

UNDERSTANDING AND ADAPTING TO LEADERSHIP CHALLENGES: NAVIGATING THE COVID-19 CRISIS IN THE BRONX

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It has been several months since coronavirus disease 2019 (COVID-19) was declared a pandemic. In New York City, the surge in COVID-19 cases during March and April presented clinical and operational challenges. It also posed unprecedented leadership challenges—situations that required individual members of our team to take ownership of emerging problems and rally others within the organization to work together to overcome them. The specific challenges in emerging hotspots will vary, but understanding the leadership challenges posed by this crisis can help hospitals face the pandemic. Three leadership lessons stand out from our experience in the Bronx, where one of us is a nurse executive: (1) build strong interdisciplinary communication, (2) create space for change and adaptation, and (3) encourage individuals across disciplines and roles to practice leadership.¹

Build Strong Interdisciplinary Communication

Communication is one of the greatest challenges for any organization facing a crisis. Crisis communication must be bidirectional. Rapidly changing updates on protocols and policies must be disseminated quickly to frontline staff. Simultaneously, the evolving issues facing frontline teams need to be identified and understood by senior decision makers.

As the rate of change accelerates, the pace of communication can overwhelm staff. Inboxes fill up with dozens of emails, and in the midst of the crisis, just

reading, processing, and implementing the new guidance can be a burdensome task for staff at every level. Hospital executives can learn lessons from public communication strategies to do better. Communication needs to be honest, timely, and concrete, and it needs to be adapted to the bandwidth and knowledge base of staff,² not all of whom are clinicians.

Ensuring that information from the front line reaches executive decision makers is equally important. In our organization, we had an existing practice of twice-daily safety huddles. We took advantage of this existing structure to relay information from the front lines to executives. Under normal circumstances, these meetings were attended by nurse managers and representatives from a few key departments and lasted about 15 minutes. As the crisis unfolded, these huddles expanded in attendance and scope to include representatives from an array of new departments and lasted up to an hour. At the newly expanded meetings, representatives from medicine, nursing, respiratory care, infection control, information technology, materials management, food service, security, and others discussed problems as they emerged. When representatives from multiple clinical and support services joined a single call, rather than holding multiple one-on-one meetings, it was possible to rapidly identify barriers to care, uncover the problem sources, and delegate development of a solution to the appropriate team.

Create Space for Change and Adaptation

Response to the COVID-19 crisis in a hospital setting requires constant adaptation and transformation, but staff can be resistant to change because

“ Hospitals cannot rely on a single authority figure to shepherd them through this crisis; they need team members across disciplines, roles, and positions to step forward and exercise leadership in their own areas. ”

it produces anxiety^{3(p653)} on top of the general anxiety of the pandemic. Creating and holding space for change, so that adaptations can be developed and diffused throughout the organization, is vital.^{4(p6)} In many hospitals, including ours, incident command centers serve as the formal structure to rapidly identify problems and devise and deploy solutions.

In the first days of the onslaught of patients with COVID-19, the frequency of cardiac and respiratory arrests increased dramatically and supplies of personal protective equipment (PPE) dwindled. Our teams were struggling to respond quickly to the emergencies with adequate PPE, which created challenging conditions for staff. To address this, the command center nominated a multidisciplinary team of physicians, nurses, materials management staff, and others to change the way that we delivered care during a cardiac arrest. That team rapidly developed a “Code Cart PPE Kit” made up of the minimum amount of PPE needed to conduct a code safely. Code teams immediately recognized the great value of these kits, which were rapidly deployed to all code carts and embraced by staff throughout the hospital.

As the pandemic progressed, it also became clear that existing practices would not be adequate to manage the growing number of deceased patients safely and respectfully. The hospital was not only running out of space and supplies, but the normal processes for managing decedents were proving inadequate. Several different services contribute to care for deceased patients, but providing such care is only a small part of each service’s larger role. The command center provided a mechanism for a diverse team to address this somber challenge. The team included a systems engineer and representatives from all the different services involved in caring for the deceased, including

nursing, transportation, health information systems, environmental services, facilities, and security, among others. The team met on an ongoing basis to identify problems and developed and disseminated updated tools and ways of working: postmortem care kits, guidelines on preparation of bodies, facilities to hold bodies, and guidance for bereaved families. This process proved to be a critical component of managing in a pandemic that produced such overwhelming loss.

Encourage Individuals Across Disciplines and Roles to Practice Leadership

Our organization did not rely on one authority figure to oversee every aspect of our response. Instead, we depended on decentralized leadership practices of individuals across disciplines and roles. Engineers who devised innovative ways to expand critical care capacity, nurse managers who developed new ways to collaborate with physician colleagues, and clinicians who quickly took on new skills to maintain appropriate care levels in the face of a surge are all examples of ways our team members exercised leadership to carry our hospital through this pandemic.^{1(p3),4(p37)}

To create enough space to treat the sudden surge of extremely ill patients, we had to transform areas of the hospital that do not usually deliver critical care. This would not have been possible without decentralized leadership from our operational and clinical teams.

At the first alert of a possible respiratory pandemic, our director of facilities ordered units to be installed in the windows of our step-down beds to facilitate the proper air exchanges and convert rooms to negative pressure. This early action meant that we were able to instantly convert our 17 step-down beds into a critical care COVID unit when case numbers increased rapidly in mid-March. During the following weeks, our facilities team modified spaces to enable the addition of dozens more critical care beds to our facility.

New spaces for critical care are useful only if they are staffed. We had to distribute the limited critical care expertise in our organization across locations and patients and redeploy staff without critical care expertise to provide care for extremely ill patients. Team-based care models, where staff

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are mixed across units, can help in situations like these. Implementing those models in the middle of a crisis, however, presented a myriad of difficulties, including last-minute staffing changes and redeployments, caregivers' discomfort in working outside their regular practice areas, and organizational challenges, as we essentially converted large portions of the hospital into critical care units.

This model is possible only when management is decentralized to the unit, which allows for comprehensive communication, coordination, and collaboration, especially between nursing and medicine. Frontline managers can work within their units to accelerate technical skill building, ensure that staff practice in the full scope of their license, and welcome new roles into the acute environment, for example, licensed practical nurses, medical technologists, certified registered nurse anesthetists, and others.

Looking Ahead

Hospitals cannot rely on a single authority figure to shepherd them through this crisis; they need team members across disciplines, roles, and positions to step forward and exercise leadership in their own

areas of clinical, administrative, or organizational practice. Organizations with robust channels of communication, open space for change and innovation, and empowered staff at every level who own their role within the organization will be better equipped to face the challenges that this pandemic brings.

FINANCIAL DISCLOSURES

None reported.

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