instead, they emptied the warehouse of PPE. They took boxes of gloves and gowns to their units, their homes, and offices (1016). The NL declared that the CEO was code purple, invoking an image of a furious, purple-faced CEO. In hospitals, a code signifies an emergency, thus heightening the idea that he was purple with anger.

Over and over NLs spoke about dwindling supplies of gowns, goggles, and masks. At first, they were instructed to simply limit the amount that they used. Soon, they were told to use only one N95 mask a day. Eventually, they learned everyone would have to reuse PPE by sending their masks and gowns to sterile processing daily for decontamination. To prevent more PPE theft, at least one NL created a separate locked area with hooks for staff to hang their gowns and masks. In the research literature, it was reported that rationing and reusing N95 masks and PPE was infuriating and terrifying for nurses (Freysteinson, 2021; McAndrew 2023). The supply chains were broken and the PPE reserves throughout the country were running low (Caroselli, 2020; Rosa et al., 2021; Shuman & Costa, 2020; Trepanier, 2020).

Discussion: Theme III. Caring for

Imagine this. There were so many people hospitalized with COVID that all stretchers, beds, rooms, and hallways were full. More sick, frightened people were crammed into the ED waiting room, begging to be seen. There were no medications, treatments, or cures for the deadly virus. The NLs knew this, and yet, they carried on,

doing what they could to care for patients and families, the nursing staff, themselves and their loved ones.

Patients and Families

This subtheme describes what it meant for NLs when they understood that there were no known treatments for their COVID patients. One said, “It’s the hardest thing for a nurse when somebody wants your help, and you don’t know what to do” (1010). The CDC had nothing to offer at that time and advised giving supportive care. Supportive care is the basic care that is provided when medications and other treatments will not work or are not available. “We went back to very basic nursing” (1012). For example, staff typically make as few trips into an isolation room as possible. “We batched meds with lunch and other services” (1012). In a research study by McAndrew et al. (2023), one participant described a comparable experience, “We basically had to relearn how to nurse, which was a lot. Normal treatment plans and disease processes that you would expect, can anticipate, and can treat, didn’t apply” (p. 6).

It was difficult to wean COVID patients off ventilators. So many treatments were tried, from early intubation to steroids. Nothing worked. Patients kept dying until, “We started proning them. Then we thought, *this is the practice*!” (1010) But proning meant it was hard to find enough available personnel to assist. Caroselli (2020) stated that proning helped, but additional staff were needed to facilitate proning heavy patients. And Mezzina et al. (2021) said at their Magnet designated hospital, proning protocols were created with staff nurse involvement.

One NL described the first time entering a COVID-19 patient’s room and the feeling of donning all the PPE. She said, “I remember … going in to readjust the patient’s

[oxygen] mask that he kept ripping off. And I remember my hands shaking just to adjust his mask" (1018). Was she afraid or touching a COVID patient, or was it something else? Freysteinson et al. (2021) reminded us that each nurse is taught to recognize the ominous symptom of restlessness as an early indication of hypoxia. The NL's hands may have been shaking in anxiety, not only for herself, but also because restlessness is a precursor to respiratory failure.

Freysteinson et al. (2021) found "the lack of personal contact with family was devastating as there were no resources to replace their support" (p. 1538). This got me to thinking about the lifeworld of NLs caring for patients who were hospitalized with COVID-19 and perhaps dying alone isolation rooms. Every one of the *lived bodies* (corporality), the nurses, doctors, and other staff, that entered the room wore masks, gowns, gloves, and usually eyeglasses or face shields. One NL empathized. "Think how fearful it must be to be hospitalized in general, and then during the pandemic when you can't even see peoples' faces, you can't read their lips if you're hard of hearing, 'cause they're wearing so much PPE" (1018). Another NL spoke about the *lived space* (spatiality), associated with the early pandemic and said, "The codes were just the worst. You couldn't get into the room. You couldn't even tell who the people were because they wore so many layers of PPE" (1016). The PPE made crowded spaces harder to navigate. The code team's bodies were be completely covered, hidden by layers of cloth and plastic, obscuring their persons, their identifying characteristics. The gasping, often dying patients must have been confused and afraid of people they couldn't recognize. Many were weak, most were on ventilators that prevented talking with the *lived others* (relationality); the few people that were permitted to enter their room. Many dying

patients wanted to see their families and spiritual leaders, but all visitors were prohibited. Eventually, staff held iPads for patients to contact family for FaceTime visits. The nurses also helped patients FaceTime with clergy for sacraments and spiritual relief. And what of temporality, or *lived time*? For the COVID-19 patients, sick, breathless, afraid, and alone, the days must have seemed endless. While some may have been too sick to be aware of the passage of time, others could only watch the wall clock or guess at the time by the amount of light coming through a window, if one was nearby. Entire chapters could be written about the situated contexts of COVID-19 patients in isolation. This snippet does not even consider age, gender, race, ethnicity, and the many other characteristics and experiences that make up the lifeworlds of COVID patients.

Nursing Staff

The NLs at HTMC showed caring and compassion for their staff who were often fearful and crying. Their statements, "I wanted to support the staff," "I needed to learn how to help us all get through this," "My strongest nurses were crying," "I really had to support my nurses," "You make time to listen," and "I didn't care if it took them an hour to compose themselves" were expressions of their caring concern. One NL conveyed what others seemed to feel:

> A lot of people think that caring is providing proper physical care and giving medications to a patient. But it is not just caring for the patient, but also for the nurses. So, to me, there should be an added piece to caring and that is *listening*. (1012)

The NLs identified listening as one of the most important aspects of caring. This harkens back to the ANA's First Position Paper on Nursing Education which

differentiates caring for, caring about, and taking care of. Caring is dealing with human beings under stress, and providing comfort to them in times of anxiety, loneliness, and helplessness. “It is listening, evaluating, and intervening appropriately” (ANA, 1965, p.107). According to Tronto, (1998) the attentiveness phase in an ethic of care is listening to another, becoming aware of spoken needs, recognizing unspoken needs, and then deciding which needs require immediate caring. McAndrew et al, (2023) found that nurse leaders in their study were protective of nursing staff, ensuring they had a voice. But there was a cost, because “they listened and absorbed staff suffering, increasing their own trauma” (p. 10).

According to Caroselli (2020) “Sometimes, a listening ear was all that was necessary. At other times, referrals were needed for more formalized assistance” (p. 169). White (2021) identified that NLs reached out personally and professionally for help with emotional issues. At HTMC, at least one NL contacted the hospital chaplain and the director of behavioral health to offer her staff comfort and support. The NLs held extra huddles to talk about feelings and give updates about PPE and COVID treatments. One NL donned scrubs and worked alongside the staff for 21 days without taking a day off, while another had a different way of caring by being available mentally and physically for her staff.

Self and Loved Ones

Assuring safe and appropriate care by staff who were scared and confused, who were “falling apart,” and “breaking every time,” was stressful for the nurse leaders. They were role models and cheer leaders who put their emotions in the background despite feeling exhausted. They knew they were needed, so they put pressure on themselves. The

metaphors “falling apart,” and “breaking every time,” produce images that show the extreme pressure that the staff nurses were feeling. It was up to the NLs to help them “pull themselves together” so that they could continue with their vital work.

In a study by Bunch et al. (2024) a participant found it was difficult for NLs to separate their work life from their personal life. “Work-related, secondary exposure to extremely or traumatically stressful events is called secondary traumatic stress” (p. 185). Several NLs at HTMC stated they had to compartmentalize or separate their life at work from their life at home by putting their feelings aside so they could focus on what needed to be done. “I’m not uncaring. I just needed to put my strength in a different place for my staff and it was hard” (1014). Another NL detached from work by taking a short walk, praying for guidance, and reflecting on the day. “If I could not disengage, I could not continue” (1012). Chipps et al. (2022) called this a mindful moment. White (2021) reported that “managers found *professional support* through discussions with their peers, and other nurse managers” (p. 1531). None of the NLs in my study mentioned seeking support for themselves from peers or other managers.

Freysteinson et al. (2021), reported NLs often became exhausted and were unable to concentrate during the pandemic. Some leaders in their study found the heavy emotional and physical burdens unsustainable. Eventually, some would hit a breaking point and would go home and cry. This situation happened to one NL in my study who called his wife on the way home from work and began crying. “When I got home, she just hugged me. That was my turning point. I got that out and it changed my focus” (1014). He maintained he almost never cried, but the stress was building. His wife’s

emotional support sustained him. Other NLs in my study were supported by spouses, children, and daily calls from family members in another state.

One NL experienced what she called “a little PTSD” for two months in 2021 from working during the early pandemic. “It’s not affecting my daily life. It’s just when you really start to peel it back and think about that exact time, it’s a little traumatizing” (1018). Although she was aware of the organization’s EAP, she felt that her family support was enough. The NL did not want to stop the interview or withdraw from the study. She also declined contacting the EAP, or any other resources. I gave her my study debriefing form (see Appendix F) that provided professional resources related to COVID-19, as well as my personal contact information. We continued the interview and discussed it again at our next meeting. Again, she declined assistance.

The literature during the early pandemic explained that NLs are at risk for developing burnout, moral distress, and PTSD. NLs were advised to take time for rest and renewal, to sleep and eat well, to focus on facts, talk with supportive friends and colleagues, and celebrate all victories, even if small (Cathcart, 2020; Doucette, 2020; Mezzina, 2021; Shingler-Nace, 2020). Above all, NLs should care for themselves with love, forgiveness, and compassion (Doucette, 2020).

Discussion: Theme IV. Going in Blind

This theme starts with an anecdote about a NL helping a night supervisor. A security guard contacted her with an urgent plea. The morgue was completely full. One deceased patient was on a stretcher and there were three more to follow. The supervisor was attending a clinical emergency and was not available to help. A quick decision had to be made at 2 o’clock in the morning. The NL sized up the situation. The beds were full.

The morgue was full. The deceased patients could not be left in a patient room or on the floor in the morgue. The NL contacted the COO and said a refrigerated truck was needed immediately. It could not wait until morning. The truck arrived before dawn. The anecdote shows us that during the pandemic, the NLs were asked to make decisions that would be unheard of at any other time.

Life Called and They Answered

There was no end to the creativity needed for NLs, and their employees to succeed during the COVID-19 pandemic. As the ED and the ICU filled to beyond capacity, more ventilators, beds, and nurses were needed to care for intubated patients. At HTMC, the PCU is located adjacent to the ICU, making it the best choice to place additional ventilator patients. Some of the PCU nurses were familiar with caring for critically ill patients on ventilators. However, those who were not would require rapid training to quickly learn enough to care for patients requiring this specialized nursing. The nurses were unsure and afraid, but they persisted. The rapid training program must have been stressful for the nurse educators also. The research literature noted similar rapid education programs for acute care and ICU training and retraining (Freysteinson et al. (2021) and an article by Caroselli (2020).

Another NL at HTMC learned his unit would become the designated COVID-19 unit. He knew that patients with COVID could quickly progress to respiratory failure and require immediate intubation with mechanical ventilation. Patients would die unless staff could correctly assess their respiratory status. In the chaos of the early in the pandemic, there was no time to install replacement doors with windows. COVID patients had to be isolated in regular patient rooms with solid wooden doors. The disease was highly

contagious, so the doors had to remain shut, making it impossible for staff to see the patients. A creative idea that was adopted by the unit was the use of baby monitors that were placed on tables just outside each patient's room. Inside the room, the baby monitor camera was aimed so the patient could be seen on the monitor screen in the hall. Whenever a staff member walked past a room, they looked at the monitor to detect changes in the patient's respiratory status and acted accordingly. They could also use the monitor to talk with patients. Trepanier (2020) identified setting up baby monitors outside patient rooms at his facility as a creative means to communicate with patients, but he did not mention using them to screen a patient's respiratory status.

Thank You for Being Here

As COVID-19 continued to spread, the staffing situation at HTMC became worse. Some nurses were sick, were quarantined at home, or resigned, leaving the nursing units more short-staffed than ever. "Anyone who could get out of healthcare at the time, did" (1020). When HTMC was required to cancel elective procedures and appointments, there was an excess of clinical and other staff from the OR, PACU, and outpatient departments. Nurses from closed departments were deployed to work in understaffed acute care areas. These nurses were called helping hands because most could not be expected to take a full patient assignment, but they could do some clinical and many non-clinical tasks to help the regular staff. Many helping hands nurses were unhappy working in units with unfamiliar specialties. They did not feel prepared to care for COVID and other acutely ill patients. They complained so much that one NL created a list of non-clinical tasks that the helping hands nurses could do. At minimum, they could communicate with patients or retrieve items for nurses working in isolation rooms. The regular staff were pleased to

have their help. But some helping hands nurses remained upset at being deployed to acute care units. One NL understood their fears and made sure to welcome them as part of his team. At the end of each day, he reassured them and said, “Thank you for being here. I’ll see you tomorrow. We’ll make it happen again” (1012). The non-research literature described similar programs in other healthcare organizations. Like the HTMC staff, the deployed nurses expressed a range of feelings about working in unfamiliar departments (Caroselli, 2020; Cathcart, 2020; Rosa et al., 2021; Sherman, 2020b).

Unpredictable Physicians

The NLs spoke of unpredictable relationships with the medical staff. Two NLs used expressive language to describe different physicians who were covered from head to foot in PPE because they were afraid of contracting COVID. The first physician was an on-duty pulmonologist who was called to intubate a young woman in respiratory distress. He hesitated to enter the patient’s room and seemed afraid. The NL told him, “We’ll get you garbed up. We’re gonna wrap you like a mummy so there’s not an inch of skin showing. And we did” (1016). The NL showed she cared, but I do not know if it was for the patient, the physician, or his family. Perhaps all of them. The second physician was terrified of contracting COVID-19 and “came in dressed like a human condom, covered from head to toe with only her eyes exposed” (1020). The patients were frightened so much by the appearance of this outfit that the medical director told the physician to take a leave of absence. The NL seemed annoyed by this physician but was much more concerned for the frightened patients.

The expressive language used here immediately conjures images of what it was like for physicians, or anyone else for that matter, to be completely covered in PPE.

Colorful language evokes meaning and makes an experience seem more authentic. On reading about the first physician, I laughed as I imagined one or two nurses wrapping a physician from head to toe in old bandages to dress him like a mummy instead of helping him properly don PPE. Then I imagined the second physician in perhaps a semitransparent hazmat suit, or a clear giant plastic trash bag, hesitating in the patient's doorway. Because I wasn't there, I had to envision what the physicians were wearing and what they looked like. And so, my situated context and lifeworld experiences influenced me to "see" these scenarios in certain ways. Other readers will envision these scenarios according to their own lifeworld experiences.

One of the best-known NL roles is advocating for patients and nursing staff. Some physicians at HTMC made sure they would never enter a COVID-19 patient's room. They would simply read another physician's notes and then observe the patient through the window, have an intellectual debate, and leave (1014; 1020). One NL was indignant. "I always said, are you kidding me? My nurses and my techs are in there exposed twenty times and you won't even go in the room?" (2014) Another described the hard work done by the nursing staff. "They physically gowned and ungowned thirty times and scrubbed, and disinfected, and turned that person, held the iPad over their face to talk to their loved ones, and talked to their families" (1020). She noted that others resented the way physicians "get the applause" and public relations staff "takes a picture" saying they're a fabulous team for how well they cared for the COVID patients (1020).

Physicians were not mentioned in the literature review except as administrators, committee members, and consultants. I wondered if NLs in other hospitals had similar experiences as those at HTMC.

Discussion: Theme V. Appreciation

Despite chaos and trauma, despite sadness and death, the NLs were able to recall instances of appreciation by the community for the critically ill patients who survived, and for the nurses and other staff.

Nurses Were Everybody's Hero

"It's interesting when you look back on it 'cause all of a sudden the nurses were everybody's hero" (1014). The community members showed their appreciation in several different ways. The local Home Depot provided what was needed. "You need 30-foot extension cords? Here you go. We ran out of plastic gowns, so they devised some for us with bags" (1016). Restaurants and stores that had to shut down sent gifts. "We were inundated with pizza… and pizza… and pizza [she chuckled]. They just constantly sent gifts" (1010). Money and gift cards were given often. "So, we organized, and I did a lot of food ordering for them [the staff]" (1018). Another example was when "the kids in the community drew cards for the heroes. All the nurses in the hospital got a card" (1010). The NL took photographs and posted them on social media and sent them to the public relations department to thank the community.

Nurses at other organizations were also called heroes by community members who thanked them with snacks and other food (Caroselli, 2020; Sherman, 2020a).

One NL (1010) described a meaningful caring moment that was posted on Facebook and on Instagram:

> Our EMS drove past the hospital with all sirens blaring. They were first responders, so we knew that they were feeling what we were feeling. We held up signs for them and clapped for them as they clapped for us. Patients watched from

their windows. Nurses watched from windows in the front of the hospital. That was really nice.

We Would Clap as they Left

Eventually COVID patients began to heal. “Then we started to think about them being discharged. It was beautiful” (1010). One NL said, “They’re not 100% when they leave, but we know they’ll recover” (1012). When COVID patients were discharged, the hospital began small rituals. One ritual was the playing of chimes overhead as a COVID-19 patient was wheeled out in a wheelchair or on a stretcher. The chimes would play so that everyone knew another patient survived. Another ritual started when a woman who had been on a respirator for months was eventually discharged. “We lined up and clapped for her when she left. We started doing that” (1010). A different NL described celebrating the discharge of a COVID patient who had been on a ventilator for more than 20 days. The NL said, “… he was just not responding and kept getting worse, and worse, and worse, and worse! Everyone really felt for this guy” (1016). The repetition of the words “and worse” characterized the hopelessness felt when caring for this patient who was not responding to any treatments. And then she said, “After twenty-something days on a ventilator, call it a miracle, God, good luck, whatever. He came out of it” (1016). This last quote makes me think of how fragile we are. Was this an ontological crisis? The exhaustion, the fear, the struggles, the dying patients. Does the COVID-19 pandemic make humans question their beliefs, their faith? Would this NL find a satisfactory explanation for why this man lived and others so many others did not?

Caroselli (2020) described a comparable ritual of staff lining hallways and applauding when a patient was discharged. She wrote, “This provided staff with a living

example of hope and reward for their exhausting journey. Similar celebrations occurred for other patients" (Caroselli, 2020, p. 169).

I Have the Best Staff in the Hospital

Several staff nurses were confused and frightened after reading a popular magazine article about COVID-19. It was very early in the pandemic and newspapers and other media were presenting conflicting information. The NL said only half of the article made sense and the rest did not. Her solution was to ask some calmer, more experienced nurses to do a review of scientific literature about the virus. She said, "they were selective with the information they were reading and sharing. Participating helped bring down the anxiety of their colleagues who were really frightened" (1020). This NL cared enough to mentor the nurses on the value of peers who review appropriate literature and share evidence-based research to improve their colleagues' knowledge, reduce fear, and enhance practice.

The NLs quickly learned how difficult it was to care for and lead others during a pandemic. Several wished for better planning by leadership to deal with the chaos. They said it would have helped to know what was done in past crises to assist them to lead in the early days (1010; 1014; 1020). Ironically, the AONL developed a document of guiding principles for nurses in leadership roles in managing crises well before the COVID-19 pandemic (AONL, 2017). Articles in the non-research literature also described nursing leadership approaches for times of crisis. They were published in 2020 indicating that the authors hoped to reach and guide NLs later in the pandemic (Caroselli, 2020; Middaugh, 2020; Shingler-Nace, 2020; Shuman & Costa, 2020; Trepanier, 2020). Would knowing about guidelines and crisis leadership approaches have helped? As one

NL in my research noted, “Everything changes . . . All these complicated things. You don’t really know what’s gonna be valuable tomorrow” (1014).

One NL stated, “Medicine is full of young people. Some don’t understand what they’re getting into” (1014). He reflected that some new nurses may never have experienced death except for that of an older family member. He went on, “You don’t realize that one day you’re gonna feel like somebody’s chasing you around with a shotgun to your back [chuckles], because you can’t stop. ‘Ok, keep going! Run!’ Not everybody’s prepared for that level” (1014). What a scenario! I completely related to it. I recalled many days in nursing when I literally ran all day to keep up, just like he described. I love nursing, but it can be difficult and exhausting. Another very young nurse was referred to EAP and then took a leave of absence because she was so upset by all the death and suffering.

Two NLs explained the pride they had in their staff. Both were emotional. One was gratified by the growth of the staff he worked with and said, “I’m not afraid to say it to anybody. I’m not arrogant or egotistical. I have the best staff in the hospital” (2014). He continued by saying they never complain or push back. The other NL wiped away tears and said, “I don’t have anything against other nurses or other teams, but I know for a fact, this is the best team to take care of the situation. When they were truly needed, they were there” (1012). He went on to say that not one staff member walked away. They all stayed.

I included some final thoughts about the HTMC nurses, their peers, and their character shared by one NL: “I think it’s about why you became a nurse … did you go into nursing because you wanted to help people? That, I think, showed the difference

between the people you were standing beside [during the early pandemic]. You don't forget those faces" (1018).

Limitations

The interviews for this study were conducted from October through December 2022. Six NLs at HTMC volunteered to participate. Other NLs did not volunteer or no longer worked for the organization. There was no way to know if they would have participated or if their responses would have differed greatly from the NLs who were interviewed.

I was concerned that the length of time between the early COVID-19 pandemic and the dates of participant interviews was too long. I thought that the NLs would forget their experiences or would be more selective about what they revealed. I asked them what they thought about it at their final meetings. Some said they weren't sure. Others told me they would not have been able or ready to discuss their experiences any sooner. It would have been "too fresh" to discuss. Perhaps that is for the best, because "a person cannot reflect on lived experience while living through the experience" (van Manen, 1997, p.10).

All NLs in this research were at least 40 years old. The experience of caring by younger NLs during the early pandemic is unknown.

Recommendations

While generalizability of any phenomenological inquiry is limited, I have included some suggestions based on the NL participants' responses, the literature review, and my personal observations.

Natural and man-made disasters, infectious diseases, and violence are increasing everywhere. Whenever any disaster strikes, acute care hospitals must be ready to treat

people in need of care. Crisis training and education were requested by participants in this study and were articulated in the non-research literature review. I suggest hospital administrators, nursing leadership, and physicians would benefit from crisis leadership training and routine reviews beyond "paper drills" and simulation scenarios.

The COVID-19 pandemic identified the need for rapid training for nurses who were quickly deployed to unfamiliar specialties and departments. This can be accomplished by experienced educators, such as nurses in professional development departments, who can identify appropriate organization-specific learning needs, curricula, and methods. Educators and training personnel from organizations that succeeded in rapidly training nurses for internal deployment could provide media presentations and publish articles or an education manual of best practices to be utilized in other disaster situations.

Although an old problem, relations between nursing and medical staff at some institutions remain contentious despite many attempts to change the culture. Patients, staff, and organizations always benefit from physician and nurse collaborative relationships. Caring, respect and cooperation are even more important among professionals in times of crisis or stress. Relationship and team building activities may help to initiate and sustain change. An example could be appointing NLs and other nurses to co-chair and be active members of goal-oriented committees or ad hoc task forces with physicians.

Research investigating the experiences of caring by NLs under 40 years old is recommended; they are our future nurse administrators and executives. Research would be beneficial to help understand what active participation in the Magnet recognition

program has in caring by NLs and other nurses in crisis situations. Similarly, new research to identify successful styles of leadership and caring in crises would be helpful.

The NL participants shared many instances of stress, crying, and “a little PTSD” during the early COVID-19 pandemic. They had the same anxieties as their staff and more. The short- and long-term mental health effects of missing PPE and supplies, suffering, and death during the COVID-19 pandemic were traumatic. Nurse leaders are not counselors. Organizations need to provide their NLs and staff with mental health support through groups and private therapy sessions. Those with EAPs must do a better job of educating staff about available services. All staff should be made aware of warning signs that signal a need to reach out for help. Caring, compassion, and respect are needed as everyone seeks a new normal after the pandemic.

And of course, more education and research are needed about phenomenology and what it means to be humans experiencing the infinite variety of life world situations.

CHAPTER 11

Conclusions

The purpose of this qualitative research was to explore the lived experiences of caring by six NLs employed in a mid-sized NJ hospital in the early COVID-19 pandemic. In March 2020, hospitals began to report shortages of beds, ventilators, medications, PPE, and personnel. I wondered if caring by nurse managers (defined as nurse leaders for this study) was possible under these unexpected and tragic circumstances. Or did the NLs only have time to rush from task to task, simply trying to get things done safely?

The chapters on Caring in Nursing, Nursing Leadership, and COVID-19, a New Disease, provide the background for this study. A search of the research and non-research literature about caring and NLs in US hospitals during the early COVID-19 pandemic revealed limited relevant articles or research studies. I selected the hermeneutic phenomenological approach of Max van Manen to explore "being-in-the-world," or the nature of caring by NLs at that time. After IRB approval, six NLs from a mid-sized NJ hospital were interviewed. Their audio-recorded interviews were typed verbatim and provided textual data for analysis. Their responses were influenced by their shared situated contexts within the hospital, as well as their individual lifeworld experiences. The analysis included reading the transcripts, deeply reflecting, writing, and then repeating the process over and over. The epoché and reduction helped identify my personal beliefs and aided in removing extraneous remarks about the phenomenon. Eventually five themes emerged: (a) on the cusp, (b) protecting, (c) caring for, (d) going in blind, and (e) appreciation. Each theme has three subthemes that clarify and contribute to the overall meaning of the theme. A vivid narrative was produced that reveals the

nature of caring by NLs during the pandemic. The emotional descriptions of caring experiences transport the reader to the midst of the chaotic hospital environment of the early pandemic. Readers of my interpretation will recognize, create, and imagine the lived experience of caring by NLs according to their own beliefs and situated contexts. In the end, there is no one definition of nurse caring, just as there is no one style of nursing leadership. Yet, it is clear that caring is the essence of nursing. The NLs revealed caring for patients, staff, themselves, and others during shortages, fear, death, and turmoil caused by the early COVID-19 pandemic.

ANONYMOUS

We stumbled, sick with shame, groping for each other
In that heaving black. We were mouthless for months.
We could've been grinning. We could've been grimacing.
We could've been glass. & so, we must ask:
Who were we beneath our mask.
Who are we now that it is trashed.

—Amanda Gorman, 2021, p. 180

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Appendix A

Letter of Cooperation

[redacted]

September 19, 2022

Liana Piehler, PhD, Faculty Sponsor

Merel Visse, PhD, Director, MHH Program

Alistair Niemeijer, PhD, Adjunct Faculty

Dear Drs. Piehler, Visse, and Niemeijer:

This letter is to assure the cooperation of [redacted] Donna E. Baird, current doctoral student, Drew University, in the Medical Humanities Department, to complete her dissertation ("The Nature of Caring by Nurse Leaders in the Early Covid-19 Pandemic").

Ms. Baird met with myself, the Nurse Manager of the nursing unit which consistently has cared for Covid-19 patients, and the Executive Director, Medical-Surgical units, [redacted]. The entire program and process was explained to us, including the consent form. We reviewed in detail the methodology of finding participants (Nurse Leaders), and the process of the interviews. All of our questions were answered, and there are no changes, additions or deletions requested by us. This study was also discussed and unanimously approved by the [redacted] Nurse Research Committee.

We have asked Ms. Baird to provide a copy of the IRB Acceptance Letter, and we formally request a copy of the results when this project is completed.

Please do not hesitate to contact me, as the liaison. We are honored to be part of this important study.

Sincerely,

[redacted]

Manager, Nursing and Clinical Research

Phone: 732-294-5874

jcraig@centrastate.com

Appendix B

Invitation to Participate

ATTENTION: Nurse Leaders*

You are invited to participate in a research study!

Research Title: The Nature of Caring by Nurse Leaders in the Early COVID-19 Pandemic

Researcher:
My name is Donna Baird. Some of you may know me. I am a registered nurse. I have held many nursing positions for over 45 years. I was the Magnet Program Coordinator at [redacted] for 14 years until I retired in 2019. I am currently a doctoral student in the medical humanities program at Drew University in Madison, New Jersey.

Participants:
Licensed registered nurses who were nurse managers, nurse directors, or in a comparable role during the early COVID-19 pandemic, from March 1, 2020, through May 31, 2020.

** The term nurse leader will refer to nurse managers, directors of nursing, and other nurses with comparable responsibilities*

Why is this research important?
Healthcare research and media stories often focus on the experiences of clinical nurses during catastrophic situations. Instead, this study will seek a deeper understanding of the lived experience of caring by nurse leaders during the early COVID-19 pandemic. Your personal caring experiences may provide new insights about caring by nurse leaders in times of pandemics, disasters, and other crises.

Who should volunteer to participate?

- Licensed RN before March 2017
- Employed as a nurse leader (nurse manager, director of nursing, or other comparable nursing position) at [redacted] for 2 or more years by March 2020
- Employed as a nurse leader at [redacted] in the early COVID-19 pandemic from March 1, 2020, through May 31, 2020

- **Please note:** Taking part in this study is voluntary; you may withdraw at any time without penalty from [redacted] or Drew University

If you agree to participate:

- You will take part in a private, tape-recorded confidential interview about your experiences of caring as a nurse leader in the early months of the COVID-19 pandemic
- The interview will take about 60 minutes in a mutually convenient time and location – to prevent interruptions, it should not take place in your office or your area of responsibility
- You will fill out a demographic form
- You will receive a follow-up telephone call 2-3 weeks later to clarify your comments and answer any questions you may have
- We will meet again in 3-4 months for about 30 minutes to summarize your experiences
- Your specific information is confidential; no identifying information will be shared
- You will receive a small, store gift card as thanks for participating

To learn more about taking part in my research:
Please contact me, Donna Baird, MPH, MSN, RN, CNE, at dbaird@drew.edu or call [redacted]

This research is conducted under the direction of Liana Piehler, PhD, Faculty Advisor, Caspersen School of Graduate Studies, Drew University, 36 Madison Ave, Madison, NJ 07940

APPENDIX C

HUMAN PARTICIPANTS RESEARCH REVIEW FORM[1]

1. Project Title: The Nature of Caring by Nurse Leaders in the Early COVID-19 Pandemic

2. Principal Investigator(s): Donna E. Baird

3. If student research, name of faculty sponsor: Liana Piehler, PhD

4. Name of anyone else involved in the study administration/data collection: Merel Visse, PhD, director MHH program; Alistair Niemeijer, PhD, adjunct faculty

5. Email address of Principal Investigator(s): dbaird@drew.edu

6. Duration of the Project (approximate starting date and completion date of data collection): September 2022-March 2023

7. Describe how the requirement to obtain training in the responsible conduct of research involving human subjects was met: Completed Responsible Conduct of Research (RCR)-Basic Course, Parts 1 and 2; November 2020

8. Review the types of research listed on the IRB website. Check the box of the type of research you believe that you are conducting.

   ☐Exempt from further review
   ☒ Expedited
   ☐ Full Review

9. Electronic Signature(s):

   Principal Investigator: Donna E. Baird Date: September 14, 2022

   Faculty Supervisor: _____ Date: _____

[1] Revised December 2018

10. Provide a brief description of the purpose and goals of the proposed research, including in what form the research is potentially to be published (e.g. thesis, dissertation, article, book).

    The early months of the COVID-19 pandemic was a confusing and worrisome time for nurses, healthcare workers, their families, and the community. Research about nurse practices in pandemics often emphasizes clinical nurses in various hospital settings. Instead, this qualitative research will seek the unique perspectives of nurse leaders who executed frequent administrative changes, supported clinical and other staff, and assured safe care of acutely ill patients during the early COVID-19 pandemic. The term nurse leader will refer to nurse managers, directors of nursing, and other nurses with comparable responsibilities. These nurse leaders differ from clinical nurses and nurse administrators with broader organizational responsibilities and titles such as a chief nurse officer, chief nurse executive, vice president, or assistant vice president. For the purposes of this investigation, the early COVID-19 pandemic is defined as March 1, 2020, through May 31, 2020. A phenomenological approach will be used to explore, describe, and provide interpretive analyses of tape-recorded interviews of registered nurse leaders employed in a [redacted] hospital in [redacted]New Jersey during the early months of the COVID-19 pandemic. Their personal experiences may offer new insights in caring by nurse leaders in times of pandemics, disasters, and other crises. I anticipate this research will be published in partial fulfilment of the requirements for the doctorate in medical humanities degree. There is the potential for additional publications and presentations related to this research.

11. Describe your participants. Indicate the total number of participants and whether any of the participants will be minors or will be from other protected populations (e.g., those whose decision-making ability is impaired or compromised in any way, prisoners, etc.).

    I anticipate interviewing a minimum of five registered nurse leaders who were responsible for or broadly affected clinical nursing at [redacted] during the early COVID-19 pandemic. Inclusion criteria: (a) licensed as RN before March 2017, (b) employed in a nurse leader role at the medical center for two or more years before March 1, 2020, (c) employed in a nurse leader role, from March 1 through May 31, 2020. Exclusion criteria: (a) became a licensed RN after March 2017, (b) first employed in nurse leader role at the medical center after March 2018, (c) not in a nurse leader role from March 1 through May 31, 2020, (d) was a clinical nurse, chief nurse officer, chief nurse executive, vice president, or assistant vice president at the medical center from March 1 through May 31, 2020.

12. How will participants be recruited (via a message, an advertisement, a phone call, face-to-face)? Are there any specific selection criteria? Will participants be compensated in any way for their participation? How will you ensure that participants do not feel coerced to participate?

    Flyers will be sent to the chair of the Nursing Research Committee for distribution. Flyers will also be sent to nurse leaders at the medical center. The flyer will give a general description of the study, the expected time of the interview (around 60 minutes), the criteria for inclusion and exclusion, and include the names of the researcher and academic advisor. Potential participants may also learn of the study from co-workers. Interested nurse leaders can respond by email or telephone call for additional information. A phone call will take place to further explain the study. Compensation will not be offered, but a small store gift card will be provided. To prevent coercion, names of participants will not be divulged to nurse administrators, other nurse leaders, or other employees at the hospital. Participants will be assured that they may withdraw from the study at any time without penalty. This will be stated in the written informed consent form.

13. How will you obtain consent from participants (or legal guardians, if minors are involved)?

    The consent will be explained during the initial telephone call and an informed consent form will be shared with nurse leaders who consider participating. Before the start of the interview, any additional questions about participating will be answered by the researcher. The demographic form will be filled out and the informed consent will be obtained before the tape-recorded interview begins. All participants will be reassured that they may withdraw any time before or during the interview and other research processes without penalty.

14. Describe the study's procedures and all activities that participants will be asked to perform. Remember that copies of ALL materials should be submitted as part of this completed form.

    At the time of the interview meeting, the consent form will be reviewed with the participant and signed. After consent, the demographic form will be provided, completed, and signed. An in-depth tape-recorded interview will take place. Each participant will be asked to recall and describe their experience of caring as a nurse

leader during the early COVID-19 pandemic. Semi-structured questions will then be asked:

- As a leader, what was caring like for you during the early COVID-19 pandemic?
- What hindered your caring as a nurse leader during the early COVID-19 pandemic?
- What helped your caring as a nurse leader during the early COVID-19 pandemic?
- Tell me about an especially critical or meaningful caring moment as a nurse leader that you experienced during those months.
- Is there anything else about caring as a nurse leader during the early COVID-19 pandemic that you would like to share?

Additional follow-up questions may be asked. The interview will take approximately 60 minutes. The participant may divulge as much or as little as desired. The tape-recorded interview will be typed verbatim and summarized. The participant will be called one or two weeks after the interview to see if there is anything else to share or explain. In 4-6 months, the participant will meet with the researcher to go over a summary of their answers. The participant will review the summary and asked if anything should be added, deleted for clarification.

15. Where will this research be conducted?

    There will be no specific location for the interviews. Each interview will be conducted in a quiet, private, mutually agreed upon space with minimal distractions, such as a meeting room or other location at the medical center or in a public space, such as a study room in the local public library.

16. Are any aspects of your research kept secret from participants? If yes, indicate what will be hidden and why it is necessary to hide this information.

    No information about this research will be kept secret except for the names, identifying data, and specific responses of the other participants.

17. Describe any potential benefits of your research to participants and/or society.

    Healthcare research and media stories often focus on the experiences of clinical nurses during catastrophic situations. Instead, this study will seek a deeper

understanding of the lived experience of caring by nurse leaders during the early COVID-19 pandemic. Their personal caring experiences may provide new insights for caring by nurse leaders in times of pandemics, disasters, and other crises. They may also identify personal, professional, and organizational needs, such as gaps in knowledge or the need for policy revisions that would benefit other nurse leaders, administrators, educators, clinical nurses, and patients.

18. Consider the risks that your study may pose to participants, including physical, psychological, social, economic, or other types of risks or harms. Explain these risks even if minimal or routine to daily life.

    The early months of the COVID-19 pandemic was a confusing and worrisome time for nurses, healthcare workers, their families, and the community. There is the risk that participants may experience emotional discomfort when recalling the events and their experiences of caring by nurse leaders during the early months of the COVID-19 pandemic.

19. If applicable, explain the procedures that you will use to minimize the risks to participants that you identified in your answer to question 18.

    If a participant exhibits anxiety, stress, or other emotions during or after the interview, they will be offered the options to continue, postpone the rest of the interview, or opt out of the study at any time without penalty. Information about the hospital's confidential employee assistant program will be provided. Additional information may be offered about accessing supportive measures from the American Nurses Association and other professional nursing organizations for nurses undergoing stress associated with the COVID-19 pandemic.

20. Discuss the procedures you will utilize to protect the anonymity or confidentiality of your participants and your data.

    Each participant will be assigned and identified by a confidential code name that will be used on the demographic form, transcripts of recordings, and related documents. When quoting or describing comments made by specific participants, pseudonyms will be used. Typed transcripts and the list of names with corresponding codes and pseudonyms will be maintained in a locked location in the investigator's home. At the end of the study, the tape recordings will be destroyed. The typed transcripts will be retained for three additional years.

21. For the majority of research projects, participants should be provided with a debriefing form that contains further information about the study and contact

information for the principal investigator(s). Will you provide a debriefing form? If not, indicate why.

Yes.

APPENDIX D

CONSENT FORM

THE NATURE OF NURSE CARING IN THE EARLY COVID-19 PANDEMIC

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1. SUMMARY and KEY INFORMATION

You are invited to participate in a research study about the nature (meaning) of caring by nurse leaders during the early COVID-19 pandemic (March 1, 2020, through May 31, 2020). The term nurse leader will refer to nurse managers, directors of nursing, and other nurses with comparable responsibilities. Your participation is voluntary. You were selected as a possible participant because you responded to a recruitment flyer, or you learned about the study from a co-worker, and you meet the requirements. There will be a minimum of 5 participants in this confidential study. The study is being conducted by Donna E. Baird, former Magnet Program Coordinator/Nurse Educator at [redacted] and current doctoral student at Drew University in partial fulfilment of requirements for the Doctor of Medical Humanities degree.

The purpose of this study is to understand the meaning of caring by nurse leaders during the early COVID-19 pandemic. As part of the study, you will take part in a confidential interview that will last about 60 minutes. The interview will be tape-recorded, and notes will be written in a journal. You will be asked what nurse caring means to you as a nurse leader. You will also be asked to share your thoughts and feelings about caring as a nurse leader during the early COVID-19 pandemic. You will be contacted one or two weeks after the interview to see if you have anything else you want to share or explain. In 4-6 months, you will meet with the researcher to go over a summary of your answers. There is a risk that sharing these memories could make you feel uncomfortable or cause you some emotional distress. If this happens, or for any other reason, you can refuse to answer any questions, stop the interview, and/or withdraw from the study at any time without any negative consequences.

We ask that you read this document and ask any questions you may have before agreeing to be in the study.

2. BACKGROUND

The early months of the COVID-19 pandemic were confusing and worrisome for nurses, healthcare workers, their families, and the community. The purpose of this study is to understand the experiences of caring by nurses who were in nurse leader roles during the early COVID-19 pandemic. Healthcare research and media stories often focus on the experiences of clinical nurses during catastrophic situations. Instead, this study will seek a deeper understanding of the lived experiences of caring by nurse leaders during the

early COVID-19 pandemic. Your personal caring experiences may provide new insights about caring by nurse leaders in times of pandemics, disasters, and other crises.

3. DURATION

The length of time you will be involved with this study is approximately one hour for an in-depth interview, a telephone call 2-3 weeks later, and a half-hour meeting in 4-6 months.

4. PROCEDURES

If you agree to be in this study, you will be asked to do the following things: Take part in a confidential tape-recorded interview that will last for about 60 minutes. The researcher will record notes in a journal. You will be asked what nurse caring means to you as a nurse leader. You will also be asked to share your thoughts and feelings about caring as a nurse leader during the early COVID-19 pandemic, from March 1, 2020, through May 31, 2020. You will be called one or two weeks after the interview to see if you have anything else you want to share or explain. In 4-6 months, you will meet with the researcher to go over a summary of your answers. At any time, you can refuse to answer any questions, stop the interview, or drop out of the study without any penalty.

5. RISKS/BENEFITS

This study has the following risks: It is possible you may experience memories that cause emotional distress when thinking about the events surrounding caring as a nurse leader during the early months of the COVID-19 pandemic. If this happens, you will be offered the options to continue, postpone the rest of the interview, or drop out of the study without penalty. You may also refuse to answer any question that make you feel uncomfortable.

The benefits of participation are: This study will give voice to nurse leaders about caring in the early COVID-19 pandemic. It may also identify individual, professional, and organizational needs, such as gaps in knowledge that would benefit not only nurse leaders, but also other nurses, administrators, educators, and patients.

There will be no payment, but you will receive a small, store gift card for participating in this study.

6. CONFIDENTIALITY

The records of the study are private and confidential. No one except the researcher and dissertation advisors will have access to it. Your name identity will not be disclosed to anyone, not even the advisors. You will be assigned a confidential code number that will be used on all forms. A made-up name will be used to quote or describe any of your comments. All typed transcripts and the list of names with corresponding codes and pseudonyms will be stored in a locked location in the investigator's home. At the end of the study, the tape recordings will be destroyed. The typed transcripts will be retained for

three additional years. Any material from the study that is published or presented will not include any information that will make it possible to identify you or other participants. If, for any reason, you elect to withdraw from the study, you may request that the recording of the interview and notes be destroyed, and your responses will not be included in the study data.

7. VOLUNTARY NATURE OF THE STUDY

Your decision about whether or not to participate in this research will not affect your current or future relations with [redacted] or Drew University. If you decide to participate in this study, you are free to withdraw from the study at any time without affecting those relationships and without penalty.

8. CONTACTS AND QUESTIONS

The researcher conducting this study is Donna E. Baird. You may ask any questions you have right now. If you have questions later, you may contact the researcher at dbaird@drew.edu or [redacted]

If you have questions or concerns regarding this study and would like to speak with someone other than the researcher, you may contact the Chair of the Institutional Review Board (IRB), Chris Medvecky, PhD, Associate Teaching Professor of Psychology at cmedvecky@drew.edu.

9. STATEMENT OF CONSENT

Please verify the following: The procedures of this study have been explained to me and my questions have been addressed. I understand that my participation is voluntary and that I may withdraw at any time without penalty. If I have any concerns about my experience in this study (e.g., that I was treated unfairly or felt unnecessarily threatened), I may contact the Chair of the Drew Institutional Review Board regarding my concerns.

Participant signature_____

Date_____

[CODE #_____]

Appendix E

Demographic Form

[CODE #_____]

THE NATURE OF CARING BY NURSE LEADERS IN THE EARLY COVID-19 PANDEMIC

Participant Demographics Form

Name: _____

Date: _____

Age: _____ Gender: _____ Prefer not to answer: _____

Nurse Leader* Role at [redacted] (circle one):

Nurse manager If yes, unit(s) or area of responsibility: _____

Director of nursing If yes, area(s) of responsibility: _____

Other comparable role: _____

Type of nursing degree(s): [circle all that apply]

Diploma Associate Degree BSN

MSN/MS DNP PhD

Other (non-nursing) degree: _____

Were you an RN before March 2017? Yes No Year of first RN licensure:_____

Were you employed in a nurse leadership role at [redacted] for 2 or more years before March 1, 2020? Yes No

Were you employed in a nurse leader role at [redacted] during the early COVID-19 pandemic (March 1 through May 31, 2020)? Yes No

Were you employed as a clinical nurse, chief nurse officer, chief nurse executive, vice president, or assistant vice president at [redacted] from March 1 through May 31, 2020? Yes No

** The term nurse leader will refer to nurse managers, directors of nursing, and other nurses with comparable responsibilities*

Appendix F

The Nature of Caring by Nurse Leaders in the Early COVID-19 Pandemic DEBRIEFING FORM

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1. PURPOSE OF THE STUDY

The study in which you just participated was designed to seek the personal caring experiences of nurse leaders during the early COVID-19 pandemic. Your personal caring experiences may provide new insights for caring by nurse leaders in times of pandemics, disasters, and other crises. They may also identify personal, professional, and organizational needs, such as gaps in knowledge or the need for policy revisions that would benefit other nurse leaders, administrators, educators, clinical nurses, and patients.

2. METHODOLOGY

In this study you were asked to complete a demographic form, take part in an in-depth tape-recorded interview, have a brief telephone discussion 1-2 weeks later, and meet again with the researcher in 4-6 months to go over a summary of your answers.

3. ADDITIONAL RESOURCES

For more information on the topic of caring by nurse leaders in pandemics consult:

American Nurses Association lists of COVID-19 resources at https://nursingworld.org

American Nurses Association (ANA). (2020). ANA Crisis Standard of Care: COVID-19 Pandemic. Retrieved from https://www.nursingworld.org/~496044/globalassets/practiceandpolicy/work-environment/health--safety/coronavirus/crisis-standards-of-care.pdf

American Association of Nurse Leaders (AONL) Resources on Novel Coronavirus (COVID-19) at https://www.aonl.org/resources-novel-coronavirus-covid-19-AONL

New Jersey State Nurses Association lists of COVID-19 resources at https://NJSNA.org

Webster, L. & Wocial, L. D. (2020). Ethics in a pandemic. *American Nurse Journal, 15*(9), 18-20, 22-23. Retrieved from https://www.myamericannurse.com/ethics-in-a-pandemic-2/

If you feel a need to speak to a professional concerning any uncomfortable feelings arising as a result of your participation in this research, please contact the [redacted] Employee Assistance Program (EAP) at 1-866-252-4468 or visit the EAP website www.mylifevalues.com/login.aspx for additional information, webinars, and programs.

Managing Stress and Self Care During COVID-19. This is a web page located on the American Psychiatric Nurses Association website and can be found under the Resources drop-down list. It offers suggestions and resources for all nurses during the pandemic and its aftermath. To access, search https://www.apna.org/managing-stress-self-care-during-covid-19/

Nurses Well-Being Initiative. This is an initiative supported by ANA and other national nursing organizations to help nurses. It offers ways to support yourself through apps and other resources. You can access it at https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/the-well-being-initiative/

4. CONTACT INFORMATION

If you are interested in learning more about the research being conducted, or the results of the research of which you were a part, please do not hesitate to contact Donna E. Baird at dbaird@drew.edu or [redacted]. If you have questions or concerns regarding this study and would like to speak with someone other than the researcher, you may contact the Chair of the Institutional Review Board (IRB), Chris Medvecky, PhD, Associate Teaching Professor of Psychology at cmedvecky@drew.edu.

Thank you for your help and participation in this study.

Appendix G

Drew University IRB Letter of Approval

DREW

Institutional Review Board
Drew University
36 Madison Avenue
Madison, New Jersey 07940

Chris Medvecky
Chair, IRB
Associate Teaching Professor
cmedvecky@drew.edu

September 22, 2022

Dear Donna Baird,

The Institutional Review Board has reviewed your proposed amendments for the research project entitled "The Nature of Caring by Nurse Leaders in the Early COVID-19 Pandemic". The IRB has approved these changes. Please note, if you make any other modifications to your research, you will need to obtain IRB approval for those changes.

Best of luck with your research!

Sincerely,

Chris Medvecky
IRB Chair

VITA

Full Name: Donna Evelyn DeAngelis Baird

Place and Date of Birth: New Brunswick, New Jersey, July 12, 1949

Names of Parents: Paul Tulane DeAngelis
Evelyn Greta Jagels DeAngelis Layton

Educational Institutions:

Secondary	Franklin High School, Somerset, NJ	HS Diploma	1967
Collegiate	Middlesex County College, Middlesex County, NJ	AAS, Nursing	1976
Collegiate	Kean University, Union, NJ	BSN Summa cum laude	1985
Graduate	UMDNJ-RWJMS/ Rutgers University Graduate Program in Public Health, Piscataway, NJ	MPH Family Health Track	1990
Graduate	The College of New Jersey, Ewing, NJ	MSN FNP Track	1999
Graduate	Drew University, Madison, NJ	DMH With Distinction	2025