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Walden University

College of Health Sciences and Public Policy

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Tracey Braithwaite

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Review Committee
Dr. Mark Gordon, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Steven Matarelli, Committee Member,
Public Policy and Administration Faculty

Dr. Victor Ferreros, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Structural Empowerment of Nurse Leaders in New York State During the COVID-19 Pandemic

by

Tracey Braithwaite

MS, Adelphi University, 2006

BS, York College, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

August 2023

Abstract

The current phenomenological study explored the lived experience of Acting Chief Nursing Officers, Chief Nursing Officers, Chief Nursing Executives (henceforth CNOs) at hospitals in New York State who were charged with responding to executive orders while maintaining quality of patient care despite staffing constraints, inadequate supplies, or lack of additional support for the duties associated with their role. Their experience of structural empowerment in relation to the COVID-19 pandemic was also studied. The theoretical framework was Kanter's theory of structural empowerment that addressed organizational behavior in the context of employee empowerment. The research question addressed how the CNOs perceived their lived experiences of structural empowerment and job satisfaction in relation to the COVID-19 pandemic, including organizational factors and leadership effectiveness. A purposive snowball sample of 10 CNOs was recruited for interviews. Data were collected from semistructured interviews of the CNOs, giving rise to 17 themes, a sample of which include challenging complications during COVID-19; perceptions of resource availability; role, responsibility and accountability; availability of PPE; COVID-19 creation of opportunity for advancement; executive orders' impact and professional responses; psychosocial support importance and impact; rapid patient surge, loss, and effects; and senior leadership support. This study may contribute value for public policymakers to construct positive social change of supporting nurse leaders in responding to future healthcare crises. The hope is that this measure might foster other stakeholders such as nursing leaders and hospital administrators to follow in a uniform pattern.

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Acknowledgements

My journey towards my dissertation completion could not have been done without the assistance of some special people who have challenged, encouraged, and supported me along the way. First, I would like to thank my heavenly father, God, who kept me rooted and grounded spiritually. When I wanted to give up, His word has been steadfast in keeping me on the right track and He has been my guiding light. Second, I would like to thank my Walden University Committee, Chair, Dr. Mark Gordon; Second Committee Member, Dr. Steve Matarelli; and the URR person, Dr. Augusto Ferreros. I truly wish you were there together at the beginning of my journey, but I know I cannot live in regrets because there is no time like the right time. You have relentlessly provided expert support and directions and also challenged my capabilities than I thought I could in ways that allowed critical review and applications geared to what my dissertation is today. Thank you. Third, I would like to thank my wonderful and loving husband, Dexter Braithwaite, who has been my support all the way when I wanted to throw in the towel. Without you knowing, you came at the right time to ask, "How is the study going?" I love you for that and more. Fourth, to my loving and compassionate children, Isaiah Braithwaite and Miracle Braithwaite. Thank you for allowing me time away from your time towards my journey. You have both been my joy, inspiration and my goal is that you have a legacy to follow. Fifth, to my parents, Donna James and Neville James. You have allowed me the opportunity of being available throughout my life, helping me to become the woman I am today and being there when I needed your help in any way. Sixth, to my sister, Monifa Kirton,Woman of God; my brother-in-law, Sean Kirton, and my wonderful

nephews: Ezekiel, Elias, Ezra, and Elim. I love you all more than words can say. Stay holding on to God's unchanging hands. My nephews, the sky is not the limit. Beyond Space is the limit. Seventh, to my mother-in-law, Gem Braithwaite. My love you have been a source of inspiration with your encouragement and fervent prayer, God-fearing woman. I love our small talks that occur for hours. Lately, I have been missing it, but I know the love remains mutual. Eighth, I would like to thank my fellow PhD Walden University graduates for being a great support and encouragement. Ninth, to my wonderful grandparents who have gone home with the lord, especially my grandfather, James Braithwaite who was a stickler for education. Tenth, to my director, Felicia Thompson of Downstate Medical Center and the Social Work Team. Felicia, you are a great person whom I am proud to call my leader. Like you always say, "Shine baby shine" and I love every bit of it. I want you to know, I am shining. My social work teammates, thank you for your continuous support throughout my journey. I could not have done this without you. Finally, to the study participants. Thank you for taking time out of your busy schedule to share your experience. Without it, this study would not be what it is today. I really do appreciate you, so continue to shine.

Table of Contents

List of Tables vii

List of Figures viii

Chapter 1: Introduction to the Study...1

Introduction...1

Background of the Study 3

Problem Statement 6

Purpose of the Study 6

Research Question..7

Theoretical Framework 7

Nature of the Study 8

Definitions of Terms 9

Assumptions..10

Scope and Delimitations 10

Limitations 11

Significance of the Study 12

Significance to Public Policy 12

Significance to Social Change 13

Summary 13

Chapter 2: Literature Review 15

Introduction..15

Literature Search Strategy...16

Theoretical Framework 17
Literature Review Related to Key Concepts 19
Structural Empowerment 21
Crisis Strategies During the Pandemic 24
Technological Advancements in the Pandemic 38
New York City Hospitals’ Response to the Pandemic 42
Summary 45
Chapter 3: Research Method 46
Introduction 46
Research Design and Rationale 47
Setting 49
Role of the Researcher 50
Data Analysis 51
Methodology 51
Participation Selection Logic 51
Instrumentation 52
Procedures for Recruitment, Participation, and Data Collection 53
Data Analysis Plan 53
Issues of Trustworthiness 55
Credibility 56
Transferability 56
Dependability 56

Confirmability 57

Ethical Procedures... 57

Summary 59

Chapter 4: Results 60

Introduction..60

Setting 60

Demographics 61

Participant Recruitment...62

Data Collection 62

Data Analysis 64

Evidence of Trustworthiness..65

Credibility 67

Transferability.. 68

Dependability 68

Confirmability 68

Results 69

Theme 1: Challenging Complications During COVID-19.................................. 70

Theme 2: CNO Perception of Resource Availability 78

Theme 3: CNOs' Perceptions of Their Leadership Effectiveness 80

Theme 4: CNOs' Role, Responsibility, and Accountability................................ 81

Theme 5: CNOs' View of Community and External Response 84

Theme 6: CNOs and the Availability of PPE 85

Theme 7: CNOs' Perception of Aggrandized Administrative Support 86

Theme 8: COVID-19 Creation of Opportunity for Advancement........................ 88

Theme 9: Creatives Strategies CNOs Used 89

Theme 10: Executive Orders' Impact and CNOs' Responses 91

Theme 11: Informal Supports 93

Theme 12: Internal Organization Factors Used by CNOs.................................... 95

Theme 13: Leadership Sustainability... 97

Theme 14: Psychosocial Support Importance and Impact.................................... 98

Theme 15: Rapid Patient Surge, Loss, and Effects.. 99

Theme 16: Realizations for Future Improvement 100

Theme 17: Senior Leadership Support 102

Discrepant Cases 102

Experience of Participants 102

Summary 103

Chapter 5: Discussion, Conclusions, and Recommendations..104

Introduction..104

Interpretation of the Findings..105

Theme 1: Challenging Complications During COVID-19................................ 107

Theme 2: CNOs' Perception of Resource Availability...................................... 111

Theme 3: CNOs' Perception of Their Leadership Effectiveness........................ 112

Theme 4: CNOs' Role, Responsibility, and Accountability............................... 112

Theme 5: CNOs' View of Community and External Response 113

Theme 6: CNOs and the Availability of PPE 113

Theme 7: CNOs' Perception of Aggrandized Administrative Support 113

Theme 8: COVID-19 Creation of Opportunity for Advancement...................... 114

Theme 9: Creatives Strategies CNOs used 114

Theme 10: Executive Orders' Impact and CNO Response 115

Theme 11: Informal Supports 115

Theme 12: Internal Organization Factors Used by CNOs................................. 116

Theme 13: Leadership Sustainability... 117

Theme 14: Psychosocial Support Importance and Impact................................. 117

Theme 15: Rapid Patient Surge, Loss and Effects... 118

Theme 16: Realization for Future Improvement 119

Theme 17: Senior Leadership Support 119

Limitations of the Study...120

Recommendations..120

Implications..123

Significance of the Study...124

Significance to Public Policy 124

Significance to Hospital Policy... 125

Significance to Social Change 126

Conclusion 127

References...129

Appendix A: Interview Questions 155

Appendix B: Invitation to Participate in Study 158

Appendix C: Distribution of Participant Responses 159

Appendix D: Themes and Subthemes 162

List of Tables

Table 1. Participant Demographics 61

List of Figures

Figure 1. Word Cloud 65

Figure 2. Primary Theme and Subthemes of Challenges 71

Figure 3. Subthemes of Information Challenges 76

Figure 4. Informal Supports 93

Figure 5. Rapid Patient Surge, Loss, and Effects 101

Chapter 1: Introduction to the Study

Introduction

The SARS-CoV-2 (COVID-19) pandemic, a severe acute respiratory syndrome, took the world by surprise. On December 21, 2019, the first cluster of patients presented with symptoms of the virus. COVID-19 was officially detected as a pneumonia of unknown cause 10 days later, on December 31, 2019, in Wuhan, China (Bennett et al., 2020; WHO, 2020). The outbreak developed swiftly. By January 30, 2020, the World Health Organization issued a statement describing the outbreak as a public health emergency of international concern (World Health Organization, 2020). On February 11, 2020, WHO gave the new disease a name: coronavirus disease 2019 (COVID-19). Acting Chief Nursing Officers, Chief Nursing Officers, and Chief Nursing Executives (collectively Chief Nursing Officers or CNOs) at hospitals in the state of New York had to remain resilient and respond to executive orders issued by Presidents Trump, Biden, Mayor of New York Bill de Blasio, and Andrew Cuomo, governor of the state of New York. Executive orders pertaining to the COVID-19 crisis were issued in quick succession. As of April 8, 2021, Trump had issued eight (Brown et al., 2020), Biden had issued 10 (Hickey et al., 2021), de Blasio had issued 29 (Husch Blackwell, 2021), and Cuomo had issued 107 (Husch Blackwell, 2021).

As soon as CNOs received an executive order and made decisions in response to it, another order would be issued. This continuous barrage of executive orders created an unstable health care system in continuous flux. The CNOs had the responsibility of ensuring that patients as well as nurses' needs were met, but more importantly, that the quality of patient care was not compromised.

On March 11, 2020, WHO announced that the outbreak had advanced to the status of a global pandemic (Saadat et al., 2020; World Health Organization, 2020). Between December 31, 2019, and April 7, 2021, 131,639,092 cases of COVID-19 had been reported worldwide, including 2,857,866 deaths (European Centre for Disease Prevention and Control, 2021). The clinical indications of COVID-19 range from no symptoms to mild respiratory tract infection with influenza-like illness with fever, cough, and fatigue, and severe symptoms such as lung injury, multiorgan failure, and even death (Synowiec et al., 2021). The lungs are the main gateway for infection; however, autopsy samples show COVID-19 DNA in the kidneys, liver, heart, brain, and blood. Some COVID-19 patients exhibit multi-organ involvement and severe complications such as multisystem inflammatory syndrome (MIS) in children (MIS-C) and adults (MIS-A; Synowiec et al., 2021).

During the initial stages of the incubation period, however, the complexities of the virus were not clearly understood. The rapid spread of the virus created a series of catastrophic events. Health care systems were overloaded with patients in crisis, with no evidence-based information on how to control the virus. At one point, health authorities believed that the virus was transmitted through either airborne or droplet forms; therefore, healthcare providers were mandated to use precautions to prevent transmission of COVID-19 through both methods (WHO, 2020). This belief was later found to be invalid (WHO, 2020).

To meet the demands of increased mortality rates, modifications were required in respect to documenting electronic medical records (EMRs), the standard use of personal protective equipment (PPE) regarding infection control protocol, the priority of patient

care, and nursing staff ratios. The system could not have continued to operate had it not been for the swift action of the CNOs. Throughout the COVID-19 pandemic, the CNOs were tasked with responding to executive orders from government officials while maintaining the quality of patient outcomes, staffing needs, and organizational needs. Still, their contributions were not acknowledged, even as their frontline nurses were credited as the heroes in this journey. A search of existing studies found no research regarding the contributions of CNOs during the COVID-19 pandemic. Thus, this study explored their experiences as nurse leaders at the height of the COVID-19 pandemic.

Background of the Study

On January 30, 2020, the World Health Organization (WHO) announced that the COVID-19 outbreak was a global emergency (Saadat et al., 2020). The virus quickly spread to the United States, causing lockdowns, an increase in hospitalizations, and higher mortality rates. Health authorities struggled to keep their residents safe while also maintaining a resilient system, and it was becoming more evident that the system was being challenged in more ways than could have ever been imagined prior to the pandemic.

One such state is New York State, where 214 hospitals serve patients (New York State Department of Health, 2021). New York State became the epicenter for the outbreak in the United States with the highest prevalence of cases (NewsRx, 2021). NewsRx (2021) reported substantial hospitalizations and deaths by the end of March 2020. In New York state regions outside of New York City, 141,496 persons were tested; of those, 47,326 tested positive for SARS-CoV-2 (NewsRX, 2021; Synowiec et al., 2021).

Between March 12 and March 30, 2020, of the 229 initial cases diagnosed, 13% were hospitalized and 2% expired (NewsRx, 2021). The demands of the pandemic outweighed hospital capacity, which led to the construction of makeshift tents for treating patients on outside grounds. Additionally, the increase in patients admitted led to unfavorable distortions of the staff to patient ratio. There was an ethical dilemma regarding which patients would be provided with scarce medical resources such as PPE gear; thus, guidelines for use of the equipment had to be compromised to ensure rapid and efficient delivery of care (Degesys et al., 2020; Rowan & Laffey, 2020). Lacey et al. (2020) noted that the availability of resources was critical for responding to the pandemic. Such a response had competing centrality in the balance between service delivery and preserving access to essential health care services, which stress healthcare organizations (Lacey et al., 2020).

A CNO is a nurse who occupies the highest office in nursing leadership within the hospital of their assignment (Gaines, 2020). CNOs are free to work at other medical facilities providing bedside care to maintain their clinical skills, but it is not a requirement for their office. The responsibility for directing crisis intervention in nursing care at a hospital is primarily left to CNOs; however, the intensity of the COVID-19 pandemic posed challenges to nurse executive competencies that guide their executive practices, as outlined by the American Organization for Nursing Leadership (AONL; AONL, 2021). An essential continuous response to executive orders prompted the need to address the four competencies identified by AONL, such as communication and relationships with management, professionalism, knowledge of health care environment, and business skills and principles. Beilstein et al. (2020) noted that the pandemic

represented stressors for hospital leadership regarding communication, leadership, preparedness, and flexibility of response. As of April 2, 2021, the Trump administration issued eight executive orders pertaining to COVID-19 (Federal Register, 2021), and more recently the Biden administration has issued 10 executive orders (Federal Register, 2021). Specific to New York State, Governor Cuomo issued 107 executive orders (Office of the Governor, 2021), and Mayor DeBlasio issued 29 executive orders pertaining to New York City (Husch Blackwell, 2021) and mandating specific responses to the pandemic.

Although not all executive orders pertained to patient care, the CNOs were charged with ensuring that orders specific to patient care were executed with precision while the ethical values of nursing were also upheld. In respect to nursing, the burden of the COVID-19 pandemic rested with hospital CNOs even more so than pre-COVID-19, even without additional support. Nurses who provided direct care to patients could request additional support to address situations as they arose, but the nursing executives were not able to request additional support in their role as nurse leaders. Further, nurses received public support as heroes of the pandemic, while the contributions of the CNOs were not heralded in popular media. Still, this work could not have been done without them.

The aim of my study is to explore the lived experiences of CNOs at hospitals in New York State during the height of the COVID-19 pandemic, particularly in relation to the influx of executive orders issued by the state governor. A search of existing studies showed a gap in the literature on this topic. No research has been done on whether

structural empowerment may have provided the necessary support for CNOs, leading to satisfactory outcomes.

Problem Statement

The COVID-19 pandemic of 2019-2021 represented a public health emergency for CNOs at hospitals throughout New York State. As nurse leaders, making the right decision at the right time spontaneously is critical to their role, even when staff members regard the decision as unpopular and restrictive. These decisions were relevant as CNOs responded to rapidly changing executive orders issued by Governor Andrew Cuomo regarding the health care system in the state.

The problem addressed by the phenomenological study was that CNOs at hospitals in New York State were charged with responding to executive orders pertaining to the COVID-19 pandemic while maintaining quality of patient care, but without adequate supplies, staffing constraints, and additional support for the duties associated with their role. I explore the lived experiences of the CNOs and provided insight into their structural empowerment throughout the crisis.

Purpose of the Study

The purpose of this study is to explore the experiences of CNOs at hospitals in New York State during the COVID-19 pandemic in relation to their perceptions of leadership effectiveness, job satisfaction, and structural empowerment in response to executive orders issued by Governor of New York, Andrew Cuomo. The phenomenon of interest is the lived experiences of CNOs at hospitals in New York State as they made decisions about patient care in response to executive directives issued by Governor Andrew Cuomo during the pandemic.

Research Question

In this study, I sought to address the following question:

RQ: How do CNOs perceive their lived experiences of organizational factors in relation to structural empowerment and job satisfaction during the COVID-19 pandemic?

Theoretical Framework

The theoretical framework for the study, Kanter's theory of structural empowerment, addressed organizational behavior in the context of employee empowerment (Kanter, 1993). Kanter (1993) proposed that employees feel empowered when the organization provides them with access to information, resources, support, and opportunities for professional development. Erickson et al. (2003) stated that "empowerment … occur[s] when an organization sincerely engages people and progressively responds to this engagement with mutual interest and intention to promote [their] growth" (p. 96).

The theory has been applied to nursing by multiple researchers. Kluska et al. (2004) and Sieu et al. (2005) proposed that access to resources is important for empowering nurses to feel competence, autonomy, and meaning in their work. Empowerment develops as employees take control of their work life and participate in decisions that affect the organization (Kanter, 1993). Casey et al. (2010) found the level of structural empowerment predicts psychological empowerment, and these two markers of empowerment predict job satisfaction.

For the purpose of my study, structural empowerment can be described in the context of organizational structures (policies, networks, and processes) that cause CNOs to feel empowered to make decisions about patient care. Nurse leaders' empowerment is

important because it influences their professional fulfillment, as well as clinical excellence (Casey et al., 2010; Leontieu et al., 2021). Nurse leaders require access to empowerment structures and involvement in policy formation, organization, and control to be effective in ensuring high quality of patient care. In general, empowerment promotes nurse leaders' engagement with the workplace, leading to better performance outcomes (Leontieu et al., 2021). I selected structural empowerment as the theoretical framework due to its emphasis on access to empowerment structures and involvement in policy formation and control in relation to ensuring high quality patient care during the COVID-19 pandemic 2019-2021. The value of empowerment theory is its application to the problem statement, purpose, and research question relating to the lived experiences of CNOs during the COVID-19 pandemic 2019-2021.

Nature of the Study

A phenomenological qualitative design was used to collect data about the experience of nurse leadership in response to the phenomenon of executive orders issued by the governor of New York during the COVID-19 pandemic of 2019-2021. A qualitative method was appropriate for addressing the research question for the study because it could be used to explore the lived experiences of individuals involved with a phenomenon (Corbin & Strauss, 2014). The purpose of a qualitative study is not to obtain factual data, but to ask study participants to reflect on their lived experiences with real-life events (Corbin & Strauss, 2014).

Data were collected through the interviews of 10 CNOs using 13 open-ended questions. A van Kaam method (Moustakas, 1994) was used to analyze the interview responses (data). An analysis was conducted to sort and identify themes and patterns of

experience by the studying participants, CNOs working at hospitals in New York State during the pandemic. The interview response data were analyzed for recurring themes. The themes were used to develop conclusions about the lived experiences of the study participants in the context of their structural empowerment during the COVID-19 pandemic 2019-2021.

Definitions of Terms

Acting Chief Nursing Officer (ACNO): A nurse who temporarily performs the role of a chief nursing officer due to vacancy (registerednursing.org, 2021).

Chief Nursing Officer (CNO): A nurse who occupies the highest office in nursing leadership (registerednursing.org, 2021).

Chief Nursing Executive (CNE): A nurse who occupies the highest level of management position within a healthcare organization (registerednursing.org, 2021).

COVID-19: Coronavirus disease 2019 (COVID-19; World Health Organization, 2020).

Executive order: An order issued by a sitting president to the executive branch or by a governor requiring public health agencies to take specific actions (Gakh et al., 2013).

Nurse executive: Occupies the highest administrative nursing role in a health care organization, leads the nursing team, manages overall patient care services, and makes administrative decisions that support organizational strategy (registerednursing.org, 2021). For this study's purpose, CNO or nurse executive was a collective noun used to represent the ACNO/CNO/CNE positions.

Pandemic: Disease that is prevalent throughout an entire country or the world (WHO, 2020).

Personal protective equipment (PPE): Equipment worn to protect from exposure to hazards that cause serious harm or illness in the workplace (World Health Organization, 2020).

van Kaam method: Seven-step method of analysis for qualitative data (Moustakas, 1994).

Assumptions

The following assumptions were relevant to the study. It was assumed that study participants (CNOs at hospitals in the state of New York) would respond candidly to the interview questions. I supported candid responses by assuring study participants that their identity and response data would be kept confidential. A second assumption was that the study data would accurately reflect the experiences of CNOs working at hospitals in the state of New York during the COVID-19 pandemic 2019-2021. Another assumption was that the phenomenological study would contribute to the literature on nurse leadership in the context of the pandemic as a public health emergency.

Scope and Delimitations

Delimitations involve choices that the researcher makes regarding the boundaries of a study regarding why certain research actions are excluded (Simon, 2011). The delimitations included the following. The researcher would not interview CNOs who were employed in hospitals outside of New York State during the COVID-19 pandemic 2019-2021. Although those nurse leaders might also have valuable opinions and reflections to contribute regarding their leadership through the pandemic, they fell outside

the study scope. The study's scope excluded nurses who are not CNOs working at hospitals in New York State during the pandemic because the qualitative and phenomenological study was done with the aim of understanding structured empowerment from the perspective of the nurse leader study participant.

Limitations

A research limitation refers to aspects of the research over which the researcher has no control, and which limits the application of the study results in other settings (Simon, 2011). The following limitations were present in the study. Some limitations of the current study were unavoidable and beyond my control, such as the intentions of the participants and their characteristics. Participants self-reported as being employed as a nurse executive of a hospital in New York state during the pandemic, but this information was not confirmed. In addition, it was possible that one or more participants would not respond candidly to the interview questions.

A further limitation was that the sample population for the current study might not be representative of other CNOs working at hospitals in the state of New York during the COVID-19 pandemic. The experience of those CNOs might have differed from those of the study participants, due to factors such as whether the hospital was located in a high-population dense urban area, the percentage of patients treated for COVID-19 at the hospital, the availability of medical supplies, and budgets to support optimal staff to patient ratios.

A qualitative study is dependent on the subjective, nonjudgmental, and accurate analysis of the data for themes (Corbin & Strauss, 2014). I maintained a research journal and audit trail to monitor for bias during analysis of data. Other study limitations

included small sample size, which is characteristic of qualitative studies. As with any qualitative study, my conclusions would not be generalizable to other CNOs working at hospitals in the state of New York during the COVID-19 pandemic, or to CNOs outside of New York State.

Significance of the Study

Recruitment and retention of CNOs are critical for the effectiveness of healthcare institutions in delivering quality care. Understanding the experiences of CNOs during the COVID-19 pandemic in response to executive orders from the governor of New York, and their structural empowerment in relation to access to resources, information, and support was beneficial to healthcare organizational effectiveness and quality of patient care. This study may contribute value for stakeholders including nurse leaders, hospital administrators, and public policymakers. By applying the results of the study to design interventions to support structural empowerment for CNOs, stakeholders can support nurse leaders as they respond to future healthcare crises.

Significance to Public Policy

The study is significant because it aimed to explore the experiences of CNOs at hospitals in the state of New York in response to executive orders from the governor of New York during the COVID-19 crisis. Documenting the way that nurse leaders perceived their level of structural empowerment, including their ability to access resources during a time of escalated need, could be useful to other nurse leaders and public health policymakers in preparing to respond to future public health crises.

Significance to Social Change

The theoretical framework of structural empowerment as it relates to nurse leaders could contribute to leadership theory, specifically how nurse leaders responded to government mandates that had to be implemented in real time with few additional resources. The study may have provided additional insights for nurse leaders and public health policymakers by giving a voice to CNOs who served at the forefront of the COVID-19 crisis at hospitals in the State of New York.

Summary

The COVID-19 pandemic developed rapidly, starting with an announcement on January 30, 2020, from WHO that the outbreak was a public health emergency of international concern (WHO, 2020). As the governor of the state of New York issued executive orders about how health officials should respond to the pandemic, CNOs at hospitals in the state of New York were charged with responding to the executive orders as soon as they were announced. The CNOs had to ensure that the quality of patient care was not compromised, as they confronted critical shortages of medical supplies and escalating numbers of patients in needing care for the virus.

The CNOs were forced to modify standards of care regarding documenting in the EMR, using PPE regarding infection control protocol, and prioritizing the order in which patients would receive care. These decisions had to be made in the face of continuously changing health information about the prevalence and transmissibility of the virus. The problem that was addressed by the phenomenological study is that CNOs at hospitals in New York State were charged with responding to executive orders pertaining to the COVID-19 pandemic, while maintaining quality of patient care but without adequate

supplies or additional support. The study explored the lived experiences of the CNOs in this context.

Chapter 2: Literature Review

Introduction

The problem to be addressed by the phenomenological study was that CNOs at hospitals in New York State were charged with responding to executive orders pertaining to the COVID-19 pandemic, while maintaining quality of patient care but without additional support to address the challenges that COVID-19 presented. The CNOs occupy a demanding and complex role that involved acceptance of accountability in leading nursing staff while sustaining quality patient outcomes (Beckman, 2020; Ingwell-Spolan, 2018; McGuire et al., 2021; Shingler-Nace, 2020).

The purpose of this study was to explore the experiences of CNOs at hospitals in New York State during the COVID-19 pandemic as related to their perceptions of leadership effectiveness, job satisfaction, and structural empowerment in response to executive orders issued by Governor of New York, Andrew Cuomo. The state orders were released in the context of federal orders issued by the Trump administration, and later carried into the Biden administration. As of April 2, 2020, the Trump administration issued six executive orders (#s13962, 13945, 13927, 13911, 13910, 13909) pertaining to COVID-19 (Federal Register, 2021), and the Biden administration issued 10 executive orders (Federal Register, 2021). To date, Governor Cuomo has issued 107 executive orders (Office of the Governor, 2021), and Mayor De Blasio has issued 29 executive orders pertaining to New York City (Husch Blackwell, 2021) in relation to the pandemic response approaches.

The results of this study's outcomes could contribute to understanding how structural empowerment of nurse leaders can support decision-making during a public

health crisis. Because it is reasonable to assume that other public health crises will occur in the future, the pandemic experience may be translated into useful practices for nursing leadership (Caroselli, 2020).

The chapter opens with the literature search strategy and the theoretical framework. Other sections included in this chapter include advance surge planning for the pandemic, hospital response to the pandemic, response of hospitals in New York to the pandemic, crisis strategies, and staff well-being. The literature review also contains topics related to COVID-19 pandemic responses, such as advancements in technology, that have been propelled by the crisis. The literature review was developed to effectively synthesize existing studies pertaining to nurse leadership during the pandemic. In the conclusion, I indicate ways by which the current study may contribute to the gap in existing research.

Literature Search Strategy

The following databases were searched for peer-reviewed articles for inclusion in this review of the literature: Nursing and Allied Health, Academic Search Ultimate, Google Scholar, EBSCOhost, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). The keywords that were used to search the databases were: *nursing leadership, structural empowerment, public health crisis, COVID-19, pandemic, executive orders pandemic,* and *governor State of New York.*

To find current sources, database searches were calibrated so that only peer-reviewed journal articles published after the pandemic began were populated. Some older studies are included when relevant to nurse leadership. The studies contained information related to nurse leadership, hospital response to the pandemic, and challenges such as the

shortage of personal protective equipment (PPE) and technological advancement due to the crisis.

Theoretical Framework

The theoretical framework for the study is Kanter's theory of structural empowerment, which addresses organizational behavior in the context of employee empowerment (Kanter, 1993). Kanter's theory of structural empowerment gained acceptance due to its close alignment with the trend toward organizational effectiveness via the effective utilization of human resources (Siegall & Gardner, 2000). As Conger and Kanungo (1988) noted, employee empowerment "is a principal component of managerial and organizational effectiveness, [and] empowerment techniques play a crucial role in a group development and maintenance" (p. 471).

Kanter (1993) proposed that employees feel empowered when the organization provides them with access to information, resources, support, and opportunities for professional development. These organizational empowerment structures are discussed in the present study in relation to CNOs at hospitals in the state of New York during the COVID-19 pandemic. Erickson et al. (2003) stated that "empowerment … occur[s] when an organization sincerely engages people and progressively responds to this engagement with mutual interest and intention to promote [their] growth" (p. 96).

Kanter (1993) revealed that power is expressed through emanate formal and informal systems within an organization. Formal power is expressed in jobs with high visibility. The jobs allow for significant discretion or flexibility in how work is accomplished and are essential to the organization's purpose and mission. Informal power is expressed in jobs that involve positive relationships between superiors, peers,

and subordinates. Informal power operates through social connections and through communication and information sharing. Both formal and informal power provide opportunities for employees to accomplish their work in meaningful ways (Orgambídez-Ramos & Borrego-Alés, 2014).

In the nursing context, the way formal and informal power is structured in the organization influences nurse leaders' perception of how much access they have to empowerment structures (Spence Laschinger et al., 1997). Formal and informal power, along with the perception of access to empowerment structures, may be significant predictors of nurse leaders' satisfaction with their nurse leadership. Kluska et al. (2004) and Sieu et al. (2005) proposed that access to resources is important for empowering nurses to feel competent, autonomous, and able to derive meaning from their work. Empowerment develops as employees take control of their work life and participate in decisions that affect the organization (Kanter, 1993). Casey et al. (2010) posited that research indicates the level of structural empowerment predicts psychological empowerment, and that these two markers of empowerment predict job satisfaction.

Health care workers worldwide encounter a variety of stressors. In particular, the COVID-19 pandemic has increased psychological strain on health care personnel worldwide. Many had to undergo rapid learning to adapt to deployment in health care sectors they were unfamiliar with (Marks et al., 2021; Mulfinger et al., 2019). Yet most hospitals failed to implement a workplace health support program. Workplace health support programs could include behavioral as well as organizational interventions to support staff mental health through structural empowerment (Mulfinger et al., 2019).

Empowerment of nurse leaders is known to be an important factor of hospital performance and occupational health (Cougot et al., 2019). Nevertheless, providing and maintaining such empowerment is a constant challenge. Hospitals are traditional organizations that are organized as bureaucracies dominated by a managerial culture of stratified control, which discourages professionals' mastery of their work and may dilute their commitment and performance (Cougot et al., 2019). Structural empowerment can support nurse leaders as they respond to daily challenges.

Literature Review Related to Key Concepts

Structural empowerment can be described in the context of the organizational structures (policies, networks, and processes) that cause CNOs to feel empowered to make decisions about patient care. Their empowerment is important because it influences their professional fulfillment and clinical excellence (Casey et al., 2010; Leontieu et al., 2021). CNOs require access to empowerment structures and involvement in policy formation, organization, and control to be effective in ensuring high quality patient care. In general, empowerment promotes nurse leaders' engagement with the workplace, leading to better performance outcomes (Leontieu et al., 2021). In addition to responding to governmental regulations such as executive orders issued by the president and state governors, CNOs must also keep up with technological advances and develop strategies aimed at providing quality and safe care to the patients using those technologies (Moura et al., 2020).

In the context of organizational power, there are two different theoretical conceptions of empowerment: (a) structural empowerment and (b) psychological empowerment (Moura et al., 2020). In the context of the hospital organization, CNOs

develop structural empowerment through their responsibility for the quality of care, as well as for supporting the professional development of nurses, conflict management, staffing ratios of staff to patients, and resource planning (Moura et al., 2020). Health care workers gain psychological empowerment through working conditions that generate motivation and contribute to their feeling of personal control in the workplace, with the additional perception that their work is highly valued as a social good (Mouras et al., 2020).

I selected structural empowerment as the theoretical framework for this study due to its emphasis on access to empowerment structures, and involvement in policy formation and control, specifically in the context of ensuring high quality of patient care during the COVID-19 pandemic. The value of empowerment theory is its application to the problem statement, purpose, and research question relating to the lived experiences of CNOs during the pandemic.

Nurse leaders use the Quadruple Aim as an accepted compass for maintaining standards of health system performance (Batcheller et al., 2017; Haverfield et al., 2020; Roth et al., 2020). The four components of the Quadruple Aim are to (a) enhance the patient experience, (b) raise quality of health in the general population, (c) reduce health care spending, and (d) improve quality of the work environment for health care clinicians and staff (Nelson et al., 2021; Shekelle & Begashaw, 2021). CNOs are responsible for the daily routines of hospital operations and multiple competing priorities (Sittler & Criswell, 2019) while experiencing “head-snapping change” in care delivery models (Crawford et al., 2017, p. 297). In sum, CNOs were confronted with the need to retool their roles, responsibilities, and competencies during COVID-19.

Structural Empowerment

In a scoping review of 672 articles, I examined the effect of nurses' structural empowerment on the quality, effectiveness, safety, and efficiency of hospital care (Goedhart et al., 2017). These studies showed a variety of quality outcomes, in part due to different methods for measuring the variables; however, all the articles reported positive associations between the structural empowerment of nurses and outcomes. The hospital environment often exposes nurses to toxic behaviors (Elkholy et al., 2020). The nurse executive can empower nurses by using a positive relational-leadership approach. In a non-experimental, descriptive correlational research study (Elkholy et al., 2020), 244 nurses were surveyed using three standardized questionnaires: Authentic Leadership Inventory, Conditions of Work Effectiveness Questionnaire, and Practice Environment Scale of the Nursing Work Index. The study results showed that most (98.4%) of the nurses reported that their leaders practiced moderate to high authentic leadership. This percentage was closely related to the nurses' report of (95.1%) relatively high levels of personal structural empowerment, thus indicating a significant relationship between the two assessments (Elkholy et al., 2020).

Staff nurse participation in clinical and organizational decisions is crucial when addressing complex patient care needs. Van Bogaert et al. (2016) conducted interviews of 11 staff nurses at a university hospital in Belgium that underwent an organizational restructuring from a classic hierarchical structure to a flat and interdisciplinary type. Staff nurses reported favorably, stating that they experienced structural empowerment since they were included in decision-making about patient care on their practice unit. The nurses did describe relatively high work demands, which at times were modified by the

structural empowerment that they were granted. The nurse managers' work environment was described as crucial for structural empowerment, while time pressures and workload were viewed as barriers to empowerment (Van Bogaert et al., 2016).

Eskandari et al. (2017) conducted a descriptive-correlational study to examine the relationship between 491 nurses' perception of structural empowerment and their commitment to the hospital where they were employed. According to the findings, the nurses described professional opportunity as the most important element of their structural empowerment. The conclusions reported a significant relationship between structural empowerment and the nurses' commitment to their employer (Eskandari et al., 2017).

In another study, the structural empowerment model was used to assess the influence of empowerment components including opportunities, resources, information, and support to prevent burnout among 297 nurses in Portugal (Orgambídez-Ramos et al., 2017). The nurses reported that professional development opportunities and access to support had the greatest impact in averting burnout, whereas access to resources had both direct and indirect impacts on burnout. Overall, professional advancement training, the chance to access formal and informal support networks, and the availability of resources needed to provide care supported structural empowerment and reduced risk of burnout (Orgambídez-Ramos et al., 2017).

Fragkos et al. (2020) used a systematic review and meta-analysis to explore the relationship between structural empowerment and organizational commitment. Results showed that structural empowerment was correlated with job satisfaction and perceived psychological empowerment. Further, job satisfaction was correlated with psychological

empowerment, noting that empowerment could be used to predict commitment to the organization. The recommendation was that organizations could increase performance by making empowerment as effective as possible (Fragkos et al., 2020). Nurses can act as clinical leaders by providing direction and support to patients and their team in delivering care. Using a mixed-method, nonexperimental survey design, Connolly et al. (2018) explored the need for structural and psychological empowerment in relation to clinical leadership behaviors. The sample population was a group of registered nurses working in a hospital emergency department. The survey results showed that while the nurses believed that they frequently showed clinical leadership behaviors, their sense of psychological empowerment was only moderate. The results showed management can create an empowering environment to support clinical leadership for nurses (Connolly et al., 2018).

The COVID-19 pandemic has forced nurse leaders to revise standards for use of PPE to stretch insufficient supplies. This compromise may have caused moral stress because it involved lowering standards in the hospital environment. Role stress, or the obligation to deliver optimal care in less-than-optimal circumstances, is a major psychosocial stressor that has been negatively associated with job satisfaction for nurses. According to empowerment theory, structural empowerment can reduce role stress and increase job satisfaction.

Orgambídez and Almeida (2020) used a cross-sectional design to analyze the relationships among structural empowerment, role stress, and job satisfaction. The sample population consisted of 124 nurses and 130 nurse assistants at private health care organizations in Portugal. In both samples, structural empowerment, role ambiguity, and

role conflict were significant predictors of job satisfaction. which indicated structural empowerment had a direct effect of increasing the perceptions of professional power while reducing role stress (Orgambídez & Almeida, 2020).

Bullying is a problem in some nursing environments. Kang and Han (2021) conducted a cross-sectional correlational study to evaluate the effects of structural empowerment and resilience in relation to bullying and nursing performance. The sample population of 435 nurses working in Seoul, South Korea reported that structural empowerment moderated the effect of bullying and nursing performance, while resilience had no effect. The study conclusions stated that increasing structural empowerment could reduce the negative effects of bullying in the nursing workplace (Kang & Han, 2021).

Similarly to Orgambídez and Almeida (2020) and Kang and Han's (2021) South Korean findings, Sauer and McCoy (2018) focused on bullying among nurses in the United States of America. Sauer and McCoy reported that 72% of new nurses were the targets of bullying. What was striking from Sauer and McCoy's study is the relevance of bullying for psychological or physical effects on nurses' health but also the effect on their nursing performance. Sauer and McCoy suggested that distress from the effects of bullying can cause nurses to make medical errors, for nurses who have such psychological distress are more prone to such outcomes. The American Nursing Center noted that bullying in the workplace is destructive and may have negative consequences for nurses (Homayuni et al., 2021).

Crisis Strategies During the Pandemic

The CNOs at hospitals nationwide responded to the pandemic by revising priorities including staffing and distribution of critical supplies. Renke et al. (2020)

described the changes made by a large academic medical center in Michigan, located outside of Detroit. The center postponed elective procedures and required outpatient visits transition from in-person to telemedicine format.

As part of the phase one response, the center opened a dedicated COVID-19 ICU and increased bed capacity from 74 to 181 beds. Expansion of the ICU resulted in greater need for hospital staff. As the need for health care providers affected the entire state of Michigan, the state governor issued Executive Order 2020–30, which allowed nurse practitioners for the first time "to provide medical services appropriate to the professional's education, training, and experience, without physician supervision and without criminal, civil, or administrative penalty related to a lack of such supervision" (Office of Governor Gretchen Whitmer, 2022). The emergency credentialing allowed nurse practitioners to be deployed to the COVID-19 ICU as frontline providers.

In New York, while nurse practitioners were essential to the current climate, similar approaches through contingency plans that were developed, were taken with other medical staff to address the crisis (New York City Department of Health, 2021). Residents, hospitals, emergency medicine physicians, and hospital-based physician groups were redeployed to areas where staffing were needed the most and a "buddy-team" system was birthed. Medical and nursing students were also used. Case managers who are the gatekeepers of the hospitals were also deployed to provide bedside care.

The COVID-19 pandemic caused an unprecedented demand for health services (Kagan et al., 2021; Maben & Bridges, 2020). Health care providers were suddenly required to improvise new methods for patient care. Nurses served at the forefront of the fight against the pandemic even as they faced increased use of new medical technologies,

equipment shortages, lack of adequate personal protection supplies, and deployment to work in areas in which they had no experience due to urgent need (Henderson, 2020). Nurse leaders were challenged to establish isolation wards, cope with sudden inflows of patients, maintain the quality of care, and motivate nurses to work during this demanding time (Wu et al., 2020). While some nurses reported concern about communicating less effectively with patients when they wore a mask while providing care, patients reported acceptance of mask-wearing staff (Vitale et al., 2020).

Surge Planning

In a review of one health care system's response to COVID-19, Stamps et al. (2021) reported that nurse leaders acted as advocates for front-line nursing staff during the pandemic, for the nurses were immersed in a challenging workplace environment. This case study conducted by Stamps et al., 2020 outlined how a council of Chief Nursing Officers at five different hospitals in Rochester, New York met in advance of the surge of patients with COVID-19 to plan jointly and with the local Emergency Incident Command Structure, the chief medical officer, chief quality officer, infection prevention, and human resources at each hospital for the oncoming crisis. The council successfully operationalized CDC guidelines for patient care as well as supporting, educating, and empowering frontline nursing staff (Stamps et al., 2020).

The command center collaborated to make operational decisions consistent across the five hospitals, and daily staff briefings according to the principles of the *Identify, Isolate and Inform* tool (Koenig et al., 2020; Stamps et al., 2020). As an example, the most current screening questions were asked of each patient as they underwent registration into the electronic medical record system to immediately identify patients

with COVID-19. Screening of employees who had recently traveled was performed consistently, including a hotline for clearing them for return to work. Stamps et al. (2020) reported that communication trees were established to keep members of the CNO council informed of potential COVID-19 patients. Effective communication is a vital component during a public health emergency to promote nurses' willingness to care for patients in the ICU (Lord et al., 2021). The command center issued daily reports with the most current information on system-wide COVID-19 efforts. Nursing leaders extended their working hours to raise their visibility to support morale and encouraged staff to voice concerns and suggestions about dealing with the pandemic (Stamps et al., 2020).

PPE Shortage

In the context of the pandemic, PPE consists of protective masks, apparel, helmets, goggles, or equipment designed to protect health care workers from infection by the COVID-19 virus (Ahmed et al., 2020; Ha, 2020; Sherman, 2020). Standards of care during the COVID-19 pandemic included recommendations that frontline health care providers use PPE to reduce transmission through exposure control. During the community transmission stage of the pandemic, PPE was essential for protection of healthcare workers (Dai et al., 2020; Ha, 2020). The coronavirus disease (COVID-19) pandemic strained healthcare systems worldwide, causing a shortage of PPE (Burki et al., 2020; Fram et al., 2021).

In a discussion of ethical conflicts that CNOs experienced during the pandemic, Sherman (2020) mentioned inadequate PPE availability as an issue that caused guilt for nurse leaders. Supply chain deficiencies were not within the control of the leaders, yet the terms of their employment included the obligation to ensure staff protection from

contracting the virus in the hospital environment. They were confronted with the need to make choices about how to best use the available supply of PPE, which sometimes involved depriving some workers of adequate PPE while providing it to others.

Ahmed et al. (2020) compared shortage of PPE (gloves, face shields or goggles, suit/gown) among doctors in the United States compared to those in Pakistan during the pandemic. Study results showed that most (87.6%) of U.S. doctors reported having masks/N95 respirators, surgical gloves (79.6%), face shields/goggles (77.9%), and protective clothing (50.4%). In comparison, doctors in Pakistan reported low supplies of PPE. Just 37.4% had masks/N95 respirators, 34.5% had surgical gloves, 13.8% had face-shields/goggles, and 12.9% had protective clothing. Reuse of PPE was not recommended but was often done to extend supplies (Ahmen et al., 2020). The rate of PPE reuse was reported by more American doctors (80.5%) than by those from Pakistan (60.3%), due to higher amounts of PPE available in the United States. A higher number of doctors from Pakistan (50.6%) reported being forced to work without PPE out of necessity, due to lack of supply. In contrast, just 7.1% of American doctors reported being forced to work without PPE due to unavailability of supply (7.1%; Ahmed et al., 2020). These statistics illustrate the advantage of living and working in a developed country compared to a less affluent country such as Pakistan.

In a report on PPE shortages, Rowan and Laffey (2020) noted the supply chain for producing and delivering the supplies was inadequate for the production and delivery required. Rowan and Laffey also noted the supply chain for producing and delivering the supplies was inadequate for the production and delivery required. The equipment was

never designed for reuse because items are heat-sensitive, which disallows sterilization by conventional high temperature methods that most hospitals use.

Shortages of PPE have led to experimentation with reprocessing the equipment in an attempt to recycle supplies. Pre-COVID-19, these protocols would have been against all infection control evidence-based guidelines as well as state and federal guidelines. Most PPE items were not designed to be cleaned for reuse and sterilization techniques were not suitable for this purpose (Rowan & Laffey, 2020). Some of the PPE was time sensitive on the length of usage prior to being discarded pre-COVID-19, but that presented an unethical dilemma during COVID-19. Rowan and Laffey (2020) described efforts by health authorities in the Republic of Ireland to address the PPE shortage by using smart communication to improve efficiency of supply chain and nationally based production of PPE to augment shortages, along with the least desirable choice of sterilization or disinfection of the supplies. Reprocessing of the PPE involved understanding the composition of the item, item functionality after reprocessing treatment, and disinfection effectiveness. Eco-friendly technologies deployed in the Republic of Ireland involved use of UV irradiation and vaporized hydrogen peroxide (vVH2O2) for cleaning respirators.

At the start of the COVID-19 pandemic, there was great variability in the availability of PPE for staff caring for COVID-19 patients worldwide. Tabah et al. (2020) conducted a worldwide survey of 1,402 health care providers regarding PPE supplies. The results of the survey from April 2020 showed that more than half of respondents reported that at least one PPE item was missing. The respondents also reported adverse health effects from wearing PPE through a work shift without relief. Approximately 817

(30%) respondents reported being forced to reuse single-use PPE in violation of manufacturer's guidelines. The average wear time of the PPE was 4 hours. For the wearer, Adverse health effects of PPE tended to occur during/on longer shifts. These adverse effects were described as heat (51%), thirst (47%), pressure soreness (44%), headaches (28%), inability to go to the bathroom (27%), and extreme fatigue (20%; Tabah et al., 2020).

Stamps et al. (2020) described how one hospital system in New York State improvised to ensure adequate PPE for health care providers. With supplies at critical levels, each hospital in the system established a PPE command center to conduct appropriate distribution while safekeeping supplies. The centers maintained 24-hour accessibility, and nurse leaders could request PPE according to need and burn rate. While PPE reuse was not the general practice, medical staff were instructed to re-use face shields and goggles. Specially trained nurses worked on a 24-hour basis to conduct "fit tests" to ensure N95 masks fit correctly. The hospital system issued a call to the general public for volunteers to sew masks for health care workers. The volunteers were provided with sewing instructions for doing so. Stamps et al. reported the hospital system was able to sustain PPE supplies to acceptable levels through this approach.

Changes in Protocol

In an editorial for the *New England Journal of Medicine*, Rosenquist (2021) described the anxiety that he and other physicians experienced as the guidelines for treating patients with COVID-19 constantly changed throughout the pandemic. The treatment of most human illnesses and conditions is derived from decades of knowledge and research. Rosenquist recounted his shock as the criteria for diagnosing and treating

COVID-19 changed overnight more than once during the pandemic. While improvisation in the face of changing information and conditions may be routine in other professions, it is not customary in medicine. Rosenquist noted that the corpus of knowledge he had acquired over decades suddenly became less relevant than information garnered from disparate sources on a moment-to-moment basis. These changes proved to be disorienting to him as a physician because he distrusted the information he was given to rely upon instead, which seemed to change too rapidly for his comfort.

Staff Wellness

The COVID-19 outbreak overwhelmed the capacity of health care systems. Because nurses provided most of frontline critical care for the surge of patients, they were at risk for infection with the virus, social isolation, exhaustion, and burnout (Anderson et al., 2020; Guixia & Hui, 2020; Hu et al., 2020; Ripp et al., 2020; Ross, 2020; Schechter et al., 2020; Wu et al., 2020). As a group, health care providers are considered to be vulnerable to developing mental health symptoms during an infectious disease crisis (del Carmen Giménez-Espert, 2020; Kagan et al., 2021; Sherman, 2020).

Mass outbreaks of infectious disease cause significant fear and distress for nurses (Pakpour et al., 2020). Kang et al. (2020) noted that during COVID-19, frontline nurses reported lack of support from uninformed or misinformed friends and family members, as well as loneliness due to the need to work in isolation while caring for infected patients. As a result of these stressors, Kang et al. reported that nurses caring for patients during a catastrophe can experience stress-related avoidance behaviors, unstable moods, disrupted sleep, eating disorders, and substance abuse.

Nurse leader support was essential for creating a safe workplace in which frontline nursing staff were protected, informed, and empowered. Hofmeyer and Taylor (2020) stated that nurse leaders were responsible for ordering and obtaining adequate supplies of protective personal equipment, quickly educating frontline nurses on skills for providing quality care for patients with COVID-19, and promoting restorative self-care.

A fully informed health care team is essential in the face of crises that require adapting to a rapidly changing work environment, synthesizing information, making complex decisions, and ensuring quality care (Purba et al., 2020). Such preparedness is especially true in response to a mass casualty event (MCE) such as the COVID-19 pandemic. There are two types of MCEs: (a) a "big bang" incident with immediate impact, such as the 9/11 attacks, and (b) "rising tide" MCEs that amplify slowly with an extended impact, such as the COVID-19 pandemic (Gupta et al., 2020; McIsaac & Gentz, 2020; Tolentino et al., 2021).

Nurse experiences with the pandemic can be similar across cultures. Zhang et al. (2020) conducted a qualitative descriptive study at a hospital in Wuhan, China, which is believed to be the original epicenter of the COVID-19 epidemic, starting in the winter of 2020. Zhang et al. interviewed 23 frontline nurses and reported three features of psychological change during the early part of the pandemic: (a) ambivalence, (b) emotional fatigue, and (c) need for energy renewal. The nurses reported that their nurse leaders served as psychological anchors for them as they adapted to the crisis.

Marshall (2020) reported on the strain that nurses experienced while caring for patients with COVID-19, noting that a focus on public health care in a mass event robbed frontline nurses of the opportunity to get to know their patients. This focus forced nurses

to work in areas for which they had not been trained, as the need arose. Nurses could experience anxiety, fear, depression, and insomnia, for treating patients with COVID-19 was not a singular event, but weeks and often months of contact with death and disability. Some nurses may have developed emotional detachment as a defense to support them through the crisis, but with potentially negative psychological outcomes later (Marshall, 2020).

Psychosocial Needs Nurse Leaders

In a phenomenological study, White (2021) examined the experiences of hospital nurse managers and assistant nurse managers in the United States during the pandemic. The study involved interviews of 21 twenty-one nurse managers, and six assistant nurse managers. Five themes emerged: (a) the feeling of obligation to serve the needs of everyone (front-line nurses and patients), (b) leadership challenges, (c) struggles with stress and exhaustion, (d) need for readily available support, and (e) coping.

Nurse leaders have reported distress due to ethical challenges associated with the pandemic (Morley et al., 2020). Staff expected their nurse leaders to display qualities of stability, compassion, honesty, and hope (Clifton & Harter, 2019). It was difficult for staff to feel trust and stability in a chaotic hospital environment where messaging changed frequently. Sherman (2020) discussed the ethical challenges that nurse leaders confronted during the COVID-19 outbreak, particularly guilt. As the pandemic evolved, nurse leaders had to implement frequent changes in organizational policies and practices. The nurse leaders also described a common theme of guilt whenever they felt they had failed to meet the expectations of staff during the pandemic.

In a report on the psychological health of CNOs during the pandemic, Sherman (2020) stated that nurse leaders described ethical conflict as they attempted to support frontline staff while addressing negative professional behaviors. Common areas of concern included guilt: Guilt over persistent shortages of PPE months after the crisis started, while knowing that staff continued to work even as they feared for their safety and the safety of their families.

Nurse leaders felt guilt about reducing hours for some staff members despite knowing they were under significant financial stress, and about furloughing some staff members when a decrease in hospitals' revenue-generating activities forced staff cuts and reduced work schedules during the crisis. The leaders also expressed guilt about lack of success in advocating for the needs of frontline staff with senior hospital executives. They felt overall guilt about not being able to provide realistic answers to questions from staff about conditions in the near future (Sherman, 2020).

The COVID-19 pandemic has raised a host of ethical challenges (Bierer et al., 2020; Janwadkar & Bibler, 2020; Jeffrey, 2020; Reja et al., 2020; Sperling et al., 2021; Turale et al., 2020); a primary concern for CNOs was the possibility they might have to make choices about rationing scarce critical care resources. Mcguire et al. (2020) noted that rationing policies in the context of a mass health event such as a pandemic varies by institution, health care system, and existing law. Most policies rely on the patient's ability to benefit from treatment and to survive as the ethical basis for providing scarce care. However, Mcguire et al. (2020) described debates about the clinical measures that may be reasonably used as the basis for that determination and which additional factors should be considered.

COVID-19 has had the effect of altering all aspects of society, with devastating impacts on health, political, social, economic, and educational spheres (Sampaio et al., 2020). Calia et al. (2020) discussed whether excessive emphasis is being placed on scientific investigation as the only possibility of solutions to the pandemic, even as health officials are challenged to uphold ethical standards, in the context of public health concerns that take precedence over individual patient well-being. Such considerations are not merely theoretical, for they can impact care choices that impact life and death.

CNOs' Leadership Style

Nurse leaders can experience conflict between the well-being of nursing staff and the need to demonstrate results beneficial to hospital finances. Prior to the pandemic, Ingwell-Spolan (2018) conducted a study of CNOs' views on ensuring well-being of staff nurses working at point of care in relation to patient health outcomes. The two interview-based qualitative studies of 25 CNOs in eight states showed that most of the CNOs believed they were acting in the best interests of their nurses and their employers.

Still, analysis of the interview responses showed that some CNOs supported peer pressure among nurses as a method of ensuring compliance with patient discharge metrics. During the interviews, nurses who were interviewed for the study indicated that the CNOs made decisions about patient care based on a desire to reduce average length of patient stay rather than the best interests of the patient. The average length of stay in hospital (ALOS) is a common metric to assess hospital efficiency. In most cases, a shorter stay is associated with a lower cost per discharge. The ALOS refers to the average number of inpatient days for patient care. It is generally calculated by dividing the total number of days stayed by all inpatients per year by the number of admissions or

discharges per year, excluding day cases (Organisation for Economic Co-operation and Development, 2020).

The average length of stay is the number of paid days a patient remained in the hospital, which is important to the financial health of an institution. Most of the nurses interviewed stated that they were forced to compromise on the quality of patient care due to the number of patients assigned to them, and due to absence of decision-making and autonomy. In contrast, many of the CNOs assumed that patient care outcomes such as shorter hospital stays could be viewed as evidence that the quality of nursing was high.

The pandemic has caused changes in the ways that CNOs execute their authority. The COVID-19 pandemic represents a classic example of an environment characterized by volatility, uncertainty, complexity, ambiguity (VUCA; Bennett & Lemoine, 2014). In a discussion of the volatility of the health care environment during the pandemic, Sherman (2020) stated that few nurse leaders could have predicted that emergency practices would become necessary in hospitals, which included conversion of clinic spaces into intensive care units, increased patient acuity, mortality rates, length of stay for patients receiving treatment for COVID-19, postponement of most elective surgeries and treatment, and rapid deployment of health care staff to clinical tasks that were outside their area of training.

Other unexpected issues included lack of adequate PPE supplies and minimization of infection control approaches from past stringent guidelines to good enough. Staff were required to quickly learn ventilator management skills, and to change from an orientation toward patient-centered care to one of public health population management where the needs of the many took precedence. The delivery model from care shifted from primary

care to team nursing, again as the needs of the many became the first concern (Sherman, 2020).

Throughout the crisis, CNOs had to make decisions about care, even as they doubted the accuracy of information and the projections issued by health authorities about the possible conclusion of the pandemic (Sherman, 2020). Decision making was fraught with complexity because there was a broad range of variables that could cause unknown outcomes. Sherman (2020) concluded the discussion by noting that in stable conditions, nurse leaders have the option of orienting their expectations of staff performance toward present needs. During the pandemic, nurse leaders had to abandon the focus on what had worked in the past, and instead risk new approaches.

Rosser et al. (2020) issued a warning about the risks of ethical violations resulting from a shift from patient-centered care to a public health model during the pandemic, when the needs of the many were prioritized over those of individual patients. The exercise of authority also changed; with the advent of the pandemic, preferred decision-making models and processes for nursing have been set aside in favor of more directive and command-oriented models. Through the continued stress of the pandemic, nurse leaders have been unable to reinstate person-centered decision-making models and processes that support patients, caregivers, community response, and collaboration in health care. The urgent need to protect the population during the pandemic has led to erosion of human liberties of patients and their significant others, such as contact with loved ones and end of life choices (Rosser et al., 2020).

Rosser et al. (2020) asserted there is a risk that nursing’s fundamental attention on person and person-centeredness may be lost. Prestia (2020) discussed the need for nurse

leaders to maintain a moral compass when making decisions about supplies, staff ratios, and prioritization of individual patient needs, which was necessary to minimize the negative impact of choices made. It was also maintained to avoid moral distress, which could erode the mental health of nurse leaders.

Technological Advancements in the Pandemic

The pandemic has served as a catalyst for technological advancements in medicine that may have taken decades to develop in normal conditions. Most of the advancements involve artificial intelligence, and all are based on computer technology. Lin et al. (2020) described the use of innovative clinical informatics to address a patient surge at a hospital in Colorado during the pandemic. Clinical informatics involve a combination of computer science, information science (IS), and patient care with the goal of enhancing workflows, health outcomes, and health care provider-patient relationships.

The initiative began prior to the anticipated surge (Lin et al., 2020). The informatics team built solutions to support anticipated needs including (a) rapidly training physicians and nurses to respond to patient surge, (b) using interactive visual decision trees to guide care choices, (c) scaling up telemedicine systems, (d) escalating use of computer tablets and remote monitors as supports for in-hospital and posthospital communication with patients, (e) facilitating consensus among physicians, (f) supporting advance care planning, (g) informing clinicians about patients' changing status in real time, (h) providing constant updates on Crisis Standards of Care, and (i) predicting surge rates.

Sherman (2020) noted that the pandemic has catalyzed rapid advancements in the acceptance of telemedicine, where patients do not visit a health care provider in person

but discuss their symptoms via a webcam or other computer device instead. The patient receives directions and diagnosis via the computer technology, eliminating the need for an office visit in many cases. In conditions of a worldwide pandemic, telemedicine reduced in-person contact between health care providers and patients while still allowing for care delivery.

The pandemic has accelerated the application of technology for health care due to the need to reduce personal contact between patients and health care providers in a mass health event (Bahi et al., 2020; Clipper, 2020, Gasser et al., 2020; Singh et al., 2020; Tropea & DeRango, 2020; Vaishya et al., 2020). Clipper (2020) explored the adoption and development of health technology tools such as telemedicine for remote patient consultations with physicians, artificial intelligence, and robotics in the early months of COVID-19 at American hospitals. The tools were originally designed as mechanisms that would be adopted gradually. The outbreak of the virus caused the tools to suddenly become essential. Clipper reported that use of the tools accelerated during the crisis because they could be used to provide patients and care providers with physical distance, rapid diagnosis, and reporting of results in real time rather than waiting for reports after the health event.

Bahi et al. (2020) discussed the use of biosensor technology in the context of the pandemic. Biosensors are the only tools available to measure nonpolar molecules involved in COVID-19. The sensors provide health care providers with high specificity for diagnosis, supporting rapid response. During the pandemic, the technology was used to identify the symptoms of the viral infection by tracking breathing rate, heart rate variability, and body temperature in COVID-19 patients. As soon as there was any

change in patient condition, the biosensor technology relayed the information to the health-care service provider. The technology monitored patient condition without the necessity of having personal contact with infected patients. Bahi et al. identified seven significant applications of the biosensors in COVID-19 patients. The conclusions of the study stated that biosensor technology has the capacity to completely change treatment of patients during a pandemic or epidemic (Bahi et al., 2020).

Virtual Reality (VR) was called into service as a vital tool in responding to the ongoing pandemic. Singh et al. (2020) provided detailed descriptions of VR technology for treating patients, tracking disease outbreaks, and training medical personnel. The technology was used for image acquisition for medical communications, physical rehabilitation, and pain management during treatment. Other technology tools used during the pandemic included multi-agent systems (MAS) that employ multiple interacting forms of artificial intelligence. Sharma et al. (2020) reported that MAS provides continuous monitoring of health status of COVID-19 patients by distributing information spatially to different locations, which facilitates planning of each patient's treatment. MAS consists of autonomous artificial intelligence entities that can work collaboratively to share data on a disease outbreak, allowing doctors and organizations to create flexible models of potential outbreak scenarios and to plan a response.

Haleem and Javaid (2020) described the advancements in medical technology as "Medical 4.0", the fourth medical revolution that involves use of electronically supported information technology, micro-computer systems, automation, treatments personalized for patient genes, gender, and condition, and artificial intelligence (AI)-enabled intelligent devices that operate via the Internet of Medical Things (IoMT). Haleem and

Javaid reported that the effects of the technology have extended to related fields in a synergistic process of knowledge sharing, where progress in one information-dependent field supports progress in others. There is a need for telemedicine management technology and remote monitoring of patients including delivery of ongoing health statistics without the need for office visits or lab testing. Haleem and Javaid discussed 10 applications of Medical 4.0 during the COVID-19 pandemic, noting that acceptance and production of intelligent medical devices have not kept pace with smart electronic devices and application devices. Adoption and production will increase as a result of the pandemic, concluded Haleem and Javaid.

In a separate paper, Javaid et al. (2020) reported that Industry 5.0, the fifth industrial revolution consisting of smart digital information and manufacturing technologies, has the capacity to generate more efficient processes for healthcare. The technology can be used to design personalized therapy and treatment protocols for COVID-19 patients based on the individual patient's information. During the pandemic, Industry 5.0 technologies contributed to advanced "smart" healthcare environments operating in real-time.

The implications for nursing leadership are significant, for the use of advanced technologies will reduce costs of care overall, but also reduce the person-to-person contact with patients, with unknown effects on patients' psychological well-being. CNOs will be tasked with rapidly learning about how the technologies can be used to increase quality of patient care (such as for diagnostics) and reduce costs of care in some aspects, but only in relation to capital investment for purchase of the new technologies.

New York City Hospitals' Response to the Pandemic

In the spring of 2020, New York City became the U.S. epicenter for the pandemic, with 168,845 of the 1,122,486 cases nationwide as of early May 2020 (Schaye et al., 2020). Schaye et al. (2020) reported on the challenges at four hospitals affiliated with New York University Grossman School of Medicine, where more than 5,000 patients were hospitalized with COVID-19. The hospitals collaborated to develop protocols for patients at all the sites. Schaye et al. (2020) described strategies for communication, planning for surges of patient admissions, and clinical care, while also attempting to maintain wellness for staff members. These strategies could be applied to medical centers that must rapidly respond to unprecedented challenges of a public health emergency.

The coronavirus disease pandemic was particularly significant as a health threat to the New York City Health + Hospitals system (Wei et al., 2020). The system responded by increasing patient bed capacity and preparing for an unprecedented patient surge. Wei et al. (2020) reported on the ways the system implemented emotional and psychological supports for patients, families, and health care providers. Dedicated staff members provided families with daily updates on patient health status, and helped patients use digital tablets for virtual visits. The hospitals' palliative care teams were expanded, so that they could conduct virtual consultations with families about care choices and decisions about end-of-life. Bereavement hotlines were implemented for those who lost a loved one. Bereavement support included individual and group sessions with mental health care providers, a free mental health care hotline, a webinar series on grief, and

respite rooms for refuge from stress, as well as free lodging and childcare. Bereavement support also included rituals to celebrate recovery or mourning.

Keeley et al. (2020) described the response of New York City Health + Hospitals to COVID-19 as it rapidly expanded capacity across its 11 acute care hospitals and three new field hospitals, which was necessary because the state of New York State had become the epicenter for the pandemic. The New York City Health and Hospitals is also a public hospital system, which served many persons of color and other marginalized groups who resided in crowded areas that placed them at higher risk for the virus transmission (Harris et al., 2020; Salway et al., 2020; Uppal et al., 2020; Wadhera et al., 2020).

Keeley et al. (2020) described how the hospitals redeployed medical staff to the health sectors of greatest need while revising recruitment and training processes. The hospital system conducted a vigorous outreach campaign to attract additional staff by contacting private staffing agencies and collaborating with the U.S. Department of Defense, as well as issuing a call for recruited volunteers countrywide. In addition, by using educational tools about COVID-19, the hospital system completed training of 20,000 staff members, within a span of 8 weeks.

Uppal et al. (2020) noted that the New York City Health and Hospitals system was vital to the city's response because the system serves a vulnerable patient population often unable to pay the full cost of health care and disproportionately affected by the virus. Clinical spaces were located and upgraded for use as intensive care (ICU) units (ICU), and ICU spaces were also created in emergency departments and office spaces.

Hospital staff was augmented by temporary workers, volunteers, and medical staff sent to New York from the U.S. Department of Defense. Supplies needed to deliver critical care were monitored closely and replenished to prevent interruptions. An emergency department action team worked with frontline nurses to transmit information on real-time events to network-level decisionmakers. In addition to staff recruitment and training in treatment of the virus, Salway et al. (2020) reported that the hospital system engaged innovative technological solutions to respond to the crisis by rapidly transitioning to a unified electronic medical record system across all hospitals. This system accelerated implementation of technological solutions to the crisis. The technological shift supported staff efficiency through rapid medical screening of low-risk patients, use of "SmartNotes," more efficient tracking of vital signs, and employment of dashboards to track bed availability and to support transfers from the most burdened hospitals. Salway et al. claimed that the advancements that the system initiated in the crisis will be retained to increase the quality of care within the system.

Hospitals in New York City responded to their status as the epicenter of the pandemic in the spring of 2020 through rapid innovation and redistribution of existing resources, while reaching out to obtain more resources. The response included concern for the mental health of patients and staff, and the advancements that the system initiated in the crisis would be retained to increase the quality of care within the system (Salway et al., 2020). The nature of the response is informative for CNOs in general in relation to learning about and planning for a response to future public health crises.

Summary

The review of literature supports the focus of the study about the lived experiences of CNOs in the pandemic in the context of executive orders issued by authorities in New York State. Most of the reported research articles, focused on a broader description of nursing leadership, pertained to nurse leaders in a general sense, rather than specifically singling out nursing executives. My study addressed the CNOs information on this gap specific to the COVID-19 pandemic response in the research. The reviewed literature also showed that hospital leaders engaged in significant advance planning for a surge in patients, and the U.S. Department of Defense provided staff to hospitals in New York City when it became the epicenter of the pandemic. Crisis strategies included rapid training of nurses and physicians in care specific to COVID-19, as well as sourcing space within the hospitals for conversion to ICU units. Advancements in technology propelled by the crisis will be retained, with benefits for patient care going forward.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of CNOs at hospitals in New York State during the COVID-19 pandemic, specifically regarding their perceptions of leadership effectiveness, job satisfaction and structural empowerment in response to executive orders issued by Governor of New York Andrew Cuomo. The study population consisted of at least 10 CNOs who were employed at the hospitals during the COVID-19 pandemic from 2019-2021. The interview questions pertained to the challenges that the CNOs faced as they led their nursing staff through a public health emergency, for which there were often inadequate resources.

This chapter includes discussion of the research study's phenomenological design and why it is appropriate. A description of the research sample participants and the recruiting approach that was used to select them, the role of the researcher, the method of collecting data, and plan for analyzing data are also included. Trustworthiness and credibility of the study are presented, as are ethical issues in relation to data and study participant privacy. This chapter is laid out according to the following sections: research methodology, sample population, limitations, assumptions, interview questions, and interview data analysis. It provides a description of the phenomenological research approach, and the ways the approach can support the study.

Research Design and Rationale

The research question for the phenomenological study pertain to the lived experiences of the study participants in the context of the theoretical framework. The research question is as follows:

RQ: How do CNOs perceive their lived experiences of organizational factors in relation to context of structural empowerment and job satisfaction during the COVID-19 pandemic?

The nursing executive had to respond quickly when the governor of New York issued a succession of executive orders on the pandemic while sustaining quality of patient care. At the same time, they were often lacking adequate supplies or additional administrative support. The study provided insight into the CNOs structural empowerment throughout the crisis.

The three types of methods for conducting a research study are quantitative, qualitative, and mixed method. Quantitative research uses statistical data to test a hypothesis or hypotheses. Quantitative studies are conducted in search of evidence and proof. In contrast, qualitative research is based on collecting subjective, personal data from study participants. Qualitative data pertain to personal experience and perceptions of a phenomenon. Mixed-methods research employs qualitative and quantitative approaches. A qualitative phenomenological method was selected for the study because the focus of the research was to understand the experiences of the CNOs under Governor Andrew Cuomo's executive orders during the pandemic. The research explored the lived experiences of the study participants and did not involve collecting statistical data in relation to hypothesis testing.

Five types of research designs fall within the qualitative category: case study, phenomenology, grounded theory, ethnography, and narrative (Merriam, 2014). Phenomenology was selected as the best method because it allows for exploration of the lived experiences of participants in relation to a specific phenomenon. The grounded theory method is employed by collecting several rounds of data, followed by data interpretation to construct an abstract conclusion related to the experiences of study participants. Because the goal of the study was to understand the experience of a specific type of health care professional and not to develop an abstract concept, this method was not selected for the study. The next method, case study, is used to explore the experience of one individual, or an event or process (Yin, 2016). Because the research involved several study participants, it was not selected. The aim of narrative research is to explore personal life and not the experiences of professional persons in relation to their work (Yin, 2016); therefore, the narrative approach was not selected. Because narrative research is used to explore the private lives of individuals, it was useful for this study. The last method, ethnography, is used to explore the experience of individuals in relation to their ethnic identity. Because ethnicity has no relation to the study, it was not selected (Merriam, 2014). Out of the five methods of qualitative research, phenomenology was the most appropriate.

The study was conducted using the telephone, video, or voice technology applications such as Zoom, MS Teams, or Skype to facilitate the interviews instead of face-to-face or in-person interviews to explore the lived experiences of the CNOs in their role as nurse leaders during a public health crisis. The interview questions were used to gather the participants’ verbal comments in response to the open-ended questions. These

interview questions (see Appendix A: Interview Questions) addressed important points such as the strategies used to respond to executive orders by New York State Governor Andrew Cuomo regarding health care, how the executive orders influenced their experience as a nurse executive during the pandemic, how having access to additional administrative support would have made a difference, and how experience with supplies such as PPE was needed to respond to the pandemic.

In a qualitative study, the way the interview questions are administered, and whether the questions are open-ended or closed, are of major importance. The interview questions for the study were open-ended to allow interview participants to provide as much data as possible about their perceptions. Phenomenological studies are usually conducted through in-person interviews, but due to the ongoing COVID-19 restrictions, the conventional in-person interview style was altered to use telephone or online video platform technology.

Setting

The site for the study was on the telephone or online via Zoom, MS Teams, or Skype online technology. An online interview involves several convenient features, including low cost and minimal time (Andres, 2012). The convenient nature of a telephone or online interview encouraged participation because it helped to facilitate a hospital's social distancing requirements if any remained. The goal of a phenomenological study is to obtain honest and descriptive data of personal experience; an online interview supported that aim.

Role of the Researcher

I was responsible for constructing the interview questions and the telephonic or online voice of video interviews. The quality of the interview responses depended on whether the participants addressed the interview questions, and by extension, the research question. The goal of a phenomenological study is to understand study participants' lived experiences in relation to the research question and the problem of interest (Merriam, 2014). Thus, I ensured that all interview questions related to the primary research question. The process of asking questions is an important component of phenomenological studies, which are conducted to explore lived experiences of participants (Agee, 2009). Qualitative inquiries such as interview questions can prompt responses that provide important data about the why and how of the participants' experiences. The interview questions (see Appendix A: Interview Questions) were based on what I intended to understand about the participants' perspectives (Agee, 2009). I was also responsible for recruiting study participants after IRB approval had been given.

Member checking of interview transcripts contributes to the credibility of a qualitative study (Tanggaard, 2008). Once each interview was transcribed into a Word document form, I emailed each study participant's their own transcript and asked that they comment on whether it reflected their lived experiences and accurately reflected the semistructured interview responses. They were also offered an opportunity to listen to their interview via audio recording if they preferred. Finally, it was my responsibility to conduct data analysis to determine the meaning of interview responses as themes that were used to illustrate the experiences of the participants.

Data Analysis

Phenomenological research employs open-ended questions to elicit responses that describe a phenomenon from the perspective of the study participant (Collingridge & Gantt, 2008). The purpose of the interview questions was to elicit written comments from participants about their lived experiences with the COVID-19 pandemic and the governmental mandates regarding operation of New York hospitals during the pandemic. The underlying assumption was that the insights gained from the research might inform the practices of other CNOs during subsequent public health emergencies. Moustakas (1994) recommended dividing participants' responses into individual statements that pertain to the research question through a process known as horizontalization. As Moustakas noted, the phenomenological concepts are expressed by the statements made by study participants, which are changed into clusters of meaning units as the analysis proceeds.

Methodology

Participation Selection Logic

After Walden University Institutional Review Board (IRB) approval was granted, the sample population of at least 10 CNOs of hospitals in the State of New York was recruited through a combination of convenience sampling and snowball sampling. The sample for a qualitative study is usually much smaller than the sample for a quantitative study (Ritchie et al., 2003). The sample size of at least 10 study participants satisfied the recommendation from Guest et al. (2006) that data collection for qualitative research should only be performed until data saturation occurs. Saturation is the point at which no new information can be obtained by going further with data collection, and can occur as

early as the sixth participant or as late as the twelfth. It is important to reach data saturation because failure to do so may adversely impact the quality and validity of the study. The main indicator of data saturation is the point when enough data have been collected that the study could be replicated by other researchers and no further coding for new themes is needed (Fusch & Ness, 2015; Guest et al., 2006; O'Reilly & Parker, 2012; Walker, 2012).

I recruited 10 study participants by contacting CNOs working at hospitals in the New York State using professional organization websites, hospital websites, direct phone calls to CNOs' offices, and publicly available email addresses. An invitation to participate was issued in letter form (see Appendix B: Invitation to Participate in the Study). Those who expressed interest and self-described as meeting the study inclusion criteria were sent an introductory email containing a recruitment web link for the interview, along with the informed consent materials. Additionally, snowball sampling was performed in which CNOs who responded and participated were asked to invite others meeting the same study inclusion criteria. The criteria for participation included employment during the COVID-19 pandemic as a CNO at a hospital in the state of New York.

Instrumentation

A telephonic or video interview was the study's instrument. As the researcher, I was solely responsible for the interview design and data collection. Each of the interview questions was related to the research question and derived from the theoretical lens. These questions sought to elicit responses about the CNOs' attitudes and beliefs about, as

well as their lived experiences with, the COVID-19 pandemic in relation to their structural empowerment as they responded to governmental directives.

Procedures for Recruitment, Participation, and Data Collection

After confirming that prospective participants met the criteria for participation in the study, an email invite was sent to the participants which included the informed consent form that the participant must have read and accepted prior to proceeding to the link for the online application or contact numbers to call in or the researcher's option to call at the designated time of participants preference to participate in the interview. By confirming in an email that they agreed to the terms, they were instructed to click on the link or call the telephone number available to begin the interview that took no more than 35 to 40 minutes to complete. Study participants were asked seven open-ended questions about their lived experiences and perceptions of the executive orders issued by Governor Cuomo pertaining to the COVID-19 pandemic. Qualitative interview questions are meant to allow for emergence of rich experiential data (Merriam, 2014). After the interview, participants had 10 working days for member checking. If a member checking response was not returned, I assumed that the transcript content accurately reflected the interview, and their responses were added to the master NVivo v. 12 software for analysis.

Data Analysis Plan

The data analysis procedure involved use of NVivo v.12 software for organizing and coding the qualitative data, followed by thematic analysis of the data using Moustakas' (1994) modified van Kaam method. The aim of analysis was to detect meaningful themes among the interview responses about the experience of being a CNO

at a hospital in New York state during the pandemic. Analysis began with transcribing the interview responses into a Word document.

After member checking, the transcripts was loaded into NVivo software. The software facilitated the search for repetitive words and phrases, assigned codes to meaning patterns, identified themes, and developed meaningful conclusions related to the phenomenon. I constructed charts in NVivo to view the themes and related data. Although NVivo software can be used to organize qualitative data, coding for themes (meaningful words and phrases that are shared among study respondents) must be done by a human being. Once the interview data were coded, I applied a modified van Kaam method of analysis for phenomenological data as recommended by Moustakas (1994).

The modified van Kaam approach was popularized by Moustakas (1994) for analysis of qualitative data. There are seven steps in this method of qualitative data analysis: (a) listing and grouping, (b) reduction and elimination, (c) clustering and thematizing, (d) validation, (e) individual textual description, (f) individual structural description, and (g) textural-structural description. Step one, listing and grouping, involved transferring the interview responses from each participant to a Word document and loading the document into NVivo software for organization and coding. Step two, reduction and elimination, reduced the data to meaning units of words or phrases, which were used as the building blocks for qualitative analysis. Step three, clustering and thematizing, involved grouping meaning units together in categories according to theme. Step four, validation, involved checking the meaning unit themes to see if the themes pertained to the research question, and if they did not, discarding them. In step five, individual textual description, the researcher constructed individual textural descriptions

from the interview responses provided by each study participant using the themes. In step six, I constructed structural descriptions of participants' shared experiences, based on the textual description for each participant. The sixth stage involved repeating steps two through five for each participant until data saturation is reached. The seventh step involved combining all the textual descriptions to express the combined perspectives of all the study participants in relation to the research question.

Nonetheless, data analysis may reveal discrepancies in the text, which should be documented. Discrepancies are statements that contradict the dominant themes/meaning units that are found during data analysis Merriam (2004). I made note of nonconforming meaning units that appeared in the text of the interview response data. Any discrepant meaning units were to be documented and discussed in the results section in Chapter 4.

A final synthesis provided the reader with a clear understanding of how the study participants described their experiences of the COVID-19 pandemic in relation to their role as CNOs. Synthesis was performed to align the phenomenon of the pandemic with the research question. The outcome contributed to understanding how the participants described their experiences as leaders during the pandemic in relation to the study's theoretical framework.

Issues of Trustworthiness

Trustworthiness is related to the idea that the data are sound and the conclusions based on the results are strong (Lincoln & Guba, 1985) as well as by ensuring that the meanings contained in the raw study data closely corresponds to the interpretations made by the researcher. I supported trustworthiness by applying reflexivity to examine the possible influence of personal bias through use of an audit journal to record my

experience with the process of research and data analysis (Berger, 2015). The journal contained reflections on the emotions, reactions, and possible misperceptions that I experienced during the entire process.

Credibility

Credibility is determined by whether there is a correspondence between the way that study participants perceive and describe their experiences and the way that the researcher portrays their accounts about a phenomenon (Lincoln & Guba, 1985). Credibility was supported by detailed descriptions of themes derived from the data together with quotes from the data, all of which related to the research question.

Transferability

Transferability refers to the likelihood that the study results could be applied to similar populations elsewhere (Yin, 2016). Transferability was supported by recruiting CNOs from across New York State, yet transferability was limited due to the small number of study participants and the subjective nature of the interview responses. CNOs at other hospitals might have had different experiences with the pandemic.

Dependability

Dependability of qualitative research refers to the extent to which it would be possible for another researcher to replicate the study findings (Lincoln & Guba, 1985). Use of an audit trail in which the researcher documents their process of data analysis and possible biases that arise during that process, enhance the dependability of qualitative research (Lincoln & Guba, 1985). The dependability of research is supported when the researcher reports about items such as raw data, use of data analysis software, or other

methods of organizing and coding data, and process notes allowing the reader to understand and critique the research process (Lincoln & Guba, 1985).

Confirmability

Confirmability describes the degree to which it is possible to establish that the qualitative phenomenological data and the analysis and conclusions about the data are not imagined but clearly arise from themes in the data (Nowell et al., 2017). My position supported confirmability by describing the research context and the central assumptions of the research in detail.

Ethical Procedures

Research ethics are designed to ensure that the human rights of human study subjects are protected. Researchers are required to provide this protection under law (U.S. Department of Health and Human Services, 1979). I completed training about the ethics of protecting the human rights of participants. My required action was to submit the study's proposal to the Walden University's IRB and seek approval to conduct research prior to starting my research. Prior ethical review of research on humans was conducted to ensure that the study aligned with Walden University standards for research in conformance with U.S. law (U.S. Department of Health and Human Services, 1979; Walden University, 2018). Participant recruitment commenced once IRB approval has been issued.

The U.S. government has established ethical guidelines for treatment of human research subjects through the Belmont Report (U.S. Department of Health and Human Services, 1979). The report is based on three ethical principles, to which researchers should adhere. The principles are as follows: (a) respect for persons – I respected study

participants through courtesy, providing an opportunity for informed consent, truthfully disclosing the reasons for the study and possible risks and benefits, and assuring participants that they could cease participation in the study at any time without penalty; (b) beneficence – I made sure not to harm study participants while at the same time supporting the quality of the research; and (c) justice – I conducted the research fairly while avoiding exploitation of subjects (U.S. Department of Health and Human Services, 1979).

My goal was to provide the prospective participants with study information including my contact information; purpose of the study; my identity and institution; protection of participant privacy and study data through confidentiality and secure storage of data; disclosure of no payment for participation; disclosure of possible risks and benefits, assurance that participants may cease to participate in the study at any time without adverse consequences; and plan for disposal of study data after the conclusion of the study (U.S. Department of Health and Human Services, 1979).

Data were collected through interviews conducted using the telephone or voice or video technology applications online via Zoom, MS Teams, or Skype. Potential ethical concerns included confidentiality of participant identity and data, for study participants revealed their identity when they contact me to indicate study participation interest. A pseudonym for each participant was assigned. To maintain confidentiality, I kept a list of the identifying pseudonyms in a secure password-protected file to which I had the only access. When beginning the online interview, participants were required to first read the informed consent form that was emailed to them prior to the interview. The informed consent included the following information: a brief description of the study and

procedures, voluntary nature of the study, risk and benefits of the study, confidentiality issues, and contact information of the researcher and IRB contact. Study data were stored in an encrypted computer file to which I would have the only access. The encrypted data file will be deleted after 5 years. Any paper files will be securely stored for the same data retention period and then confetti shredded at the conclusion of the required data retention period.

Summary

This chapter included a description of the phenomenological research design and the rationale for the selection of the method from among the range of available methods. The chapter also included discussion about the role of the researcher, the use of technological application and the telephone number to conduct the interview for the study, recruitment of participants, sampling technique, the data collection instrument, and the data collection and analysis that were used to draw conclusions about the phenomenon of interest. Chapter 4 includes a description of the results of this study. The chapter begins with a description of how the study data were collected, organized, and prepared for van Kaam analysis according to the method recommended by Moustakas (1994).

Chapter 4: Results

Introduction

This study focused on the lived experiences of CNOs during the COVID-19 pandemic. It explored both internal and external organizational factors used by CNOs as they responded to the catastrophic epidemic in real time. Additionally, I explored the strategies and resources necessary to maintain functionality in the midst of COVID-19. In the quest for information, data were collected from the 10 CNO participants by applying the phenomenological research approach to understand and explore their lived experiences. The principle research question asked the following: How do CNOs perceive their lived experiences of organizational factors in relation to structural empowerment and job satisfaction during the COVID-19 pandemic? This chapter provides a descriptive focus on the research setting, participants, participant recruitment, data collection, process for data analysis, and the methods of ensuring trustworthiness. Following the presentation of all the factors that were listed in the latter, a summary of the results and findings is presented.

Setting

For this research, I used interviews as the central focus of my data collection. Due to pending COVID-19 restrictions, all the CNOs requested not meeting in person. Seven interviews were conducted face-to-face using either the Zoom or Microsoft Teams online platforms, and three were conducted by telephone. For each interview, the maximum time allotted was 40 minutes. One telephone interview, along with one via Microsoft Teams, were done after hours to accommodate participants' schedules. The participants' privacy was maintained in all aspects of the interviews. Any distractions were minimal

and not prolonged. Following the interviews, I sent all participants the unredacted transcripts for review via email. Five out of 10 participants responded. No one responded with corrections except for one name correction. I used the data from all participants, whether they responded or not.

Demographics

The population of interest was nurse leaders who held the title of ACNO or CNO. Some of the CNOs held two titles. Even if they held more than one title, they met the established participant criteria. There were two males and eight females. Each participant was assigned powerful pseudonyms to maintain confidentiality, to which they were receptive. They also were eager to complete the interview in less than 40 minutes. The participants were located in different parts of New York State, and their experiences varied. While their time in the position was not short, none had had experience of dealing with a pandemic such as COVID-19. Table 1 illustrates the demographics of the participants.

Table 1

Participant Demographics

Participant	Gender	Time of interview (in minutes)
Ms. Perspicacious	Female	31.04
Ms. Supreme	Female	15.12
Mr. Legendary	Male	32.05
Mr. Superior	Male	38.29
Ms. Mighty	Female	31.08
Ms. Intelligent	Female	28.11
Ms. Prestigious	Female	23.57
Ms. Prevail	Female	35.02
Ms. Accomplished	Female	28.31
Ms. Eloquence	Female	20:00 (recording system failure)

Participant Recruitment

On December 14, 2022, I received approval from the IRB (approval # 12-14-22-0521286) with an expiration date of December 13, 2023. Based on the research design, I used an internet search engine to locate CNOs at varying hospitals, along with their telephone numbers. I attempted to reach 20 CNOs via this method, but only four of them were responsive to this method. However, one was omitted after the response time after saturation was reached. Another CNO noted they could not participate in the study at that time. Two participants were obtained through this recruitment method. I also used a snowballing technique that was very instrumental in recruiting the next eight participants. Once I had contacted each participant via email, and they agreed or confirmed their participation, I replied to thank them for participating in my research in advance and provide them with informed consent. If they had to reschedule the interview time, they notified me in advance. One participant rescheduled due to a conflict. All 10 participants received the informed consent form explaining the inquiry of my investigation, confidentiality, and the study risks and benefits, and they all expressed their commitment and interest in the study.

Data Collection

Data collection is a technique by which the researcher gathers the information necessary for their study. There are several means by which data are collected including participant observation, direct observation, semistructured interviews, and case studies. For my research, I used semistructured interviews with 10 CNOs. The timeframe of collecting the data began in early February 2023 and lasted until the end of that month. I was careful to follow the approved protocols of data collection to safeguard the quality of

the data and kept the methods of research using interviews to the online platforms (Microsoft Teams and Zoom) and the telephone.

At the initiation of the interviews, all participants provided consent. Then, the data collection was completed in the accordance with the procedures and ethical rules discussed in Chapter 3. To obtain the necessary data, semistructured, open-ended questions were used to encourage responses without limitations. I conducted 10 interviews using Zoom, Microsoft Teams, and the telephone. I reached saturation by the time I interviewed the 10th participant. Each participant was asked 13 semistructured, opened-ended questions linked to my main research question.

All interviews were audio-recorded and transcribed verbatim, except for one participant in which the audio failed after 20 minutes; however, I was able to capture the participant's response as I was writing down their responses as a backup in case such a situation arose. Because the participant's response was short, no important information was missed. The participant's responses were then transliterated into a Word document. Each interview was saved separately, labeled with a code to protect the identities of the participants, and stored on a password-protected computer. These data will be kept for 5 years according to Walden University requirements on participant confidentiality and data securing policy.

Throughout the data collection process, I was transparent. After the interviews were transcribed, I provided each participant with the opportunity to review and correct any information captured in their transcript that was not a true reflection of their response. Transparency is important to ensure that the meanings encompassed in the unredacted study data closely correspond to the interpretations of the participants

(Lincoln & Guba 1985). None of the participants had any corrections regarding their transcription.

Data Analysis

Qualitative data analysis is the process by which the data are organized and coded; from the codes, themes are derived with the overall goal of addressing the research question. The modified van Kaam data analysis approach was applied by using the recommended seven steps. The first step was interpreting the data and developing an analytical understanding of the concreteness of the collected data (Moustakas, 1994). The purpose of strategy was to analyze the data as they related to the main focus of exploring the perceptions and lived experiences of the participants.

The process of data analysis involved transcribing the participants' responses and using NVivo v. 12 software to code and develop a thematical framework to increase validity. I used NVivo software mainly to manage and store the data. The thematic analysis was data-driven from an inductive perspective, as opposed to a deductive approach. The analysis was both an interactive and an introspective process. First, all 10 transcripts were read and uploaded in NVivo v. 12, followed by a word frequency query conducted using only four-letter words with a maximum of 50 reoccurring words (see Appendix C). They were coded independently line-by-line, which resulted in developing initial codes. Still, further steps were taken to examine the developed codes, using the pattern coding approach to further analyze the data into smaller components, and create strategically confining patterns and relationships before the emergence of themes were established. Careful review and re-review were done to ensure accurate representation of

the participants' experiences. As a result, central themes and sub-themes were developed from the codes identified. The word frequency query can be seen in Figure 1.

Figure 1

Word Cloud

Evidence of Trustworthiness

Evidence of trustworthiness is imperative in qualitative research because the way internal approaches are used to determine exactitude within research (Guba & Lincoln, 1985). To ensure an evidence-based approach, I developed a strategy that authenticated and emphasized the procedure for participant selection but also working closely with my dissertation committee and applying a research approach that is mandatory but also a succinct rationale of the investigation. In doing so, my committee members were

dynamic because they provided the direct approaches to produce and enhance quality research instrumentation, visually viewed from the perspective of the interview questions.

The interview questions were necessary to help stimulate comprehensive responses from participants. All were provided with the 13 questions fundamental to encourage engagement, participation, and probing necessary in supporting the guidelines for data saturation, which was met after I had completed interviews of 10 participants. To prevent lack of understanding of the interview questions, I was able to provide clarification by either re-reading the question or providing insightful interest on what the question was examining. This process helped participants remain engaged and helped them to provide responses directly related to the probing question.

My intention was to have all interviews audio recorded. However, due to a system failure, data for one participant could not be recorded as intended. Still, that did not have any bearing on the interview responses, for my back up plan was to also record the interviews manually. Fortunately, the responses were short and succinct, which made it very easy for me to record them in that manner. As a result of a system malfunction, only nine audio recordings were conducted. What was notable about the audio recording was that it was able to capture the participants' raw responses in real time regarding to their experiences during the COVID-19 pandemic. Some participants' responses were lengthy, while some were relatively short. Nonetheless, using the audio recording equipment provided me the fortitude of not having the aggravation of writing word for word what the participant had said, which would have affected the 40-minute time allotted. Using the audio recording helped to minimize inaccuracy of the transcribed data and the manual

recording of the interviews. After the data were collected, member checking was completed by emailing each participant's individual transcribed data for review.

To maintain my focus on the participants' responses, I was careful not to provide my own subjective thoughts and ideas as a means to provide the participants with clarification during the data collection. In addition, I was able to dissipate all personal or prejudicial experiences that would have drawn me into an emotional discussion. It was a necessary approach to diminish bias or persuasion of the participants. In employing such an approach, the specification was in accordance with the method of bracketing (epoche) in research mentioned by Moustakas (1994).

Credibility

Credibility is an imperative component of research which provides a transparent approach from the research process and procedural means of supporting the results. In an attempted to establish credibility, I was able to foster such a process by ascertaining supports of several peer-reviewed data sources and other research methods. Using such an approach allowed me the opportunity to have a diversified perception from the CNOs through semistructured interviews. These participants shared material from personal perceptions they felt were true depictions of their experiences. Additionally, when in doubt, they asked for clarification of the interview questions I provided to help them decrease any inaccurate responses. Of note, the participants voluntary devoted their time and effort in the development of new information by providing expertise of the subject matter supportive of the study. Further, they were not compensated for the interviews in any way. When member checking was employed after the interviews, I was able to confirm that all information was accurate, which demonstrated transparency.

Transferability

Transferability refers to the prospects that the study results may be applicable from a generalization standpoint or circumstantial to similar populations elsewhere (Yin, 2016). Transferability was supported by the recruitment of CNOs from across New York State, which allowed for a parallel and diversified study of their experiences. As a result, this study allowed readers to have a visual depiction of the limitations and standardization of transference within this phenomenological study.

Dependability

Dependability of qualitative research looks at whether the research is reliable and whether replication of the findings is possible by another researcher in a comparable setting (Lincoln & Guba, 1985). The participants provided descriptive details of their experience through face-to-face and telephone interviews whereby open-ended questions were used for data analysis to provide a conclusive presentation. I used an audit trail in which I was able to document the process of data analysis and potential prejudices that arose during that process to enhance the dependability of my research (see Lincoln & Guba, 1985). I was able to support the study's dependability by reporting on the raw data, use of data analysis software, or other methods of organizing and coding data, thematical framework and process notes, allowing the reader to understand and critique the research process (see Lincoln & Guba, 1985).

Confirmability

Confirmability was sustained when I was able exclude all personal prejudices and focus on ensuring accurate reporting of the data collected. To maintain sustainability, I applied caution to verify the results by providing a standard strategic plan on conducting

the interviews, how the data were collected and analyzed, and how confirmability was established and elevated within this qualitative phenomenological research.

Results

The focus of my phenomenological study was on obtaining the perceptions of the lived experience of chief nursing executives during the COVID-19 pandemic. Within Chapter 4, the results were derived from the central research question: How do CNOs perceive their lived experiences of organizational factors in relation to structural empowerment and job satisfaction during the COVID-19 pandemic? To answer the question of inquiry, a succinct analyzation of the participants' interview transcripts was conducted. In addition, the formulation and classification of codes, the development of primary themes summarizing the meaning of participant experience and subthemes surrounding the chief nursing executives in New York State were also strategically examined (see Appendix D).

The primary themes that emerged were CNOs' (a) challenging complications during COVID-19; (b) perceptions of resource availability; (c) perceptions of their leadership effectiveness; (d) role, responsibility and accountability; (e) view of community and external response; (f) availability of personal protective equipment (PPE); (g) perception of aggrandized administrative support; (h) COVID-19 creation of opportunity for advancement; (i) creative strategies used; (j) executive orders impact and professional responses; (k) informal supports; (l) internal organization factors used by CNOs; (m) leadership sustainability; (n) psychosocial support importance and impact; (o) rapid patient surge, loss, and effects; (p) realization for future improvement; and (q) senior leadership support (Figure 2). The theoretical framework selected to magnify the

responses of the nursing executives experience and their ability to respond appropriately was Kanter's theory of structural empowerment, which examines organizational behavior from the perspective of the employee who gains empowerment (Kanter, 1993).

Theme 1: Challenging Complications During COVID-19

The majority of the participants expressed their perception of the *challenging complications during Covid-19*, which was the epitome of the participants' struggles during the pandemic. Their resounding concerns were centralized on the challenges they faced. The perceptions provided insights into what they felt and how they processed the experiences (Figure 2).

Mr. Legendary described his experience as "dealing with something new" and "chaotic," "stressful," "a real struggle," and he felt the brunt of it. Mr. Legendary further shared that while it was cumbersome, "it was nobody's fault," yet they were being blamed because of "inconsistent information," which resulted in the perception that leaders "did not know what they were doing" when "they felt that they were proactive." Further expanding on his description, he noted that "messages were changing quickly" and "information was pushed out quickly."

Figure 2

Primary Theme and Subthemes of Challenges

Ms. Mighty shared some of Mr. Legendary's familiarity and she noted that "the country and the world were experiencing the pandemic for the first time" and "we were experiencing this it as a global issue for the first time." She noted that "the ink could not dry on a policy before it was changed." She added, "It was difficult." She stated that they did not know any better than to acknowledge those issues to staff.

Ms. Accomplished felt that "they did not have appropriate information to handle the pandemic." She noted that there was a "lot of miscommunications was disseminated by the media," which presented "difficulty incorporating that information in clinical settings."

Ms. Prestigious reflected on her experience and highlighted that "they were not prepared for the massive influx of patients" and "were not prepared for the rapid pace at which patients came." She added that "they were surprised."

Ms. Intelligent expressed that the "COVID pandemic was a huge unknown" and "they did not prepare for what was to come or happened." She added that it was a "catastrophic event."

Ms. Perspicacious noted that she felt that the "information was changing rapidly and the guidelines were unclear because it was new" and they "did not have prior experiences with COVID." She added that "internal communication was critical, and it was stressful."

Mr. Superior added further that "it was stressful for [him]." In "the early phases of the pandemic in particular," he said, "we couldn't always deliver to the front line staff and plus to our patients, as well, everything that really was needed because we didn't have the personnel resources," which was "primarily focused on personnel resources we didn't always have." He added, "We didn't have treatment protocols that have been studied."

Out of this theme subthemes such as (a) burnout; (b) changing PPE protocols; (c) CNO judgment questions; (d) inequitable allocation of resources; (e) information; (f) remote work; (g) staff loss, recruitment, and retention; (h) staffing ratio; and (i) time in leadership role and the impact were derived, expanding more to the *challenging complications during COVID-19*.

In response to *burn out*, Ms. Accomplished expressed that "there's a lot of burn out, you know, a, a lot of people just were fearful." She added, "People are not sleeping,

eating well. I mean, people crying and people were visibly physically, sick from, you know, because so much in the media going on initially, you couldn't tell what was true but not what was not true." In support, Ms. Prevail expressed similar sentiments of "a year of grief and feeling burned out."

Mr. Legendary noted that there was opportunity for burnout and they had to make the toughest decisions of which his staff who did not agree in the beginning was able to support them in the end by confirming, "As much as we were against this in the beginning, it was really the right thing to do because we would've burned ourselves out or we would've gotten run down."

Most of the participants felt that there was sufficient PPE; however, because of the constant *changing PPE protocols*, complications ensured. Mr. Legendary believed that "there was enough PPE for everybody" and they "had many resources" and felt that they "provided everything including equipment, food and rest to support staff." He further added that the "recommendation changing" was a problem. "He felt that as the information changed for leaders, it changed for staff," which led to the "whole trickle-down effect." He added that there was just a lot of "mixed messages."

Mr. Superior noted that the "availability of PPE got a lot of attention from the press and literature" but "they were required to speak with supply leaders in organizations to assure that we had adequate PPE, protective equipment, supplies for personnel and space suits." He added that the "changing of protocols" was a challenge and "if it wasn't wet or soiled, you could reuse it, but there was a lot of frontline staff resistance to doing that."

Ms. Mighty expanded further on the problem by highlighting that "the executive order about where to wear PPE was very important, and we worked on that." That was one of the protocols of that kept changing because they would see nurses walking around in a surgical mask or a social worker going in to see a patient with a surgical mask, "and then you would see people that are emptying the trash in full PPE with boots."

CNO's judgement question was mentioned earlier by Mr. Legendary, who felt that his leadership was challenged because there was concerns that "CNOs did not know what they were doing." He in fact had staff praise him for making the tough decisions when they disagreed. While Mr. Legendary's experience came from direct staff, some CNOs felt that their senior leadership challenged their capabilities, which led to responses of either the CNO/CNE resigning, serious dialogue, or the senior leader indicating remorse while the other quit.

Mr. Legendary felt that there was some conflict with his immediate supervisor, the chief operating officer, "not a significant amount, but we did, we didn't always agree." He said, "It was a bit of a micromanager. On the other hand, they sometimes had some pretty significant dialogue about that and we didn't always agree." He continued, "So that was some tension about that, but you know, not to the point where it really interfered with, you know, managing and organizing what needed to be done."

Ms. Accomplished echoed similar sentiments that she "had a rocky relationship with [her] CEO who believes that [she] shouldn't work remote" when the rest of her staff worked remote and felt as a result she was "not fueled in for [her] boss." She left the agency due to conflicts with her superior. Ms. Prevail talked about her experience from the perceptive of being proactive, which landed her into a conflict of resources waste.

However, she felt confident enough that she had done a good job in supporting her team as well as the organization. She noted, “That was one of the things that my boss apologized for actually, that realizing that it made sense.” She mentioned that they “stopped acting locally and that became centralized and all the strategies came from corporate nursing and they were very good strategies that really served all of the systems.”

Mr. Legendary felt that there was inequitable *allocation of resources because when* “resources get shared at that level, but did not get shared down more on the ground floor where it was needed for hospitals like us.” He added that most of the resources went to “one of the most wealthiest, largest health systems in New York. They had more resources and then they probably knew what to do with [them].” Ms. Mighty voiced that her “colleagues across the way, got resources. So that was very unfair.”

All participants felt there were challenges, particularly surrounding *information.* What derived from this subtheme were additional subthemes of information such as surge of information, fluctuation of information, delay of information, lack of appropriate information.

Figure 3

Subthemes of Information Challenges

Some participants felt that while remote working was widely supported in their organization and was helpful, it became a challenge. Mr. Legendary stated, "Working remotely meant you're engaged in all of your meetings because all of our meetings were virtual. You're answering all of your emails, you're answering your phone calls, you're getting the calls forwarded to yourself" and "to try and give that work life balance, it's still stressful."

Ms. Accomplished supported a legendary point of view but expanded on what her experiences were when it came to remote working. She stated,

I mean, I'm an advocate of people working remotely, but I also believe when people work remotely, they have to be available. So I found it very discouraging when you would call somebody and get a busy signal, they didn't respond back. But people

would say, "Oh, my computer was down. I have poor access." So many times I would have to do things myself. I would have to draft,…letters myself, schedule meetings myself because my admin was not available.

Another challenge was *staff loss, recruitment,* and *retention*. Some participants felt that this was a major challenge.

Mr. Legendary said, "Obviously, recruitment and retention are always a big issue now."

Ms. Accomplished noted, "I think we could have got ahead of it because now you have the great resignation." She clarified, "Now you have the quiet, quiet resigning. Right. Um, so many other things that have so much burn out. I mean, there's so many nurses that left completely, in healthcare." She went to elaborate,

I'm trying my best and I have staff that are resigning. But how is it impacting me as a leader? You know, when we think of emotional intelligence and where you should be, I think the importance of being a leader is also being able to be honest to say, "I also have some fears but I'm still here for you." You know, and it's not a sign of weakness. It's really, it's a sign of reality to say just because you have a title doesn't mean that you don't have that human nature component of you.

She further provided an explanation of the great resignation by noting that "we had about 42 staff that ultimately left nursing."

Mr. Superior added that protocols around the use of agency personnel and their assignments change in terms of protocols of care. He acknowledged that a few people did not make it, and some staff members, in the first month, quit: "We didn't lose a lot of people in the first 4 to 6 weeks, but we did lose some people." He recalled, "One nurse

for sure who said 'I'm not exposing myself to COVID. I got two young kids, I got a wife, I got a family' and he just up and quit."

Prior to COVID-19, there was a nursing shortage and the experience with the pandemic widened that gap further with the loss of staff, which greatly affected the staffing ratio. Mr. Superior noted that the staffing ratio was about be two nurses for 30 patients. He further expounded that the ratios far exceeded anything they had previously experienced at a time then that they "were still learning about how to care for patients." Mr. Superior was clear to note that they "were extremely short staffed and there was frankly [he] would say a lot of despair among the staff." Ms. Mighty shared similar experience because she too noted, "We didn't have enough staff for that period."

The *time in leadership role and the impact* played a significant role during the COVID-19 pandemic. Still, the participants were very seasoned from experience being in the role for a short time barring some limitations. Ms. Prevail who had been recently promoted noted it was a challenge: "I was on a new team, I was new in my role, and then one of the worst things in our professional careers happened collectively. And so there wasn't a strong foundation of relationships to start with."

Theme 2: CNO Perception of Resource Availability

Resource availability was discussed by all participants. They did state that they had sufficient resources. Mr. Legendary noted,

> Part of us running the command center was working very closely with our materials management and purchasing department, and they were extraordinary. They were finding supply line chains that they had never used before. It got to the point where we were actually buying directly from other countries instead of

> going through the manufacturers. Fortunately, we never ran out of anything. We never ran out of masks, we never ran out of gowns. To be able to maintain the supplies and the resources so that the staff had what they needed, that was by far the biggest satisfaction because we were all seeing the pictures from the other hospitals.

Further, he felt confident: “We’ve never run out of our stuff and we’re being asked to do all these things. We’re being asked to take care of all these patients. We’re being asked to expose ourselves to all these things.” He continued, “The fact that they [the staff] felt that they were always supported and had what they needed, you get that feeling of the job well done, so that is your job satisfaction.”

Ms. Prestigious echoed Mr. Legendary’s views:

> I think access to resources at any time is very important. But certainly during COVID, nobody wanted to hear, and certainly I did not hear from our senior team, we can’t afford that before, that’s too expensive. There were no expenses that we weren’t willing to pay to ensure that our frontline team members had what they need to deliver care, or that we wouldn’t be able to live up to our promises, to our patients to deliver the highest quality of care possible with the resources we had available. I believe very strongly that there were no barriers, no resource constrictions on us other than the availability of resources but their only concern was running out it.

Ms. Mighty elaborated on that theme:

> I don’t really think that we never had it. I think that there was always a fear that we didn’t have it, but I don’t think that any of the nurses ever went without it. I

> think that they had it, but there was a fear that we were going to run out. And at that time, reusing the masks or the N95s, which we were definitely short of, was of concern. But nowadays, people use it a lot. I used to take mine home and wash it. You could put it in the washing machine. It really worked. But at that time, you really didn't know. That was what I lost sleep over at night.

What was also great to view was how the participants defined the *resource availability*. In an example shared, Ms. Prevail discussed that *resource availability* was definitely vital:

> Depending on how you define resources, I define it very broadly. I mean, I think during the pandemic and probably all the time people think of resources they think about staffing. Right? And it's so much more than that. It is absolutely staffing. Right? There's no getting around that. It's equipment, it supplies, it's financial resources, it's wellbeing resources, it's support, it's advocacy. I mean, resources is really just so broad that it's all of those things. So staffing was abundant, right? The organization was really great about making sure that we had staffing. Supplies were not an issue and we had PPE in abundance. So the organization did a really good job with that.

Theme 3: CNOs' Perceptions of Their Leadership Effectiveness

All participants were critical of their leadership expertise during the COVID-19 pandemic, yet none of them felt that they did an unsatisfactory job. The felt the response from the frontline staff to their leaders was a signal that they had done great work. Those who felt that their leadership was questioned in the end received an apology from the

leaders and staff who initially doubted the strategies used were very happy for the leadership.

Ms. Eloquence noted, "I have a lot of experience. Therefore, things have not changed that much."

Ms. Supreme shared, "I think I was pretty effective in my role. I mean people took my lead, I think possibly because I demonstrated the behaviors that I expected people to have." She added, "I was there with them, not hiding behind and giving direction but being with them and being exposed just as they were to COVID."

Mr. Legendary said, "I think my leadership style, it never changed. It's always been the same before COVID, during COVID and after COVID." He further noted, "I think my senior leadership, so my COO, my CEO, they knew what we were doing and appreciated everything. I always felt appreciated and recognized. Again, publicity wise, it's always the front staff who got that, which they should've."

Theme 4: CNOs' Role, Responsibility, and Accountability

Every participant embraced their role, responsibility, and accountability. They all knew of the job that they had committed to and thus applied every aspect of their knowledge and expertise into what had to be done.

Mr. Superior indicated that one of the principles and values of his leadership was called "presence." He continued,

> So you know, it's a concept that… has a fair amount of attention and literature generally. It's one of the characteristics of leadership that I speak about regularly with teams I lead. Now what do I mean by presence? Well, it is physical presence but also emotional and social availability. With teams that I lead, being present

with information, support. and opportunities to both listen and bring the contributions or ideas of others into the work and the mission that we have before us. So, I do that in many ways; it's again through communication patterns, both formal and informal during the pandemic, and it was particularly necessary. I mean, I've always been… a leader who rates my success as a leader, by how much time I'm not in my office.

Ms. Supreme shared, "I was able to get things done and I was able to remove barriers that I may have encountered." She maintained that she remained visible throughout the COVID-19 pandemic because it was important.

Mr. Legendary noted, "One of the most important things I've always said is, 'You would never ask somebody to do something you wouldn't do yourself.'" He went on to demonstrate and provided the example:

For about three hours together, we all moved the bodies. They all said, "Well, as the senior vice president, as a chief nursing officer, we never would've expected you to be on the loading dock with the tractor trailers." I said, "That's what leadership is. Leadership is, you don't ask people to do something that you wouldn't do yourself."

Ms. Prevail recognized her role during that time:

There was that cascade from my role throughout the levels of leadership that made it to the frontline and that everybody from the frontline and between not just the frontline, but also that my leaders who I'm very invested in, leaders, manager level, assistant nurse manager level, that they felt it as well. So that was important

to me. And those were very quantifiable, tangible ways, not just that I think I did a good job, but those were things that say like, “yeah, you did all right together.”

Ms. Perspicacious recognized the importance of support:

When I think of my leadership and the support that I was providing, as I know myself, I was looking for support as well, or needing it, right, and kind of recognizing that I needed to support myself and to support the team. I think in a moment, it was because we met multiple times a day, I had a sense that this team felt supported because we were talking and we were talking very openly about not just the operational side of, we were talking openly about how we were each doing, because again, this was affecting everybody in every way.

Ms. Intelligent assessed her role with confidence:

I think that I was a very strong leader, I had to quickly assess the organization, understand who my key players were, who I can count on, who I couldn’t count on. I really get to understand the culture and the workings. And I had to do it super quick. But I think one of the successes that I had. I came here as a very experienced chief nursing officer and I had tremendous relationships outside of the organization. So when nursing needed, you know, travelers, because we needed so many more nurses to take care of the patients and or get sick and out, I was able to secure travelers very quickly. I have very strong organizational skills. So I’m very organized to my approach.

Ms. Prestigious shared her experience of going to the COVID-19 Unit. She stated,

During the height of the pandemic from the beginning, my neighbor was in hospital and the senior leaders in the hospitals kept saying, “We’ll take you to the

> non-COVID units." I was like, I don't want to go to the non-COVID units. I want to go to the COVID units. "But you going to have to wear all this protective stuff." I said, "I'll wear all the protective stuff. I want to go where the action is." That's being with those nurses and team members that I'm asking to be in those units. So they're no better than them. If I catch COVID, I catch COVID, but I'm asking them to go to the front lines. I have to be able to be there as well.

Theme 5: CNOs' View of Community and External Response

Some of the participants shed light on the importance of community and external response during this time. They felt the outpouring commitment of the community regarding food and other needed resources as a great attribute that encouraged them to continue to provide the care necessary. It was also an affirmation that confirmed that the community was with them. A number of the participants mentioned the support of organizations such as Greater New York Hospital Association as well as their peers at other facilities and of best practices was great to see.

Mr. Superior noted, "There's a lot of community presence and contribution… and I really felt, that that was adequate."

Ms. Mighty indicated,

> I saw a tremendous amount of resilience, and I thought how the community rose to the occasion and fairly responded to the staff. So I had funny comments coming from the staff that they were putting on weight because so much food was coming into the hospital because the people around were cooking for them. All the restaurants were sending in food. I think that was a wonderful thing. We were

hearing from Greater New York, you really had to try to follow the rules of the day. There was not a time for innovative leadership.

Ms. Intelligent voiced that everything changed almost daily: "So, we kept in touch with our hospital associations, Greater New York, to make sure that we were getting the messages and the changes as they were happening." She believed,

> Collaborating with my CNO colleagues across the country, it was really great to learn from what other people were doing. And to be honest with you many, many people learn from what we were doing here because I think we did some very many best practices, but it was also really important to have the opportunity to vent and collaborate and sort of talk to my colleagues about what they were experiencing so that we can together come up with better ways of managing what we were dealing with.

Theme 6: CNOs and the Availability of PPE

The participants felt that PPE was never a problem, and it was always available; therefore, staff were never without it. Some felt that strategic approaches had to be taken to obtain the supplies.

Ms. Intelligent noted, "Many of my colleagues in other hospitals ran out of PPE and literally using garbage bags for gowns. I was very grateful that we jumped ahead of the curve and ordered enough PPE and ordered everything that we needed."

Mr. Legendary noted that although they had enough "PPE, [they] were fortunate because [they] had …[their] purchasing group and materials management were very

aggressive about getting their supplies; however, they had to in non-conventional ways." He added, "It was a real struggle to try and get enough PPE." He continued, "To be able to maintain the supplies and the resources so that the staff had what they needed, that was by far the biggest satisfaction because we were all seeing the pictures from the other hospitals."

Ms. Prestigious recalled,

> We had, even though we had a large quantity of supplies because we didn't know if the supply chain would cut off. Because we did see different avenues that we had used in the past and even newer avenues that we were opening up, some were closing down, and they weren't able to meet our requests for additional supplies. So in effort to, again, not knowing how long these first surge of the pandemic last that we did ask people to, review if possible, their masks, their N95s, their gowns, working with our infection control teams as to what would be the safest way to do it if we needed to not do what we normally would've done, not knowing, thinking it's probably better to have self-protection rather than to have no protection.

Theme 7: CNOs' Perception of Aggrandized Administrative Support

The participants' response to having an *aggrandized administrative support* came with mixed feelings. Some felt they had an abundance of administrative support while other felt that more would have been best.

Ms. Prestigious said, "I don't think I needed additional administrative support. I have plenty of administrative support. I had all the administrative support that I needed during the pandemic."

Ms. Eloquence believed she had “enough administrative support [and] did not need any more.”

Mr. Legendary recounted his experience: “Again, because we’re such a lean and flat organization, anytime you’d have more hands available, it would’ve been great.” He added, “Anytime you can get more resources, it always would’ve been good.”

Ms. Intelligent felt the same way as Legendary as she pondered her experience. She stated,

> Oh gosh, I did. … we definitely could’ve used it. I mean the number of phone calls that came in, we had a lot of lack of resources. What we did do very quickly is we looked at departments and you might have lived through this, we looked at departments. that were not necessarily critical to functioning inpatient care areas. Like for example, we looked at finance people and so they were working on things that they could have helped us when we really needed someone to answer the phones, someone to send out messages, and someone to keep up with the changing information, like those kinds of administrative tests. So we did use staff from other disciplines and other departments to help us with that. I would say during COVID we needed a lot of support, any support because it was just a very overwhelming task. Our census jumped by, you know, over 100 patients very quickly and they were all very sick patients on isolation.

Ms. Perspicacious noted they needed additional administrative support: “We repurposed some roles into now more COVID-19 response, and it’s like these strengths and talents and the real commitment and devotion that was so apparent.” He continued,

"We brought ambulatory focus people into the acute care setting, all to support these new strategies, and yeah, that was incredibly helpful."

Theme 8: COVID-19 Creation of Opportunity for Advancement

The views in retrospect of the creation of opportunity for advancement, were mixed with the majority of participants noting that COVID-19 did not create such opportunity. Nine participants felt that there was no opportunity for advancement except for one who obtained a new job.

Ms. Eloquence echoed what the majority of the participants noted because for her "nothing had changed."

Mr. Legendary noted,

> From a nursing perspective, I'm at the top of where I can go to. I'm a chief nursing officer and a senior vice president, so there's really not much more advancement unless I want to look at stepping outside. To me, the next level of advancement would either be as a chief operating officer or as a CEO. That's not really the issue. I think my senior leadership, so my COO, my CEO, they knew what we were doing. They appreciated everything. I always felt appreciated.

Ms. Prevail stated, "It did do that for me, my experiences, my gains in working with the team, the outcome did set me up for another opportunity, the opportunity that I'm at now, which is much bigger in scope." She noted that she has more responsibility and a bigger dual executive title. She believed that because she was "able to demonstrate that [she] was effective in a crisis and the ways in which [she] could add value to another organization for what [she] learned did offer [her] opportunity."

Ms. Intelligent expressed, “I wouldn’t say career advancement because I’m as high as I’m interested in going. I’m a senior VP at this point.”

Theme 9: Creatives Strategies CNOs Used

Some of the participants used creative strategies to help them manage effectively. Some felt that they had to be innovative while other felt it was not a time to be innovative. They had to create units as well as repurpose staffing roles and responsibility to address the crisis at hand.

Mr. Legendary shared that he fostered a number of creative strategies. He noted that to preserve his staff he created schedules that would allow his leaders to be flexible to balance work and life. He stated that his directors did not agree with him because they wanted to be present. However, afterwards, they were appreciative of his leadership. What he also did was allow his staff to have a perspective that he was in this experience with them and he helped them with expired patients for “3 hours,” which was a surprise to his staff. His staff took the liberty to notice that given his title and current status, he was able to get to their level and help move the bodies. They noted, “We saw you here all the time. You were here with us,” where they’d say, “There are other senior leaders who really didn’t have a place there.”

He added, “When staff say, ‘Listen, we appreciate that you were here, that we saw you were in this with us,’ that’s really where the satisfaction came from.” He also referenced his ability to have staff buy-in to change their jobs to meet the guidelines set forth in the EO (executive order). He added that he told the persons whose roles have been repurposed, “Listen, you’re now our COVID SWAT team. What that meant is as these executive orders come out and we have to react and respond to them, you’re going

to be the group that we're going to rely on to help us do that." He continued by stating that really got them just the opposite of what you would expect: "The morale enough, they became enthusiastic about it because they're like, 'We're the group that they're coming to when they need to get something done.' It's continued that way, so it's been really good."

Ms. Prevail noted that there were a number of decisions made but she had to make the tough choices:

> We need to think about opening surge units, shutting down services, training nurses differently, all of those things where not everyone saw the vision necessarily at the same time. And there wasn't a whole lot of openness at times in out of the box approaches. So sometimes I had to kind of just push through with what I felt really convinced to do for my teams, to get them the resources that they needed or to think about our resources differently in terms of reallocating them and kind of "act now and ask for forgiveness later" was a lot of what I had to do. The challenge with that obviously is that in the moment where you were acting and there's not a whole lot of support or agreement, it can make for a pretty tense climate.

She also noted that she had about 20 agency nurses prior to COVID-19 receiving their first patient.

Ms. Intelligent noted that because of her strong organizational skills she was able to secure travel nurses very quickly "because [she] understood what [her] staff needed from a clinical perspective."

Theme 10: Executive Orders' Impact and CNOs' Responses

The views of dealing with *Executive Orders' Impact* and *CNOs Response* was both of mixed perception. The majority felt that Governor Andrew's Cuomo's leadership was exceptional; however, the surge information, sudden changes in protocols and delay of information made their response quite cumbersome, which resulted in a debacle in the information.

Ms. Prevail insinuated,

> I would say that the executive orders I thought were a godsend. I think probably early on, there were times when we were kind of waiting to hear from the state, we need to make something happen here. In retrospect, I just see it so differently than in that moment. None of us knew what we were doing, so I just had so much more empathy and grace for everyone involved that I just don't need to really remember having a complaint in that way.

She felt that as a result of the Executive Orders that were disseminated, relaxed licensure resulted. Additionally, she stated,

> Shaping the way that we're thinking about staffing models now. Right? I mean, how wonderful that those happened. And we are bringing, at least I'm in the hospital … FTEs to bring LPNs back into the hospital permanently. And all of that was spurred by those executive orders and us being able to be more expansive, now we see there's value. So I just think that when we talk about structural empowerment, that is how not only are we responding to a crisis, but we're looking toward the future.

Mr. Superior noted,

> To not have guidance would have been created chaos…We didn't always agree 100% with everything that came from the Department of Health, but of course, we honored whatever came from the Department of Health and we implemented it. So, we then would create policies and then we would educate and train and communicate to the staff directly, via the unions, et cetera. So, there and of course, to the management team.

Mr. Legendary suggested,

> Executive order is a nice way of saying "unfunded mandates." Unfunded mandates is the thing that ruins and destroys us because you're being told, "Now you have to do this on top of all the other things you did." There was no funding or support or resources. The executive orders, some of them were good and some of them were harmful.

He believed that some of the executive orders were harmful because though there is written language to support the use of "out of state nurses in New York State." He explained, "A number of states are in agreement packages where they recognized each other's license, but because we are not part of that, forget it." He did acknowledge that if executive orders "hadn't been in place, again, [they] wouldn't have survived because there's no way [they] would've been able to have enough staff to take care. That was a very positive one."

Ms. Intelligent suggested that the executive order "helped to elevate the standard of practice in some respect and give support to the nursing staff." He continued,

> I think that the Governor was aligned with a lot of the goals, certainly having the Cares Act in and of itself was huge because we were able to secure over a $100

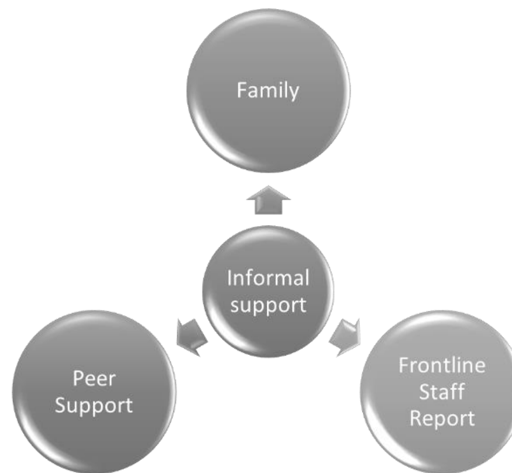
million, I believe, you know, millions of dollars in equipment and different things through the funding. So I do think that that that was really well done.

Theme 11: Informal Supports

The *informal supports* were great systems that supported the leadership of the participants, including family, peer support, and frontline staff, which add a humanistic element in support of the decisions made by the participants (Figure 4).

Figure 4

Informal Supports



One participant was keen to point out the difference between formal power and informal power. Ms. Intelligent noted, “Formal power comes from having the title and wearing the badge and being in the role but not necessarily personal power which is informal power.” She stated that because she was a new staff at the hospital, she had to get to know people and one way she did this was “having visibility” and following through as a leader.

A couple of participants felt that their family was supportive of them, and they were able to draw strength which alleviated there need for social supports. Peer supports were a great means to not only get the job done but also fundamental in providing emotional support as they felt that they were never alone and had each other. The frontline supports were also very essential in achieving the mission, vision, address executive orders, and completing goals.

Ms. Prevail felt she “had unconditional family support.” However, she added,

> At work, I think support was inconsistent. There was certainly support in terms of what was needed operationally. I don’t think there was a whole lot of support for, I would say probably not a whole lot of support for me as an individual in terms of what I felt my teams needed from a well-being perspective, from maybe a strategy perspective, especially during the early part of the pandemic where there were times when we needed to think a little bit more creatively.

Ms. Prestigious noted that to have a strong informal support must “have been established prior to the pandemic that you are a visible leader.” She continued,

> And again, my prior experiences had always been to visit the hospitals and make rounds on the unit and speak to the frontline team members and speak to patients. And so I think that continued during the pandemic. So my leadership did not change. Certainly, I did not have as much time to go to the hospitals as I would’ve liked because it was rapid decision making that had to happen of staffing, of utilization of the supplies, where we were going to ship the supplies, looking at where patients could be safely admitted to where we had to transfer patients.

Ms. Eloquence exclaimed, "If we did not then it would have been a problem. But we had the support of everyone!"

Mr. Superior insisted,

> Whatever time it was, I always felt when I come back tomorrow or later today, my peers… I had a particularly strong relationship, I mean there were basically two senior vice presidents, and we're accountable to manage the organization on a day-to-day basis. We had very good relationships" (see Figure 4).

Theme 12: Internal Organization Factors Used by CNOs

All participants felt that they had to use organizational factors to help guide their leadership and job satisfaction.

Mr. Superior noted, "The way in which we communicated with one another" was "key, especially while they were in the command center."

Mr. Legendary felt the ability to sustain their ability to function was "to manage this with what [they] had."

Ms. Intelligent attributed the factors that influenced her leadership and job satisfaction: "The amount of support of encouragement and leeway to do what I needed to do. so that I think the kind of leadership we have in the Executive suite really empowered me to be able to get the job done. And I think that was critical"

Ms. Prestigious thought,

> It had to do with the culture of our organization prior to the pandemic that we did not approach. When you look at structural empowerment, it's about us all feeling safe regardless of what our roles may be, feeling safe to be able to verbalize concerns, we have able to verbalize what's going right and what's not going right.

> Being able to pivot on the dime. If we made a decision to realize that may not have been the best decision to be able to say, stop that. Let's do something else without people feeling that their feelings were going to be hurt.

Ms. Prevail suggested that the main organizational factor that influenced her leadership was the following: "I would say the fact that the organization as a system was a relatively, I would say comparatively very well-run organization."

Ms. Eloquence felt that "it was a team approach."

Ms. Perspicacious attributed her experience to the following:

> Think back again, to each leaders, including myself, we had a lot of autonomy. Right. We had a lot of trust from the executive teams as well as our local teams to really develop plans, which we were making the best decisions we could in the moment, but there was a lot of support and encouragement and recognition for the efforts."

Ms. Mighty likened her experience to "a lot of informal power and structural authority." She added, "People, again, we worked together, but the chief nurse was really played a pivotal role in giving an opinion and leading things. So, they wouldn't do things generally without having nursing input, which was really very good."

Ms. Accomplished related her experience: "Having that structure of a leader above a nursing leader because my manager is not a clinical person and having the structure of somebody who understands the clinical components of what was going."

Ms. Supreme associated her experience with information:

> Information that we had was readily available and we were kept informed of every step of the way. We knew what the incidents were in the community. Early

on we kind of got a sense of what was working and what wasn't working. I think just the constant flow of information really helped not just me but helped everyone else who was here through it to really do their job.

Theme 13: Leadership Sustainability

The majority of the participants were able to sustain their leadership roles due to a number of components of structural empowerment, their leadership experience, and organizational factors that had a bearing on their job satisfaction. All of the participants appeared to have had challenges but were able to maintain equilibrium not just independent but within the system in which they are employed. They felt that nothing had changed about their leadership style even in this crisis and the internal challenges they faced.

Ms. Supreme noted, "I think my performance during the pandemic is what has ultimately led me to this role (CNO) today."

Ms. Accomplished noted,

> She [her leader] was always like berating somebody… somebody was always on the hot seat and what would happen, people would be fearful of being the, target of her. So instead of owning up to what they did wrong they say, oh, it really wasn't me. It was (me), you know, like, and so people would shut their responsibility and shift it to somebody else…even though I was not responsible for some of these things… it fall under my profile, I wound up taking the brunt of a lot of the issues that were not mine. I was not rewarded from this at all.

Ms. Perspicacious felt that her leadership was sustained but “not certainly a change in [her] career, but there was acknowledgement, recognition, value on what [she] personally do[es] here.”

Theme 14: Psychosocial Support Importance and Impact

All of the participants felt that the importance of psychosocial support and its impact was vital. While some felt that they had their family to support them, others felt that they staff benefited greatly from this support and thought that it might has been a benefit in the beginning but they were not sure if staff would have had the opportunity to use it.

Ms. Superior noted,

> From my peers, I think it was fine. I think for the staff that I was accountable to lead, we work very hard to and we did establish resources through the Department of psychiatry and social work services and others. and other avenues to formalize and create opportunities for people to come together and talk about their experience and so forth. Staff didn’t really take advantage of that interestingly enough. And we did both virtually and in person.

Ms. Eloquence pointed out, “Everyone needed support but certainly some staff could have used support, but it was stretched.”

Ms. Prestigious commented,

> For me personally, I don’t personally think I needed psychosocial support. I was a former critical care nurse. This was code situation and code situations you don’t panic, you focus on the issue at hand. Address it and that’s how I approached it.

And so I don't think, there's anybody I needed to speak to about what was going on.

Ms. Prevail expressed her feelings as having more:

I would say, gosh, my goodness, a lot more, it would've been great to have, and I don't know where we would've gotten them from, but just onsite therapy resources, onsite at the ready resources for people to have someone to talk to, perhaps that would've been really, really great. I don't know that people would've had time to avail themselves to those resources because of how busy they were. But it feels like in theory that it would've been just great to have just a place that people could just go immediately and have something."

Theme 15: Rapid Patient Surge, Loss, and Effects

Most participants felt they were prepared to some degree but not to the extent of what they experienced in retrospect to *patient surge, loss and effects.* Ms. Intelligent and Ms. Perspicacious expressed their experience with patient surge. Ms. Intelligent noted that "our census jumped by over 100 patients very quickly.

Ms. Perspicacious indicated, "It was just the pure volume of patients and the way they presented." She continued, "We just did not have the capacity, the physical capacity in the hospital so who we created all these new patient care areas, right, all of our conference rounds, the cafeteria, spaces that were never intended to have patients."

Both Mr. Superior and Mr. Legendary give a descriptive insight of the rapid loss of patients during the COVID-19 pandemic. Mr. Superior noted that "many people died of COVID in the organization."

Mr. Legendary shared his experience of having to maneuver the expired patients. He stated,

> At one point, we had a tractor trailer that had 72 bodies in it, and they delivered us a second one. The instructions that we got was that our facilities department had to build shelves in the second one to basically triple the capacity. Once they had done that, I had to gather a team to go out and move the 72 bodies from the one tractor trailer to the other tractor trailer.

Ms. Supreme explained, “I was never dissatisfied in my job, except for when I felt that I could not meet the patient’s needs because so many patients died on their own because it was occurring so rapidly and not under normal circumstances.”

Ms. Mighty was able to share the effects that patient loss had on staff. She noted that there were about “six or eight doctors and nursing sobbing on the floor in front of the nurse’s station. Sobbing on the floor in front of the nurse’s station, because what was it? The fourth, fifth, or sixth patient had passed that day, and they were besides themselves” (see Figure 5).

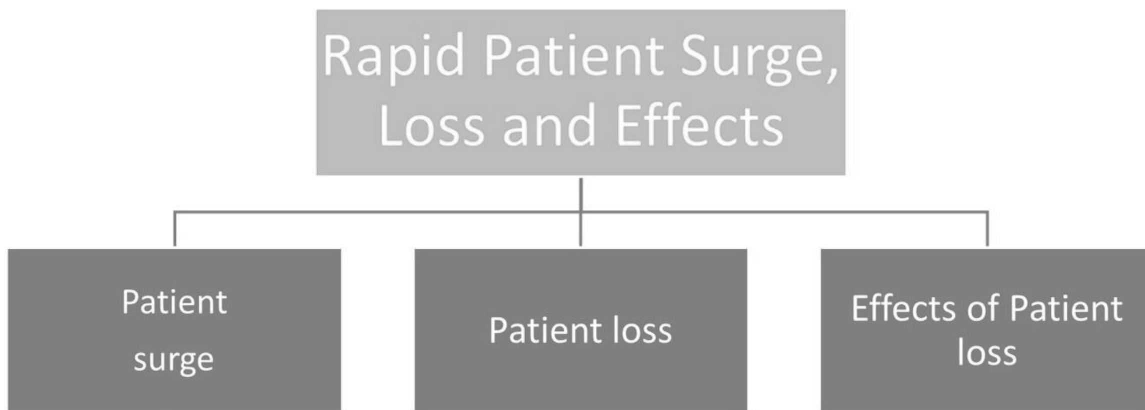
Theme 16: Realizations for Future Improvement

What derived from the experience on the *realization for future improvement* was the lesson learned.

Mr. Legendary noted that “as an organization, obviously, you have to support frontline, but you though, is the importance of supporting the middle management. Those director roles is very important.” Another aspect of support, he noted that “we learned through this is that there’s a lot of things that we can do remotely, even in leadership positions.”

Figure 5

Rapid Patient Surge, Loss, and Effects



Ms. Intelligent reflected on what leaders can do better in the future. She noted, "Well, how can I improve? I think it's really important for any nursing leader to reflect on their practice and see what they could do better."

Ms. Prevail revealed, "Being able to demonstrate that I was effective in a crisis and the ways in which I could add value to another organization for what I learned did offer me opportunity for advancement."

Ms. Accomplished shared, "I would say that my leadership skills were enhanced during this time because, you know, I've never experienced this before. So it gives you an opportunity to bring out skills, those emotional intelligence competencies to be self-regulating for yourself."

Theme 17: Senior Leadership Support

Many of the participants emphasized that their leadership support gave them autonomy and were supportive of their decisions. Some of them had difficulty and felt that their leader was not supportive or questioned their leadership.

Ms. Accomplished felt that the senior leadership berated her and she took the brunt of the blame because her colleagues who were fearful did not want to own up to their insufficiencies."

Mr. Legendary acknowledged that he was supported by his senior leadership team. He made decisions beneficial to his team members and his leaders did not know of this change until he discussed the change with them at a later time.

Ms. Prevail emphasized that she had a good leader but earlier in the COVID-19 pandemic her leadership was questioned. However, later on, her boss acknowledged his mistake and it was a good call she had made to hire 20 nurses in advance.

Ms. Mighty stressed that her leadership was supportive as well and made sure that what she and her team had was necessary to address the goal.

Discrepant Cases

There was no participant who was uncooperative and felt that they could no longer participate in the interviews. They were willing to share what they had gone through and the challenges they faced. They all provided a descriptive, graphic illustrations of their experiences that shed light on the reality of the COVID-19 pandemic.

Experience of Participants

The participants, CNOs, were the source of all data collected for analysis. Their experiences described how they were able to navigate through the COVID-19 pandemic.

I examined their responses closely to stimulate inquiry of the tools they used and the measure or lengths they went to, to narrate a detailed account of their experiences. Many of the experiences shared were comparable to their peers' accounts and gave gravity to the reliability and validity of their experiences. There were also some variations in their accounts due to their unique experiences, internally and externally, of their organizations. Their roles, perceptions, behavior and leadership performance were also part of the scope of this study.

Summary

The detailed results in Chapter 4 provided a descriptive narrative of the experiences of the participants. They who were eager to take part in the study and were able to provide valuable and visual responses via Zoom and telephone interview. The sample size consisted of 10 CNOs who were asked 13 semistructured, open-ended questions that pertained to the research topic and question. Data analysis was done using NVivo 12 by creating fragmented data, resulting in codes that helped to formulate 17 themes. I also used visual figures to provide clearer understanding of relationships. Following this chapter, Chapter 5 provides vivid insights on how the results will be beneficial in advancing the body of knowledge on policy development regarding strategies for future pandemics. Also, included in Chapter 5 are limitations, their influence on trustworthiness, recommendations for future research, and implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Chapter 5 recaps the research purpose, methods of inquiry that reinforce the findings, and the results. The aim was to specifically answer the following question: How do CNOs perceive their lived experiences of organizational factors in relation to structural empowerment and job satisfaction during the COVID-19 pandemic? To provide deeper meaning to the recommendations, my purpose was to discuss the process used to analyze the data collection completed by face-to-face and telephonic interviews. Interview data were analyzed, and themes developed as outlined in Chapter 4. I used a rigorous procedure to produce valid conclusions. In addition, I discuss limitations of the study, the effects on trustworthiness, future research recommendations, and the implications for positive social change.

My research focused on the lived experience of CNOs at hospitals in New York State during the COVID-19 pandemic as they made decisions regarding patient care. This examination was to understand their perceptions of leadership effectiveness, job satisfaction, and structural empowerment in responding to Governor Cuomo's executive orders, which led to the modification of standard protocols regarding PPE, documentation, social distancing, reconfiguring outpatient care, closure, a focus on in-patient vs. out-patient services, and the transition from in-person to virtual services via telemedicine. I considered strategies used to sustain CNO leadership in response to these orders, which seemed to create surges of new information that led to new or enhanced policies. In addition, I took a humanistic approach to elicit the abundance of responses because the CNOs were not exempt from the emotional toll of the pandemic, hence my

reason for seeking to understand their experiences in a deeper manner. In addition, the focus was to obtain factual information from the participants based on their shared lived experiences of real life events (Corbin & Strauss, 2014).

I used a phenomenological qualitative research design to collect and extract data through 13 open-ended questions regarding 10 CNOs' experiences in response to the rapid occurrence of executive orders issued by the Governor Cuomo of New York during the COVID-19 pandemic. As a result, this qualitative method of approach was a succinct design to address the research question appropriately and explore the lived experiences of participants involved with the phenomenon (Corbin & Strauss, 2014). A van Kaam method (Moustakas, 1994) was used to analyze the data. I conducted analysis to sort and identify themes and patterns of experience by studying the participants, who were CNOs working at hospitals in New York during the COVID-19 pandemic. Based on recurring themes, I developed conclusions about the lived experiences of the participants within the context of their structural empowerment and job satisfaction during the COVID-19 pandemic 2019-2021. Kanter's (1993) theory of structural empowerment, which addresses the behavior of organization within the parameters of employee empowerment, was my interpretive lens. Kanter theorized that when employees are provided with access to information, resources, support, and opportunities for professional development, they feel empowered within the organization.

Interpretation of the Findings

The goal of qualitative research is to generate valuable and concise data to provide an illustrative account and a deeper exploration and understanding of participants' experiences. Further, data interpretation depends on a researcher's

theoretical perspective (Austin, 2015). Austin (2015) further elaborated that the way a participant experiences a phenomenon is enhanced for the researcher when a deeper understanding of the participant's perspective is gained. This perspective is relative to the research question, which is useful not only in answering the question but also incorporating the interpretation logically and holistically (Babbie, 2002). My study's findings illustrate the contextual dimension parallel to the anticipated outcome, as well as an expansion of participant awareness of their roles and responsibilities during the COVID-19 pandemic.

The emphasis was to ensure that the results were comprehensible and replicable to other researchers without prejudice. In further support of this viewpoint, Babbie (2002) claimed that replicability is a necessary scientific norm. Applying such an approach requires data to be analyzed not only using the responses of the lived experiences of the participants to reveal supporting data for interpretations, but also to disclose data that differ from the way a researcher may make sense of the information (Babbie, 2002).

The findings support that although CNOs are prepared for emergency disasters, nothing could have prepared them for the COVID-19 pandemic as this event was happening globally. Thus, all CNOs in the world were experiencing it at the same time. Additionally, the mysteries of COVID-19 were a challenge to their leadership, considering their responsibility to their subordinates who were looking to them patiently for leadership and guidance. The CNOs did not have the answers on many occasions on how to proceed in response to challenges presented by the pandemic. Most of the participants shared that although they are resilient, they could not have done a successful job without the collaborative efforts of key internal stakeholders, such as senior

leadership, frontline directors, nursing staff, colleagues in other areas (physicians, lawyers, procurement management, psychiatry, social workers, and so on), and external stakeholders (New York Governor Cuomo, fellow CNOs, organizations, community, and family). The participants also felt there were lessons learned from their experiences regarding how they can proceed in terms of organization structural procedures to prepare for daily operations to address future pandemics.

To understand the parameters, a thematical analysis was conducted to bring together initial codes into a coherent entity (Babbie 2002). As a result, the following themes were derived from the data: (a) challenging complications during COVID-19; (b) CNOs' perception of resource availability; (c) CNOs' perception of their leadership effectiveness; (d) CNOs' role, responsibility and accountability; (e) CNOs' view of community and external response; (f) CNOs and the availability of PPE; (g) CNOs' perception of aggrandized administrative support; (h) COVID-19 creation of opportunity for advancement; (i) creative strategies CNO used; (j) Executive Orders' impact and CNOs' response; (k) informal supports; (l) internal organization factors used by CNOs; (m) leadership sustainability; (n) psychosocial support importance and impact; (o) rapid patient surge, loss and effects; (p) realization for future improvement; and (q) senior leadership support. Based on the perceptions of the participants, a careful presentation of the results of the themes was independently analyzed.

Theme 1: Challenging Complications During COVID-19

The first theme is *Challenging Complications during COVID-19*, which presented results of significance regarding the barriers that participants had to overcome when addressing the COVID-19 pandemic. As a result of this theme, further in-depth

knowledge was discovered through the subthemes of (a) burnout; (b) changing PPE protocols; (c) CNO judgment questions; (d) inequitable allocation of resources; (e) information; (f) remote working; (g) staff loss, recruitment, and retention; (h) staffing ratio; and (i) time in leadership role and the impact.

The first subtheme of *burnout* was felt by some of the participants, which was not surprising given the chaotic and stressful toll that the COVID-19 pandemic took on health workers. While many were not the frontline staff, managing day-to-day operations consumed their position of accountability from policy interpretation to developing rules geared to meet the needs of staff and patient alike. They showed resilience throughout their experience with burnout.

The second subtheme was *changing PPE protocols*, which was perceived to be confusing because by the time the participants believed they had understood and made procedural recommendations, the situation had changed. Many of the participants believed that the constant PPE protocol changes was one aspect that created a barrier to addressing the COVID-19 pandemic. As a result, there was a lot of confusion on the right PPE to wear.

The third subtheme was *CNO judgment question*, which was noticeable from both the senior leadership and subordinates' perspective of some of the participants' accounts. The participants seem to insinuate that being proactive was predetermined, yet they had no idea what they were dealing with, which led to doubts or lack of confidence in their leadership. It seems that judgments coming from their leadership were not expected, but coming from their subordinate's perspective was nearly anticipated. From a leadership standpoint, some CNOs felt they did not have the autonomy to do their job. On the other

hand, the subordinates questioned the CNOs' competence in dealing with the pandemic. Most misgivings seemed to stem from the confusion in terms of the many policy changes, PPE protocols, and lack of knowledge regarding the COVID-19 pandemic, particularly when they felt that they were being proactive and a team-player.

The fourth subtheme was *inequitable allocation of resources*. Some of the participants believed that the distribution of resources was biased. They drew conclusions based on their perception that resources should have been distributed based on needs, as opposed to well-funded hospitals with better reputations receiving more resources. This ilicited emotional responses for these participants regarding inequitable access to resources.

The fifth subtheme was *information*, which was the most consequential of the challenges. Out of this subtheme, five other subthemes originated: *surge of information, fluctuation of information, delay of information, lack of appropriate information, information blaming,* and *cataclysm of information*. All participants felt that the *surge of information* was a challenge in itself. Though they are all experienced in their position, dealing with a bombardment of information proved overwhelming. To add to their perceptions on the challenges of information, the *fluctuation of information* was also a barrier that challenged their leadership when it came to developing procedural policies. By the time they had or were almost finished, the documentation changed again, which created a conundrum. Another information challenge was *delay of information*. Some participants felt there was a time-sensitive response protocol; however, by the time they got the response from Governor Cuomo, they did not have sufficient time to respond, another factor that affected their leadership capability.

Lack of appropriate information was also the basis of challenges encountered by some of the participants. They perceived that the rapid, yet fluctuating, surge of information led to a lack of appropriate information dissemination. Therefore, their collaborative efforts were clearly concerning on all levels, specifically as they tried to ensure subordinates were sufficiently informed and able to provide appropriate patient care. Notably, some of the participants disclosed some *information blaming*, but because the COVID-19 pandemic was a new phenomenon, subordinates also realized no one could be blamed, nor did they really know what they were addressing. Reference can also be directed to misinformation dissemination by some media networks, which led to the next and last challenge, *cataclysm of information*. The participants were faced with having to reinform their staff about what they knew was current.

The sixth subtheme was *remote work*. While some participants embraced it, remote work was a major challenge for some participants whose role was also repurposed at times to ensure that they met daily operational goals. Another concern was that participants felt they sometimes could not reach their subordinates who worked at home due to technological difficulties over which they had no control that could not be addressed instantly when the staff were off-site.

The seventh subtheme was *staff loss, recruitment, and retention*, which participants expressed was indeed a challenge because several staff left for many reasons directed at the COVID-19 pandemic over which leaders had no control. Recruitment and retention were also challenging. Every hospital was short of staff; enticing new staff was difficult as well as retaining them.

The eighth subtheme was *staffing ratio*, which was impacted by the loss of staff. Additionally, the inability to recruit and retain staff contributed significant to the staffing ratio. Some participants discussed the difficult and overwhelming changes in staff to patient ratio.

The ninth subtheme was time *in leadership role*, which was a challenge from the perspective of the time the participant was in the role of CNO. Having a profound need to adjust to the culture of the organization instantly without having keen understanding of the key players proved to be crucial. Further, the staff had not had the opportunity to get to know the new leaders in a dynamic way, particularly because everyone was wearing masks. Therefore, being aware who was under those masks was perplexing.

The overall results of the theme *challenging complications during the COVID* pandemic showed there are still improvements in areas that will need significant updates reflective in policies, rules, and regulations. This subtheme also illustrates that while collaborative efforts were taking place, the way in which they were occurring were not always effective, which is cause for critical improvement. Additionally, some participants received total support from their leadership while others' decision-making capacity was questioned by their leadership. Keen attention should be regulatorily driven to ensure that leaders receive the support they need, especially in a heightened and catastrophic event such as the COVID-19 pandemic.

Theme 2: CNOs' Perception of Resource Availability

The second theme was *CNOs' perception of resource availability*, which illustrated that all CNOs felt that there was adequate resource availability; however, some felt that inequal distribution was an understatement. Based on the differential approach to

resource distribution, careful coordination could make a difference in creating successful allocations. Also, applying a collaborative approach from an interagency approach by using needs-based perspective as method as opposed to simply handing out resources would have been useful and could prevent the conclusion of prejudice in resource dissemination.

Theme 3: CNOs' Perception of Their Leadership Effectiveness

The third theme was *CNOs perception of their leadership effectiveness*. This theme reflected the participants' account of how they view their leadership and illustrated the importance of their performance. The participants all felt that their leadership was effective. Some buried the responses from the perspective that experience played a huge role, and having that background prepared them for the pandemic in some ways, which is why they remained resilient.

Theme 4: CNOs' Role, Responsibility, and Accountability

The fourth theme was *CNOs' role, responsibility, and accountability*, which depicts the CNOs as having a deeper understanding of their roles, responsibility, and accountability. They were confident in the role that they played and believed that responsibility and accountability are a reoccurring scope of their practice. Of importance was the emphasis placed on the functionality of their job about which they were very serious, and they did seek ways of ensuring staff and patient safety. While they were committed to the roles assumed, there were times they did not collaborate with their senior leadership. Though they had no malicious intent, they felt that they were being proactive. Clearly, the importance of communication improvement was justifiable.

Theme 5: CNOs' View of Community and External Response

The fifth theme, *CNOs' view of community and external response* provided a vivid perception of the participants' reflection of how the community and Greater New York Hospital Association (GNYHA) were supportive of the hospital they represented. It has been always important for an organization embedded in community to receive support, which was the case for all participants. GNYHA showed significant support in simplifying executive orders to help them process any manageable information into policies.

Theme 6: CNOs and the Availability of PPE

CNOs and the availability of PPE was the sixth theme, which was a major element during the COVID-19 pandemic. The majority of the participants expressed that there were no issues, for their organization had made preparations in the event of a disaster. They noted that the process of obtaining additional PPE was a challenge. In particular, having a collaborative approach with procurement management in seeking more PPE was essential, for they were very concerned about their staff not having any PPE.

Theme 7: CNOs' Perception of Aggrandized Administrative Support

The seventh theme was *CNOs' perception of aggrandized administrative support*, which focused on whether more administrative support was necessary. There were differing understandings which led some to note that they felt that their leader was supportive while others felt that their leader was not supportive and could have been more so given the current circumstances. What is of concern for those who did not feel supportive is the leverage of autonomy granted and the view of the participants as experts

in their field. Additionally, from a subordinate perspective, they felt that having more administrative support was necessary. Others noted they did not need additional support because what they had was enough.

Theme 8: COVID-19 Creation of Opportunity for Advancement

The eighth theme was inquiry on the *COVID-19 creation of opportunity for advancement*. The majority of participants felt that opportunity was not created because they were comfortable where they were, while two of them felt COVID-19 allowed them the opportunity to grow because they were promoted. Those who felt COVID-19 did not create opportunity of growth believed that they were able to grasp experience because the pandemic was one of a kind.

Theme 9: Creatives Strategies CNOs used

The ninth theme considered the *creative strategies CNOs used*. While many believed that it was not a time to be innovative, new ideas of daily management operations were implemented at times without senior leadership's awareness. The CNOs created new schedules to accommodate their work and personal life balance, created a backup system that allowed for adequate coverage and less burnout, hired more nurses prior to receiving their first patient, maintained visibility, addressed concerns that could be addressed immediately, repurposed their role at times to show solidarity and support, and made split second decisions that were out of the norm. Some felt that their senior leadership questioned their judgment but all they could think about was their staff who were on the frontlines and needed their support. As servant leaders, these CNOs used selfless strategies in the decisions they orchestrated. De Zulueta (2016) suggested that servant leadership is putting away egoistic goals and focusing on needs of others.

Theme 10: Executive Orders' Impact and CNO Response

The *Executive Orders' impact and CNO response* was the tenth theme that viewed how CNOs reacted to these orders. All interviewed CNOs were appreciative of Governor Cuomo's leadership during the COVID-19 pandemic and felt that without it there would have been more chaos. However, from a public policy perspective, they believed that the orders were cumbersome not only from an information surge and confusion perspective but also the guidelines in place could not be used, for example, out-of-state nurses that were desperately needed to maximize the health and well-being of the public. Additionally, funding was necessary to reorganize systems to provide support. A few felt some of the mandates were unfunded, which was a burden on the organization. Still, they followed thorough despite their perceptions, which reflects that the interagency collaboration, though perceived as useful, created a financial burden on the organizations and policymakers. Also, they discussed the government needed to take responsibility to ensure that all systems were supported. Such support would have helped to ease the burden of systems already in need from an economic perspective, which would also enhance the performance of all hospitals.

Theme 11: Informal Supports

Informal Supports was the eleventh theme that focused on other supports available to CNOs to help them succeed in their role during the COVID-19 pandemic. Derived from this theme was that their family played an enormous role in supporting them throughout the COVID-19 pandemic, which kept them emotionally stable. Additional support came from their colleagues who were CNOs at other hospitals in New York State and across the United States. At this level, the participants were able to vent

their feelings and receive adequate support on best practices. Moreover, they also had the support of staff and colleagues in other areas who were there to encourage them by letting them know how much they were appreciated, which allowed them to feel that they were not alone, and they had additional assistance beyond formal supports and even if they did not have formal support.

Theme 12: Internal Organization Factors Used by CNOs

The twelfth theme was *internal organization factors used by CNOs*. CNOs' use of organizational factors varied. Most of the participants employed the team approach, collaborative efforts, autonomy, innovation, respect, colleagueship, and the role model method. Participants believed that without having a team approach they could not achieve success of their daily operations and imagined that without having it would things would have been very difficult. In using the team approach, they fostered collaborative efforts to create media of enhancing communications and a sense of strengthening the organizational bandwidth. Most of the participants suggested that they were allowed the autonomy to make decisions without being ridiculed, which empowered them.

Though they realized that it was not a time of self-preservation, they had to be innovative in their approach. The COVID-19 pandemic was a new phenomenon, and they had staff and leadership who were depending on top leadership and expertise. The CNOs showed respect by being supportive of their frontline staff and also getting their "hands dirty," which they did when maintaining visibility and flexibility in their somewhat repurposed role. Though they did not have to change anything about their function, they felt the need to role model by showing solidarity and prove they were not exempt from the experience as it was occurring. They believed that colleagueship was a tremendous

factor essential in any organization, and they considerably appreciated this factor because they believed they were not alone and support from their colleagues was imperative in their day-to-day operations.

Theme 13: Leadership Sustainability

Leadership sustainability was the thirteenth theme and was viewed from the participants' perspective of the outcome rather than a self-centered approach. They measured their sustainability when they felt that the staff needs were satisfied, and they did feel supported. They supposed that without their staff, they could not sustain their leadership role that gave them great job satisfaction. Some also felt that their senior leadership was very supportive of them, and that fostered an environment of trust and confidence that they would do a great job. Some noted they were told how much they were appreciated, and they felt that and did not believe it was mere words. Others thought that what was important was their family and other CNOs who were supportive of them, which gave them the courage to keep striving for the good of all.

Theme 14: Psychosocial Support Importance and Impact

Psychosocial support importance and impact was the fourteenth theme, which looked at the needs of CNOs and whether psychosocial support was a necessity. The participants' views varied. The majority believed that they needed it as well as their staff, yet the minority believed they did not, but their staff did. They noted that they were many supportive services available to all staff from psychiatry and other supportive means like electronic resources. Those who took advantage of the services felt it was not a weakness but a strength because from a humanistic approach, they believed they were all human beings who at times all needed support. One participant noted that he felt the effects of

post-traumatic stress from the many times the phone would ring or a sound of the text received. He noted that he literally had to change the tones to eliminate such feelings which was helpful.

Some participants suggested that though the services were available to staff, there might not have been enough time for them to access such valuable resources. Having seen the rapid surge of patients' deaths daily and having to look at the refrigerated containers in which they lay was all the reason for these important and valuable resources. The participants' mixed feelings did shed light on the importance of psychosocial support, its impact, and the need for it in the future, which should drive new or enhance existing policy for both policymakers and the government. In doing so, it would maximize the health and well-being of CNOs by possibly mandating debriefing sessions to help them cope during such high intensity experiences on a weekly basis via in-person or telemedicine.

Theme 15: Rapid Patient Surge, Loss and Effects

The fifteen theme was *rapid patient surge, loss and effects*, which took a toll on everyone from CNOs to frontline staff. The participants provided feedback that they felt unprepared for the massive surge and patient loss. They concluded that they had never experienced anything like it and that tested the authority of their leadership in many ways. Many felt that it took a toll on all staff. Some recalled that they had no words for frontline staff who were experiencing death and dying more rapidly than they would normally. The CNOs often asked themselves what they could tell their staff to comfort them, as the pandemic was causing emotional and physical fatigue. The participants too felt helpless in these moments when they saw their staff so distraught. They noted that

social distancing negatively played a big part in comforting their staff who previously might have been given a hug.

Theme 16: Realization for Future Improvement

Realization for future improvement was the sixteenth theme. Some of the participants engaged in a keen review of what worked during COVID-19 and what should remain. Some believed that creating the work and personal life balance was a great model and should be kept in support of staff but also to ensure that organizational needs are met and staff be retained. Part of such an approach was supporting their frontline leadership, creating a backup system that decreases emotional and physical fatigue, and allowing staff to attend to their personal life and the maintenance of remote work. Additionally, one CNO has already begun efforts to employ License Practical Nurses (LPN) who were vital during the COVID-19 pandemic. Without them, there would have been a greater deficit of nursing staff. While some had challenges from remote work, most felt it was worthwhile and should stay. Also, the promotion of staff was key to show recognition and gratitude for a job well done during the COVID-19 pandemic for staff whom they believed were there supporting everyone, no matter what.

Theme 17: Senior Leadership Support

The seventeenth theme was *senior leadership support*. The majority of the participants felt that they received such support as opposed to those who felt that they were criticized or that their leadership judgment was questioned. Some of the participants noted that their leadership gave them autonomy to make decisions of which they took advantage and were told by their leaders that the process was working. Those who felt unsupported appeared to have been in a battle by themselves in a time of confronting the

COVID-19 pandemic when it should have been a collaborative approach. Certainly, CNOs need to feel empowered to promote and be effective in their leadership without having to be in tug of war, which is grounds for improvement.

Limitations of the Study

Limitations in a research study inhibit a researcher's control and creates restrictions for applying the study results in other settings (Simon, 2011). There were several limitations unavoidable and beyond my control, such as the intentions of the participants and their characteristics, the self-reporting of the participants which could not be confirmed, and the participants possibly not being candid in sharing their experiences. Additionally, the sample size of the population was not a representative of all the CNOs in New York State during the COVID-19 pandemic and their experiences that might vary. The setting of the hospitals in which the most of the CNOs were employed was bounded by high-population dense urban areas as well as suburban areas. Some participants in the urban areas believed that there appeared to be inequitable distribution of medical resources and an increase of staff to patient ratios. Another limitation resulted from the technical data failure while using a recording application, so it was important that I manually record as a backup to the interview.

All study participants voluntarily agreed to take part and were not known to me. They provided truthful and honest feedback to the interview questions asked, and as a result no bias or any judgmental approach was taken.

Recommendations

The focus was to gain a deeper understanding of the CNOs' experiences on structural empowerment and job satisfaction. The study was exploratory in nature and

provides strong insights of the CNOs' experiences, who are in the highest position of nursing within the hospitals they are employed. Several recommendations could be derived from the results to be applied globally and effectively to other emerging disaster situations.

The need to improve better and more effective communication from an interagency perceptive is important to create less of a barrier for the participants whose staff and senior leadership depended on them to deliver extraordinary information and leadership. The results point out that information challenges created a catastrophic state over which the participants had no control. Therefore, it is important that CNOs receive accurate and timely information to be disseminated accurately to their subordinates to decrease misinformation and confusion.

Another important highlight is the need to improve working relations and collaborative efforts between other senior leadership and CNOs. It is customary for participants of such high echelons to experience such difficulty but excellence in performance should receive more than intermittent attention. Rather, actions can be taken to improve commitment to recruiting more CNOs and empowering them. Part of providing empowerment for the CNOs is providing attention, allowing the space and grace of listening, and supporting the participants to feel empowered and not be in fear of constant criticism: "There is nothing more demoralizing than pursuing a strong vision without the resources to succeed" (Light, 2008, p. 211). Therefore, it is imperative that to achieve the vision and mission of the organization, better working relationships should be ensured instead of blaming or judging the CNOs who are readily available to take the

organization to its highest potential. Lessons ascertained are that there is no separation between leaders and subordinates (Hofstede et al., 2010).

The need to empower CNOs with greater autonomy is relevant to structural empowerment and job satisfaction. "To expand power, share it" is the basis of allowing participants to feel empowered by inhibiting laws and regulations that put limitations on the power of CNOs to lead (Kanter, 1979). When participants experience powerlessness, it can prove to be more detrimental than when they exert power (Kanter, 1979).

The need for psychosocial support for CNOs, who are high-performing executives, needs to be reviewed. The premise is that CNOs get paid for the role they assume, but the bottom line is that they are as human as the housekeepers and have many of the same feelings, wants, and desires. The results illustrate that most the participants felt psychosocial support was necessary for them and as well as their subordinates. Others were nonchalant as though their experience came with the territory of their job function and so they did not feel the need for such support. However, the overwhelming majority felt that support was important for developing policies that ensure their accessibility to such supports.

The last and final recommendation is the CNOs need to create appropriate work and personal life balance for themselves. Throughout the study results, CNOs were placing their staff needs above their own without consideration that they also need to have an equilibrium. They were selfless in terms of ensuring their staff had all the support they needed in addition to psychosocial support but had removed themselves out of the equation.

Other recommendations that might be fruitful is pursuing further support to the body of information. Future researchers can use a quantitative research method to explore more data collection and analysis to develop or enhance current policies. In addition, a case study approach might also create an opportunity to challenge the foundation based on the theoretical assumptions presented. Also, a mixed study design might allow greater expansion to this research, thereby strengthening all research aspects. The opportunity to understand the research from every angle might be productive in providing overarching knowledge much needed so that inferences can be draw and validity can be applied.

Implications

This study provides responsive results that confirm the research questions of: How do CNOs perceive their lived experiences of organizational factors in relation to structural empowerment and job satisfaction during the COVID-19 pandemic? The research started from a broad approach and ended with more specific perspectives with the aim of gaining a deeper understanding of the CNOs' experiences, which will add to the body of knowledge. It was my intention that the recommendations made can provide room for improvement in more effective leadership and subordinates' relationships, increase the autonomy of leaders, and allow the CNOs the opportunity to make contingency plans to create a satisfying work and personal life balance. Government-backed incentive policies can foster the implementation of strategies that would promote positive and healthy lifestyle behaviors within healthcare organizations and a benefit to the health and well-being of the populations served.

Significance of the Study

The research significance demonstrated that for the CNOs, recruitment and retention are critical for healthcare institutions to deliver effective, quality care under the high intensity of catastrophic events. Having a greater knowledge shed light on understanding the experiences of CNOs during the COVID-19 pandemic and how they responded to the executive orders from the New York State Governor Cuomo as well as their structural empowerment in having access to resources, information, and support, which proved beneficial to healthcare organizational effectiveness and quality of patient care. This study contributes value for stakeholders such as nurse leaders, hospital administrators, and public policymakers by applying the results to design interventions that can support structural empowerment for CNOs and stakeholders who can support nurse leaders in responding to future healthcare crises like the COVID-19 pandemic.

Significance to Public Policy

The study is significant from a public policy standpoint because its aim of exploring the experiences of CNOs at hospitals in the state of New York in response to executive orders from the governor of New York during the COVID-19 crisis was instrumental in concluding the need for policy and legislative framework. CNOs are educated about emergency preparedness regulations on how to be effective managers in a crisis, but their previous training could not prepare them for the magnitude of the COVID-19 pandemic. Every decision regarding quality patient care, staffing levels, and documentation was critical, and there was no room for mistakes because lives depended on good decisions. The CNOs had to review and modify policies based on the mandates received expeditiously to offset the confusion among their subordinates. However,

despite their efforts to minimize confusion, they found themselves competing with misinformation disseminated through other means such as media outlets and social media.

Based on the results of CNOs' experiences from a structural empowerment standpoint, hospitals and policymakers can design interventions to prepare for future public health crises by developing policies to ensure that CNOs are able to access resources during a time of escalated need. In that case, they would gain undoubted autonomy along with the collaboration and usefulness of public health policymakers in preparing an appropriate response. Additionally, policymakers should address misinformation in an emergency to decrease confusion within hospitals, communities, and media sources. However, "mandate with care" as mandates can be viewed as triggers as opposed to targets (Lewandowsky et al., 2022).

Significance to Hospital Policy

CNOs maintain an important position in hospitals. They are responsible for patient care, safety, and quality throughout a patient's entire hospital stay. The CNOs' role keeps hospitals operational in invaluable ways toward excellence in patient care. Changes in hospital policy can be based on the experience, knowledge, and understanding that CNOs have gained during this unprecedented health crisis, for the last pandemic occurred over 100 years ago. Although the COVID-19 pandemic was a first for all those presently alive in the world, it may not be the last pandemic in their lifetimes, thus the need to design interventions to empower CNOs to face future health crises. Hospitals can base future policies for readiness on attending to the experiences of CNOs

who are a valuable and intrinsic part of the organization. Therefore, the present study can inform hospital policy in a direct, meaningful way.

Significance to Social Change

Kanter's framework of structural empowerment when applied to chief nursing officers might contribute to leadership theory, specifically on how they responded to government mandates that were unfunded, yet they had few to no resources, which required real-time applications in unfamiliar territory. Mandates are not to be ignored, for some CNOs noted them as direct and official orders that had to be addressed, disregarding preceptive considerations or autonomy. The Congressional Budget Office (2023) revealed that mandates "require a nonfederal entity to take action or comply with a prohibition." The unfunded Mandates Reform Act of 1995 (UMRA) requires examining the implications of mandates on all levels of government (Federal, State, City, Local and tribal) and private sector entities. However, the applicability of the UMRA in a crisis should be reviewed further by policymakers to help offset the financial struggles and resource accessibility that CNOs faced during the COVID-19 pandemic.

Furthermore, policymakers should encourage collaborative and coordinated approaches to ensure that CNOs are equipped with adequate resources to address mandates without prejudices in future crises. Therefore, policymakers can support funded mandates and adequate resource distribution needed to eradicate unjust practice in a crisis. CNOs' attention should not be consumed by inequities of resources but rather by the roles and responsibility to which they have contractually agreed.

For CNOs to maintain sustainability, there must be adequate resources and sufficient support (De Zulueta, 2015). De Zulueta (2015) noted that no matter the level of

"resilience" CNOs demonstrated, they cannot perform well in "unsupported and toxic organizational cultures." Therefore, government policies addressing and encouraging collaborative and healthy working environments would be a significant intervention to improve CNOs' resilience and experiences. Such policies are necessary for not only the CNOs but also for maximizing the health and well-being of the population they serve.

Conclusion

The COVID-19 pandemic developed rapidly, starting with an announcement on January 30, 2020 from WHO that the outbreak was a public health emergency of international concern (World Health Organization, 2020). The problem addressed by this phenomenological study was that CNOs at hospitals in New York State were charged with responding to executive orders pertaining to the COVID-19 pandemic while continuing the responsibilities that maintain quality patient care, all while adequate supplies and additional support were at critically unavailable levels. The present study explored the lived experiences of the CNOs in this context. The CNOs were compelled to modify standards of care for documentation in the EMR, using PPE for infection control protocol, and prioritizing the order in which patients would receive care. Although there were standard protocols already in place pre-COVID-19 pandemic, changes were intensified during this situation of crisis to ensure the safety of staff, patients, and the community. These decisions had to be made in the face of continuously changing health information about the prevalence and transmissibility of the virus. As the governor of the state of New York issued executive orders about how health officials should respond to the pandemic, CNOs at hospitals in New York were charged with responding to the executive orders as soon as they were announced. CNOs had to ensure that the quality of

patient care was not compromised, as they confronted critical shortages of medical supplies, staffing and escalating numbers of patients in need of care for the virus. The experiences of CNOs resulted in the best available information to inform policymakers of the need for future public health restructuring through guided, collaborative, and coordinated decisions, and pandemic responses. Thus, government involvement will serve to optimize the quality of services to the population they serve at hospitals to ensure a brighter, more equitable future for all those involved in facing health crises.

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Appendix A: Interview Questions

Thank you for taking time to participate in my research. I am Tracey Braithwaite, and I am a PhD in Public Policy student at Walden University. As you know from my invitation to participate email, I am looking at NY State Nurse Executive responses during the state level mandates during the pandemic. I am using Kanter's structural empowerment theory, which addresses organizational behaviors in the context of employee empowerment, to learn more about your experiences. Kanter's theory describes six main concepts in structural empowerment - opportunity for advancement, access to information, access to support, access to resources, formal power, and informal power. With these in mind, let's begin with question #1.

1. Based on Kanter's theoretical approach, how did access to information influence your lived experience in relation to job satisfaction during the COVID-19 pandemic?
2. How important was access to support a necessary aspect of your lived experience in relation to job satisfaction during the COVID-19 pandemic?
3. Access to resources is an important aspect of structural empowerment. How did you perceive it to be vital in your experience in relation to your job satisfaction during the COVID-19 pandemic?
4. Describe your experience with supplies such as personal protection equipment (PPE) and other needed supplies during the COVID-19 pandemic.

5. According to Kanter, formal power suggests one must have flexibility, visibility and creativity in decision making, how did you perceive the role of formal power as it relates to your job satisfaction during the COVID-19 pandemic?
6. Kanter defined informal power as having effective relationships with peers, subordinates and superiors within your organization. How has your informal power contributed to your job satisfaction during the COVID-19 pandemic?
7. What organizational factors influenced your structural empowerment and job satisfaction in relation to the COVID-19 pandemic?
8. How do you perceive your leadership effectiveness as it relates to structural empowerment and job satisfaction in relation to the COVID-19 pandemic?
9. How did executive orders issued by New York State Governor Andrew Cuomo influence your leadership effectiveness, structural empowerment, and job satisfaction during the COVOD-19 pandemic?
10. What strategies did you use to respond to executive orders from New York State Governor Andrew Cuomo during the height of the COVID-19 pandemic?
11. How would having additional administrative support made a difference in your experience as a Nurse Executive during the COVID-19 pandemic?
12. How would psychosocial support make a difference in your experience as a Nurse Executive during the COVID-19 pandemic?
13. Being rewarded for a “job well done” is a key driver of job satisfaction. During the COVID-19 pandemic, do you feel your executive leadership performance has set the stage for a career advancement opportunity that will bring you added job satisfaction?

a. If Yes, please describe the career advancement opportunity(ies) for me.

b. If No, why do you believe these opportunities are not available to you?

Appendix B: Invitation to Participate in Study

Dear Participant:

My name is Tracey Braithwaite and I am a doctoral student at Walden University. I am writing a dissertation on Structural Empowerment of Nurse Leaders in New York State During COVID-19 Pandemic. I am only interviewing persons who were employed as CNOs specifically Acting Chief Nursing Officers, Chief Nursing Officers and Chief CNOs at hospitals in the state of New York during the COVID-19 pandemic. I would appreciate if you would take the time to participate in a brief online interview regarding your experience as CNOs during the COVID-19 pandemic.

It is your choice whether to participate in the interview. You will not be compensated for participating. You will not be required to reveal your name or any personal information on the online interview form. You have the option of using the telephone or online application such as Zoom, MS Teams or Skype. Completing this interview poses no risk to you as it is confidential. You will receive an access link to use at the scheduled interview date and time. You will be asked to complete the interview only once, which will take about 40 minutes to complete. During the interview, I will be asking brief questions that would require brief responses. After the interview, you will have 10 calendar days for member checking. If your response is not returned within that time frame, I will assume that the responses accurately reflect the interview. You may request to receive a copy of the results of the study when the research is complete. You might find them interesting.

Please feel free to contact me with questions or concerns about this research using the contact information listed above. If you have any questions regarding your participation in the study or if you want to verify the authenticity of the study, please contact my Dissertation Chair, Dr. Mark Gordon at mark.gordon@mail.waldenu.edu. If you have other questions or concerns, you may also contact Leilani Gjellstad, Director of Office of Research Ethics and Compliance, irb@mail.waldenu.edu

Sincerely,

Tracey Braithwaite

Appendix C: Distribution of Participant Responses

Name	Description	Files	References
2 CNO with multiple title		1	2
8 single title		1	1
accountability		10	84
Advancement		4	7
burn out		3	3
Challenges		5	8
burn out		3	3
Information blaming		1	1
Information cataclysm		5	13
Information Delay		1	1
Information fluctuation		3	5
Information upsurge		5	11
Lack of appropriate information		2	5
Recruitment and Retention		3	12
Staff perception- CNOs did not know what they were doing.		1	3
timing in leadership position		2	8
CNO leadership effectiveness		9	83
CNO Title holding and formal power		3	9
2 CNO with multiple title		1	2
8 single title		1	1

Name	Description	Files	References
COVID-19 creation for opportunity for advancement		0	0
Advancement		4	7
No opportunity for advancement		6	12
Creative strategies used by CNO		8	42
Effects of rapid patient loss		7	16
Executive Order impact		10	42
External Organization Support		3	5
Importance of psychosocial support		10	38
inequitable allocation of resources		3	11
influential internal organizational factors		6	11
Informal supports		9	40
Information blaming		1	1
Information cataclysm		5	13
Information delay		1	1
Information fluctuation		3	5
Information upsurge		5	11
Lack of appropriate information		2	5
Leadership style adjustment		5	6
No opportunity for advancement		6	12
Perception of Community Support		3	5

Name	Description	Files	References
Perception on Availability of resources		10	43
PPE experience		10	52
Rapid increase patient volume		1	3
Recruitment and Retention		3	12
Response to additional administrative support		8	11
Staff perception-CNOs did not know what they were doing.		1	3
Timing in leadership position		2	8
Upper leadership Support		8	47
Ways to improve		2	7

Appendix D: Themes and Subthemes

Name	Description	Files	References
Challenging complications during COVID-19		7	76
Burn out		3	3
Changing PPE protocols		1	1
CNO judgment questioned		1	3
Inequitable allocation of resources		3	11
Information		7	36
Information blaming		1	1
Information cataclysm		5	13
Information Delay		1	1
Information fluctuation		3	5
Information upsurge		5	11
Lack of appropriate information		2	5
Remote working		1	1
Staff loss, recruitment and retention		3	12
Staffing ratio		1	1
Time in leadership role and the impact		2	8
CNO perception of resource availability		10	43
CNO perception of their leadership effectiveness		9	83

Name	Description	Files	References
CNOs' role, responsibility and accountability		10	93
CNO view of community and external response		5	10
Community response		3	5
External organization response		3	5
CNOs and the availability of PPE		10	52
CNOs' perception of aggrandized administrative support		8	11
COVID-19 creation of opportunity for advancement		9	19
Advancement		4	7
No opportunity for advancement		6	12
Creative strategies CNOs used		8	42
Executive Orders impact and CNO response		10	42
Informal supports		9	39
Family support		3	3
Frontline staff support		5	28
Peer support		4	8
Internal organization factors used by CNOs		6	11
Leadership sustainability		5	6

Name	Description	Files	References
Psychosocial support Importance and impact		10	38
Rapid patient surge, loss and the effects		8	20
Effects of patient loss		4	4
Patient surge		2	4
Rapid patient loss		5	12
Realization for future improvement		2	7
Senior leadership support		8	47