ORIGINAL RESEARCH

Lessons learned from nurse leaders during the covid pandemic-implications for prelicensure baccalaureate nursing programs

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ABSTRACT

Background and objective: This phenomenological inquiry explored the lived experience of acute care nurse leaders during the pandemic to better understand their experience of vulnerability as it contributes to enhancing the leadership curriculum in baccalaureate prelicensure nursing programs.
Methods: Data were collected through semi-structured interviews with eight nurse leaders using a Gadamerian, hermeneutic, phenomenological framework. Data analysis included researcher immersion, understanding, abstraction, synthesis/theme development and finally, illumination and illustration of the phenomena.
Results: Final analysis of the data revealed four interrelated major themes: Life Changing Experience/The Emergence of a New Unit Culture, Critical Leadership Functions for Supporting and Sustaining the Nursing Workforce, Managing Patient/Personal/Political and Professional Boundaries, and The Essentiality of C-Suite Contribution to Operations.
Conclusions: The study suggests a requirement to continue to train student nurses on core competencies of nurse leadership but encourages a shift from didactic and perhaps stagnant pedagogy to a more robust, participatory, experiential model and one that affords students leadership clinical placements and both role modeling and short-term mentorship experiences. This approach to student learning should include a competency-based model of instruction and assessment, utilization of experiential learning to help students apply theoretical knowledge to practice and student engagement in exercises in reflection towards developing self-awareness. Role modeling and mentorship opportunities should be prioritized. Suggestions for future research include exploring the application of this study's findings to acute care setting new leader orientation programs and studies that measure the changes in leadership competence among nursing students after participating in the new curriculum.

Key Words: Baccalaureate nursing education, COVID-19, Hermeneutic inquiry, Nursing leadership

1. INTRODUCTION

The COVID-19 pandemic resulted in an unprecedented challenge for healthcare systems globally, forcing nursing leaders to navigate complex and evolving circumstances with little to no preparedness. Despite the plethora of current literature on the experiences of nurse leaders during the pandemic, there are minimal studies that explore the phenomenon of personal vulnerability and stressors related to serving as a nurse leader in in-patient facilities and how these learnings might contribute to the development of competency-based baccalaureate nursing education. Previous research has examined various other concepts related to the lived experience

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of nurses who served in critical leadership positions during the pandemic including leadership styles and strategies, operational and political challenges, crisis communication, burnout versus resiliency, innovation, nurse wellbeing, team dynamics, policy lessons, nursing activism, and factors influencing nursing involvement in policy. However, little is reported on how to translate these learnings into specific, leadership learning objectives and outcomes and how to infuse both into the BSN curriculum to best prepare future nurses for similar crises. This study examines how lessons learned by nurse leaders during the pandemic can enhance undergraduate nursing education when considered through a Gadamerian, hermeneutic perspective.[1,2]

1.1 Literature review

1.1.1 *Leadership styles and strategies*

It is evident in the literature that nursing leadership was burdened with making critical decisions among conflicting data and pervasive uncertainty.[3–6] In response, nurse leaders employed various adaptive leadership styles to manage the crisis effectively, enhance care, and mitigate moral distress, including transformational, servant, compassionate, and authentic leadership.[7–9] Transformational leadership emerged as particularly effective, fostering a culture of respect and transparency, which significantly improved workforce satisfaction, reduced burnout, and enhanced resilience through trust and collaboration.[10,11] Authentic leadership, promoting team engagement and personal development, also contributed to reducing burnout and building resilience.[4,12] Compassionate leadership, despite its emphasis on emotional intelligence and altruism, did not always meet the heightened need for compassion, especially in high-stress environments like emergency and intensive care units.[13,14] While servant leadership was beneficial in reducing burnout and enhancing psychological safety, it failed to capture the collective intelligence of the broader nursing community.[15] In contrast, destructive and toxic leadership styles posed significant challenges such as increased burnout and poor organizational outcomes, highlighting the detrimental effects of negative leadership behaviors.[16] Toxic leadership, particularly prevalent in acute care settings, exacerbates issues such as decreased organizational commitment, higher turnover rates, and increased interpersonal conflict.[16,17] These adverse outcomes emphasize the need for supportive and constructive leadership styles to foster teamwork, resiliency, trust, and collaboration, especially in situations of crisis and uncertainty.

1.1.2 *Operational and political challenges*

Beyond leadership styles, nurse leaders faced significant challenges due to volatile organizational and political environments, including balancing staff resiliency with new accountabilities, rapidly evolving protocols, shortages of personal protective equipment (PPE), and moral distress.[10,17] When attempting to resolve issues, especially in resource allocation, there were discrepancies between unit managers and chief nursing officers.[18] Despite these challenges, nurse leaders played a crucial role in advocating for political awareness, policy development, and fair practices, underscoring the need for proactive support in future crises.[3,11,19] The key to their efforts may be attributed to finding the balance in making critical decisions, building trust, and ensuring self and staff resilience and safety.[17]

1.1.3 *Crisis communication*

Communication challenges were common in the beginning of the pandemic, allowing leaders the opportunity to develop crisis communication skills.[11,20–22] Effective crisis communication was vital during the pandemic, with nurse leaders needing to adapt quickly to ensure clear and transparent messages.[11,20] Developing effective communication was a key factor in addressing the wellbeing of the nursing workforce during the pandemic, disseminating crucial information, and fostering trust and confidence.[11,21,22]

1.1.4 *Burnout vs. resiliency*

The dual roles of clinical and managerial responsibilities contributed to significant burnout among nurse leaders, driven by heightened levels of stress and fatigue, increased workload, fear of infection, demanding responsibilities of taking care of COVID-19 patients, concerns of self and patient safety, shortages of PPE, staffing issues, and moral distress.[3,10,11,15,17,23] Despite these challenges, many nurse leaders found resilience and fulfillment through their commitment to patient care and effective teamwork, highlighting the importance of open dialogue, versatility, flexibility, adaptability, and inclusivity in mitigating burnout.[8,24] It is evident in the findings that nurse leaders experienced a significant sense of vulnerability because of not only the fear of infection but the burden of sustained fatigue and relentless workload.

1.1.5 *Innovation*

Nurse leaders continued to creatively innovate, despite the times of tragedy. Advances in telehealth, work redesign, and emergency response strategies were implemented to address the evolving demands of patient care and enhance safety.[25,26] Telehealth was implemented on a larger scale, policies and procedures were revamped, telepsychiatry was utilized, and emergency teams were created and deployed in crises.[21,25–27] These innovations not only improved patient care but also set a precedent for future healthcare delivery models. One hospital implemented a COVID-19 Inpatient Working Group (CIWG), a group of leaders that were em-

powered to make decisions and coordinated a pandemic response using evidence-based practice without bureaucratic processes.[27] Other facilities started using telehealth to see patients without risking exposure and telepsychiatry to address the monumental mental health crisis that was being exacerbated by the pandemic.[25,26] Telecommunication was also used so that inpatients could see and speak to their family members via iPad considering visitors were eliminated in most hospitals.[28] Nurse leaders continued to exceed expectations and create a better patient experience during a time of tragedy and uncertainty.

1.1.6 *Nurse wellbeing*

The COVID-19 pandemic amplified and exposed the vulnerabilities of healthcare workers, such as moral distress and burnout among healthcare professionals, emphasizing the importance of supportive and compassionate leadership.[29] Nurses faced exposure to uncontrollable variables, heightened anxiety, and emotional distress, which significantly impacted their mental health.[30] Younger and less experienced nurses reported greater levels of burnout and vulnerability, partly due to perceptions of being easily replaceable. These findings highlight the critical role of organizational leadership in ensuring nurse wellbeing and maintaining a supportive work environment during crises.[31]

1.1.7 *Team dynamics*

The COVID-19 pandemic necessitated rapid adaptations in team dynamics and working styles. Diverse teams, composed of individuals with varied knowledge and critical thinking skills, proved successful in generating novel and practical solutions.[32] Shared leadership emerged as a key facilitator, encouraging autonomy, participation in decision-making, and proactive problem-solving and skill development[16,32] Inclusive human resource management also has been shown to promote team cohesion and adaptability during times of crises.[32]

1.1.8 *Policy lessons*

The COVID-19 pandemic exposed significant vulnerabilities in healthcare systems, revealing the urgent need for effective leadership, emergency planning, and enhanced service delivery. Despite the critical role of nurses in shaping health policy, they are often excluded from leadership roles and decision-making processes.[33] Nurses have demonstrated exceptional skill in analyzing information and informing practical health guidelines based on frontline experiences.[34] To improve future emergency responses, it is crucial to incorporate nursing leadership into policy development and emergency preparedness, while navigating the political context.[21,35]

1.2 Nursing activism

Nurses have trusting relationships with society, authorizing them to advocate and protect their patients and communities, especially during the COVID-19 pandemic.[35] Their expertise and frontline experiences have driven significant political and legislative action, influencing health policies and response strategies.[31,36] Nurses played a pivotal role in raising awareness, advocating for increased resources, and utilizing social media to effect change.[35,37] Their activism has highlighted the importance of their inclusion in future policy discussions and decision-making processes.

1.2.1 *Factors influencing nursing involvement in policy*

Nurses and nurse practitioners remain underrepresented in media presence and policy leadership due to many factors, including social and historical factors, despite their crucial role in disease and public health monitoring.[33,38] Barriers to their involvement include time constraints, limited policy knowledge, heavy workloads, gender issues, and negative perceptions of the nursing profession.[39] However, factors such as educational background, professional experience, and institutional support positively influence their ability to contribute to health policy.[39] Expanding nursing education to include policy and public health components could further enhance their involvement in shaping effective health policies.[36]

It is evident that nurse leaders played a pivotal role in driving resilience, innovating healthcare delivery, and navigating organizational, resource and political challenges during the pandemic. While these studies have expanded the understanding of the experience of nurse leaders during the pandemic, none have addressed how to translate these learnings into meaningful, measurable learning outcomes necessary to include in the BSN curriculum. There is also little in the literature that addresses the experience of shared vulnerability and extraordinary stressors as they factor into nurse leader role competency. There is a need to understand more fully the lived experiences of nurse leaders during the pandemic to best understand what skills they relied upon to remain effective in the extreme circumstances posed by the pandemic. There is much to learn about how these experiences can inform the development of specific learning outcomes and objectives for BSN programs to prepare new nurses for similar situations to come. The insights and lessons learned in this study can help inform future training of new nurses. It is essential to translate these lessons into defined learning outcomes which can in turn influence the design of assessment structures and experiential learning pedagogy.

2. METHODS

This study employed a Gadamerian, hermeneutic, phenomenological, analytical framework.[1,2,40] Gadamer's framework establishes a philosophical, hermeneutical (relating to the meaning of texts and the ways in which they are understood) approach that prioritizes the importance of tradition and language in understanding texts and experiences. It is grounded in the principle that the interpreter's horizon, shaped by one's cultural background, influences their interpretation and understanding of any text. The "fusion of horizons" occurs when the interpreter's perspective merges with the text's meaning, thus creating a new and shared understanding. This framework is particularly useful when understanding the context and cultural significance of texts is a priority as is the case in this study.

This strategy includes identifying and selecting the appropriate research question, identification of preunderstanding, gaining understanding through dialogue with participants and the text (hermeneutic circle and fusion of horizons), and establishing trustworthiness. Data analysis included researcher immersion, advancing understanding, construct abstraction, synthesis/theme development and lastly, illumination and illustration of the phenomena. Gadamer viewed hermeneutics not as developing a way of understanding, but as a process to make known the conditions in which understanding, perception, experience and knowing itself takes place.[40] In the current study, this approach was used for the systematic study of the nurse leaders' narratives of their professional experiences during the pandemic with the aim of understanding how their sense of vulnerability, stressors and lessons learned might influence baccalaureate nursing leadership education to best prepare future nurse leaders for like situations. Findings were primarily considered in light of nursing education, yet study findings yielded several suggestions for future research. This research was conducted in accordance with the ethical principles for human subjects research and received approval from the Marymount University Institutional Review Board prior to data collection.

2.1 Participants

Institutional review board approval was obtained for the investigation, and participants signed an informed consent. A purposive snowball sampling of nurse leaders was recruited utilizing email introduction and discussion of the study purpose. One nurse leader meeting criteria for the study served as seed for identifying others who met criteria for participation. A total of eight nurse leaders were identified via snowball sampling. All met criteria and all eight were available and consented for participation. All eight participants were employed in large, urban, inpatient facilities in a variety of settings, representing leadership roles including chief nurse, director, supervisor and manager positions. All had served in their positions for at least one year prior to the pandemic and continued in their positions throughout, held a BSN or higher degree, and were employed full time.

The data collected from these eight participants achieved saturation, as evidenced by diminishing data variation, no additional significant variation in perspectives, and no new themes emerging from data review. Inclusion criteria for this study included any nurse leader serving in an in-patient facility with responsibility for the supervision of registered nurses at any time during the Covid Pandemic. Exclusion criteria included nurse leaders working in or for other than acute care facilities or those without supervisory and/or operational management responsibilities.

2.2 Data collection and instrumentation

A semi-structured interview guide was developed by the investigator and was used for data collection. The interview guide included open-ended questions to facilitate the participants' discussion of their lived experience as nurse leaders during the pandemic. The interview guide was reviewed and approved by two professors engaged in baccalaureate nursing education prior to study start. For the content validation of the semi structured interview guide, in addition to initially conducting an exhaustive literature review on the subject, the procedure known as expert judgement was used. Although no method or procedure can guarantee validity, this research study utilized various tools to assist in the reduction of validity threats and increase the credibility of the conclusions reached within the study. These included mechanical recording, 'rich' data (verbatim transcripts), use of contradictory evidence (researcher accounting for contradictory evidence), member checking (echoing, paraphrasing, and seeking further clarification), respondent validation (opportunity for those interviewed to review their verbatim transcript, and neutrality (researcher reflection of personal bias). Reliability was established through rigor, control and uniformity of the interview process.

Data collection took place via zoom during pre-scheduled interview sessions. The participants selected the time and location of their choice for the experience to be comfortable, private and convenient for them. Interview length was between one and one-and-half hours and took place from December to July 2023.

2.3 Data analysis

The data analysis methodology utilized for this study was based on Gadamer's ideas regarding text interpretation and the framework of Guba and Lincoln's fourth generation data

evaluation strategy.[41] A critical component of this approach to data analysis is adopted from Guba and Lincoln's notion of construction. Constructions are descriptions that participants form to make sense of situations they experience. The ontology, epistemology, and methodology of inquiry utilized by hermeneutical phenomenological research are grounded within a constructionist paradigm.[42] According to Denzin and Lincoln,[43] the term constructivist-interpretive explains the dual nature and function of this method of inquiry. Participants' stories are considered constructions. These constructions are used to form meaningful description that participants create to make sense of situations they experience.[45] Data analysis merges/fuses these meaningful descriptions/horizons into new constructions, which then either validate constructions in the literature or create new explanations related to health, person, environment, or nursing. The participants in this study formed constructions of their experiences serving as nurse leaders during the pandemic. These constructions (shared during the interviews) were communicated in the study participants' stories that later formed the narratives. Through the process of data analysis, after both analytical and interpretive consideration, these constructions were analyzed. Through the lens of the researcher, bringing to bear her foregrounding and prejudice, new constructions or themes emerged. From the verbatim transcripts, a summary of comments from each interview was created. These interpretive and reflective summaries were sent to study participants for content review, clarification, and/or feedback. It should be noted, however, that Gadamer does not offer specific or clear-cut methodology for data analysis and interpretation. As such, the approach to data analysis for this study utilized Ricoeur's[45, 46] suggested interpretive process and series of three analytical and interpretive steps: analytical reading of the text, interpretive reading of the text, integration of the whole.

This is supported by Creswel's[47] approach to qualitative research analysis and interpretation, including data preparation/organization for analysis, data exploration, description and theme development, reporting, interpreting, and validating the accuracy and credibility of findings. This process evidences an intuitive approach of using detailed data to develop general themes. Methodological rigor was maintained in accordance with the criteria of Lincoln and Guba.[48] Credibility was established by recording interviews to serve as reference for the development of themes and the use of participant transcript reviews. The participant transcription reviews focused on confirming accuracy. These were followed by several participants' review of emergent themes, sub themes, perspectives, interpretations and conclusions after data analysis to verify accuracy. Dependability and confirmability were established by an audit trail inclusive of author notes, interview recordings and transcripts as well as the reflective journal notes initiated and maintained by the author.

Themes were identified by a single reviewer and were subsequently sent to participants for member checking. Theme identification began with researcher familiarization with the data through immersion to gain deeper understanding of the meaning of the content. Subsequently, data was grouped into categories to identify themes and relationships. Through iterative analysis and reflection, themes where then refined. Themes were validated through member checking.

3. RESULTS

Final analysis of the data revealed four interrelated major themes: Life Changing Experience/The Emergence of a New Unit Culture, Critical Leadership Functions for Supporting and Sustaining the Nursing Workforce, Managing Patient/Personal/Political and Professional Boundaries, and The Essentiality of C-Suite Contribution to Operations. These four themes craft a basis for developing specific outcomes-based design for the leadership curriculum in undergraduate BSN programs (see Table 1).

Table 1. Essential Themes and Thematic Elements

Essential Themes	Thematic Elements
Life Changing Experience/The Emergence of a New Unit Culture	Awareness of vulnerability Experience of inadequacy Value of relationships Emergence of support groups Greater eagerness to share Gratitude Value of the team Resiliency
Critical Leadership Functions for Supporting and Sustaining the Nursing Workforce	Presence Communication Creativity Risk Taking Innovation Establishing New Partnerships Positivism
Managing Patient/Personal/Political and Professional Boundaries	Political-ethical conflicts Political polarization and professional moral distress Helplessness to persuade others Family conflict
Essentiality of C-Suite Contribution to Operations	Engagement of executive leadership Inclusion in decision making Informed reasoning in decision making Value of pre-existing trusting relationships

Notes. Identified Essential Themes and Associated Thematic Elements of Each Theme

3.1 Life changing experience/the emergence of a new unit culture

For all the nurse leaders, the experience of the pandemic fundamentally changed their perspectives of their jobs as well as the nature of their relationships with both staff and patients.

Each of the nurse leaders identified their witnessing the power and influence demonstrated at the middle manager level. "... it would have fallen apart without them... ". The nurse leaders noted newly observed appreciation for the accountability and responsibility evidenced by these managers and their ability to shape the culture of the units they served. This also demonstrated itself in the lasting support structures not previously part of unit culture that was forged between nurse leaders and units... "and we would just talk, talk it through and hang out... group stayed together." This sharing supported nursing leaders at all levels of the organization and created a willingness to be vulnerable to each other not previously present. Each nurse leader expressed newfound gratitude "the gratitude to my staff was, I'm gonna cry. It was so shocking what they did every day!" The appreciation for how the team came together, the putting aside of minor frictions, the shared goal of saving those who could be saved and the relentless willingness of the staff to keep coming back to work undaunted created a unit wide culture of "can do" and a strength to support each other not seen before, but which remains now. Each nurse leader acknowledged their sense of vulnerability as overwhelming... "feeling inadequate to support these nurses ... you know, you wanted to do more.... feeling vulnerable about that... ".

All the nurse leaders expressed the newly better appreciated value in forming more authentic relationships with staff "... but the time I spent building relationships with frontline team members really became invaluable." One nurse leader expressed how this experience influenced her perspective of her job and her role by offering "... what made me show up every day here ready to go was every one of my nurses... the nurses here will support me every which way I go, and so, and I feel that goes both ways." These feelings sustain over time. As does the sense of mutual trust "...being responsive to their (staff) needs bred trust... ". All nurse leaders reported that even years later, the experience of working together during the pandemic fostered a new way of operating as a unit and as a team... "we look back on this experience and the things that we've learned that we don't even realize yet we are going to be so much stronger... like the resiliency we built... " All nurse leaders reported value in what the experience of leading during the pandemic left them with ... "the silver linings outweighed the madness." Unanimously, nurse leaders felt that the demonstrated effort in creating a new spirit of teamwork sustained the nurses during the pandemic and created a new culture that embraced risk taking, idea generation and a willingness to embrace multiple perspectives"... this group of people pulls together and does what they need to do to get done... what needs to get done." This new spirit was also identified as fostering a supportive environment and one that sustained a sense of belonging and purpose.

3.2 Critical leadership functions for supporting and sustaining the nursing workforce

The nurse leaders shared a common concern about the degree of impact they could have and a sense of inadequacy. They all reported a focus on presence and frequent rounding as a means of managing these feelings. One nurse leader reported her observation of the staff always "... looking down... unresponsive, almost closed in, and all I could think about were ... the theories about helplessness and hopelessness". In addition to the value of presence, all nurse leaders identified communication as vital to sustaining the nursing workforce. "Communication (was) first and foremost". Sharing information was greatly hindered by daily or sometimes hourly shifting and sometimes contradictory information. "For the first year that was it... was the uncertainty and ... how do you convey comfort and confidence when (you, yourself) are not so sure". Each nurse leader identified resilience as a necessary quality to continue to support the workforce as they weathered the uncertainty and the "... never ending story... " as the pandemic dragged on. Risk taking was also frequently identified as a necessary skill to navigate the ever shifting and at times seemingly insurmountable challenges of the pandemic. "All bets are off, anything is game, try whatever you can... we just got to get ... through safely." Innovation and boundary challenging were frequently identified as essential skills for managing complexity and necessity to address unprecedented situations. "We have our community college... I went to the dean, and I said, I need your students, and I'll pay them all... employ them. They have clinical skills... I'll create a role for them... I need them working here". The ability to initiate and sustain partnerships that had not previously existed was viewed as imperative. Lastly, each nurse leader addressed their own sense of readiness to tackle the multiple and relentless demands of their role. They expressed a positivism about their energy, commitment and stamina. "I was up to the challenge... I can go to war... and this is my war".

3.3 Managing patient/personal/political and professional boundaries

During the pandemic, differences in personal and professional ethics and conflicting political polarization created

significant political-ethical conflicts for nurses, often placing them at odds with the perspective of patients, patient families and their own families as well. They were at times challenged to choose their job or their family as nurses who embraced the value of vaccinations while others did not. This was especially evident in certain geographic areas. Conflict existed, creating sometimes dramatic tension between jobs, patient care, and personal ideals. "... it was really hard when you know a president saying it's... a hoax... it made our job much harder." This fact created a particular challenge to nurse leaders who now had to serve as support and counsel for nurses who experienced significant emotional burden and shared vulnerability. Over the long course of the pandemic the nurses witnessed the slow progression of vaccination acceptance, while the unvaccinated patients they cared for daily were dying. This caused considerable moral distress... "there was the political imposition, there was the fear of the unknown... people coming to truth varyingly." Nurse leaders reported prioritizing the identification of nurses at significant emotional risk and arranging for either days off or onsite counseling services. This varying acceptance of the vaccine by the public, family and patients was witnessed every day and experienced by nurses as immeasurably regrettable. They firsthand watched the difference in incidence and illness severity between patients who were or who chose not to be vaccinated. They viewed this as contributing immensely to their sense of futility and helplessness "... everybody believes something different." Exposure to misinformation or misrepresentation in mainstream media and social media was experienced as infuriating to nurse leaders and the staff. "... nurses, people, very diverse population across all ... and even my conservatives (nurses), more public and leading nurses were irritated because they're seeing the reality... and then what's being put out in the media is lies... ". One nurse leader shared that as she grew more and more forceful and persuasive in her belief in vaccinations, she was advised she was no longer invited to her family's Thanksgiving Day dinner "... and you're out there and you're trying to share your truth... cause you're just worried about people... please get vaccinated... ".

3.4 The essentiality of C-suite contribution to operations

The word essentiality was used to explain the theme that emerged evidencing the essential and necessary contribution of the C-suite leaders in mitigating or exacerbating the sense of vulnerability experienced by the nurse leader participants. Its use is intended to define this C-Suite leader support as fundamental or indispensable for the mitigation of vulnerability and contribution to the leadership functioning and efficacy of the nurse leader role during the pandemic.

Executive leadership was experienced by the nursing leaders as either tremendously assistive or problematically detrimental. The fundamental difference was suggested to be their inclusion in decision making and the degree of communication focused on planning, resource availability and the operational challenges faced by the nurse leaders and their teams. What was experienced as least helpful was being told what to do without benefit of participating in the decision or limited in the understanding that senior leadership truly understood the operational challenges. "I was just told that this is this... the way we're going to approach it." Organizational decisions such as not deploying nurses to areas most impacted by the pandemic were understood as particularly injurious "... what we had was where you can take your PTO. We don't need you in inpatient areas. I feel that was the absolute wrong approach." Lack of long-range consideration of how to best support operations was also identified as a serious breach of leadership responsibility compounded by feeling excluded from contributing to how resources should be allocated "... not feeling or being informed of other decisions that were being made, or the plans that were being made." But over and above all else, the presence and participation of senior leadership was viewed as the most essential variable in supporting both the nurse leaders and the operations teams. They felt there was "... the absolute need for the executives to be included.". But presence alone was not considered sufficient. Each of the nurse leaders expressed an urgency for the senior leadership team to demonstrate a clear and inclusive understanding of the priorities and challenges of the nurses caring for patients "... so dependent on the organization...... and the ability to reason and provide a sound basis for our reasoning." The nurse leaders unanimously expressed an awareness that what mattered most was the type of relationship that existed between executive leadership and front-line operational staff. They expressed the value of existing functional and supportive relationships, the challenge of their absence and the difficulty in trying to establish trusting relationships during the pandemic if they had not been present prior "... so it did make me understand how important relationships are when you have a crisis like this... so there isn't second guessing... ".

4. DISCUSSION

The findings of this study suggest which nurse leader skills proved most helpful and effective during the pandemic and advises the need to train nursing students in mastering these skills in preparation for their future roles as nurse leaders. It is abundantly clear that nurse leaders relied on their ability to be spontaneous, to lead 'in the moment' without plan, to see past official titles and engage the entire team in problem

solving, and to remain confident in communication, critical thinking, and problem-solving skills.

It is evident from all the nurse leader narratives that it was vitally necessary to understand one's own strengths, weaknesses, values, and biases in order to call upon their therapeutic use of self. This involved intentionally using personal qualities and skills to lead during the pandemic.

A reexamination of the current baccalaureate nursing school leadership curricula is best served to consider if the current pedagogy and content optimally supports the intent of educating nursing students about the critical elements of nursing leadership in general and during times of crisis in particular. Shifting from theoretical learning to opportunities to practice challenging scenarios that call upon the student's ability to act in the moment and reflect on their learnings will need to replace or at least augment stagnant, didactic learning.

Considered within a Gadamerian analysis, what emerged from the nurse leader narratives was the role of self-reflection in sustaining nurse leaders during the crisis and the value of experience or self-reference necessary to be an effective leader. In Gadamer's construct of analysis (40), this concept of reflection plays a pivotal role and informs how to best enhance student nurse leadership education. Collectively, the nurse leader's reflection on their experience during the pandemic craft a hermeneutical dialogue. This establishes a broader context within which we can determine a shared and better understanding of how to move the current structure of student nurse leadership education to one that fosters a process to attain and demonstrate competencies while remaining open-ended for continued competency development.

Recommendations for content revision include embracing a competency-based model of instruction and assessment, utilizing experiential learning to help students apply theoretical knowledge to practice and student engagement in exercises in reflection towards developing self-awareness. Role modeling and mentorship opportunities should be prioritized.

4.1 Competency based instruction

A shift to competency-based education will be essential to ensure that newly graduated nurses have been trained in essential leadership skills and are able to confidently demonstrate these skills during their transition to practice.[49] This curriculum design outlines the competencies expected for nurses and focuses on the key behaviors they should demonstrate along with steps needed to advance their proficiency levels. It encourages nurse educators to design teaching strategies to best match their students' learning style. Competency based education provides targeted feedback and focuses on student individual progress and competencies.[50] This is especially important when training future nurse leaders to manage crisis situations. Competency based education is grounded in knowledge yet prioritizes self-assessment and develops student nurse ability to lead during dynamic states of change. The American Organization of Nurse Leaders[51] outlines specific leadership competencies for various leadership roles ranging from system nurse executives to unit-based nurse leaders. These competencies are broadly categorized as those focused on professionalism, health care environment, communication and relationship management, and business skills and principles. The narratives of the nurse leaders in this study suggest the essential competencies that require emphasis in the nurse leader curriculum should also focus on collegial communication and authentic behavior, team orientation, the ability to cultivate and sustain trust, the ability to clearly create an expectation of individual accountability, advocacy skills, ease with risk taking, inclusive decision making, and effective presence.

Considered within a Gadamerian lens[52] effective nurse leadership during times of crisis will require competency in not imposing one's predisposed ideas of leadership. Instead, effective nurse leaders will be those skilled in ease with dialogue that encourages a fusion of horizons where multiple perspectives are brought together to not only craft shared understanding, but to also arrive at best decisions in dynamic and stressful environments. This will require critical reflection and the questioning of assumptions and an intense commitment to open communication. Gadamerian interpretation would suggest that the most effective nurse leaders will be those skilled in the dynamic interaction between long held leadership tradition, individual experience and the ongoing process of dynamic interpretation and response.

4.2 Reflective and pragmatic learning

According to James,[53] in order to support the development of student nurse leadership education, a greater understanding of the role of emotions in experiencing leadership, along with the impact of role models and an awareness of the cultures of healthcare workplaces are required. This is best accomplished through reflexivity and pragmatic, experiential approaches to learning. Reflexivity in learning, particularly considered within a pragmatic framework, focuses on the examination of a student's own assumptions, biases, and experiences. This exercise of actively questioning and reflecting on how personal perspectives might influence understanding and action supports both learning relevance and critical thinking. Pragmatic learning requires the opportunity to apply knowledge to real-world situations.[54] It emphasizes reasoned problem-solving. Both considerations support recommendations for scenario based and experiential learning

strategies.

The findings of this study emphasize the need to move from a singular instructional model to one that focuses on supporting student concept learning by creating opportunities to reflect on what is being instructed for the purpose of drawing connections with previous learnings geared towards reinforcing skills and competence.[55] The exercise of purposeful reflection will provide student nurses with the opportunity to consider how relationships, communication, policy and risk taking can influence the care they provide. Each of these variables prove relevant to successful leadership behavior during the pandemic and would do so in general and in future disaster situations.

Reflective exercises should include reflection on specific experiences, the consideration of one's role and responsibilities during the experience including actions, and a deep dive into what learning opportunities are needed to develop future competencies. A well-structured exercise in reflection should not only include a description of the situation, but also focus on student thoughts and feelings, evaluation and analysis of the situation, and finally conclusions drawn from this analysis.[56] Opportunities for reflection should prioritize ones focused on clinical events, ethical dilemmas, and teamwork, while each including the identification of the student's own assessment of their performance's strengths and weaknesses.

Reflective practice when considered in the context of nursing education, holds value and is in and of itself a necessary competency for continual professional development.[57] As considered by Vaughn,[58] reflective teachings in nursing leadership curricula are vital to not only the integrity of nursing education, but to the future of the profession at large.

4.3 Simulation based and experiential learning

Moving out of the classroom into real-life based instructional modalities will need to replace the current and traditional didactic instruction model for student nurses. Simulated patient care scenarios, virtual reality and case studies will prove more effective towards developing leadership competencies.[59] As noted by Labrague,[60] simulations that challenge nursing students with ethical, resource, relationship, policy and communication dilemmas will help foster critical thinking and decision-making skills. Most importantly, these simulated experiences will help students learn how to make quick decisions under pressure. According to Martinez-Galiano et al.,[61] field experiences including participating in disaster relief efforts will also support student learning by introducing students to means and methods of working with other disciplines and across varying leadership structures. In addition, assignments that place students in community settings will assist students in learning how to build relationships, proven essential by the findings of this study.[62]

Rentmeester & Liebzeit[63] offer that nurses serve as authorities in the domain of healthcare but are responsible to the authority and autonomy of their patients who have ultimate responsibility for choice about their plan of care. When considered within Gadamer's philosophy, balancing the tension between these two conditions requires phronesis or nurse demonstrated practical wisdom and critical thinking. Effective nurse leaders are those who can apply prudence and moral principles to individual, unique and dynamic situations.[64] This will require nursing education to include not only practice but also reflection and simulation. By simulating real-life scenarios, nurses can learn to anticipate potential problems, make quick decisions, and adapt to changing circumstances, all of which are essential for developing phronesis.

Gadamer's concept of the "fusion of horizons" suggests that when student nurses face new experiences, they are not starting from zero.[63–65] They bring existing knowledge, bias, and understanding to the situation. These are then influenced or modified by the new experience and new learning and understanding emerge. The use of simulation training permits students to fuse their theoretical learning about leadership concepts with practical application.

4.4 Role modeling and mentorship

According to the Institute of Medicine,[66] leadership is an essential skill for nurses in all settings. Leadership mentoring programs are considered important contributions for the education and development of emerging and diverse leaders for the nursing profession.[67] Balluck[68] identifies that the lack of adequate leadership training and resources are obstacles to encouraging nurses to feel prepared and confident in taking on leadership roles. Mentorship programs reduce the likelihood of nurse leaders experiencing imposter syndrome, encourage a shift from a fixed mindset of skill to a growth mindset that embraces time, talent and experience as an effective process of leadership development. What may be considered as most valuable in mentorship programs is the relationship of the mentor with the mentee and the role modeling opportunity it affords. This relationship may be grounded in a shared humanity and desire to grow encourages assertive leadership. Perhaps the most helpful learning is the dynamic to be comfortable being wrong.[67]

The mentor-mentee relationship establishes a safe space for sharing ideas and for risk taking along with strategies for handling conflict and interpersonal challenges. The narra-

tives of the nurse leaders clearly identify that they depended on these very skills when faced with making decisions in an ambiguous and uncharted set of circumstances. When considering the current curriculum design for baccalaureate nursing programs, it is evident that unlike clinical courses such as medical and surgical nursing, students are not routinely offered placement in a clinical setting for the purpose of observing or partnering with nurse leaders in the field. Doing so would permit greater opportunity for students to witness role modeling behavior which would help shape professional identity and associated self-esteem and confidence in their own leadership potential.[69]

An evaluation of nursing mentorship potential illustrates contribution to the development of student nurse leadership education. These suggestions when considered within Gadamer's philosophy supports the philosophy's emphasis on dialogue, understanding, language and conversation.[70] Mentor-mentee conversations should focus on important aspects of nursing care and ethical challenges and should be open and authentic with opportunity for student reflection. Consistent with Gadamerian constructs, the goal of both the mentor-mentee relationships and the conversations that define it should not be limited to the transfer of knowledge but are best understood as the transformation of understanding for both individuals.

4.5 Study limitations

This study had a relatively small sample size consisting of eight participants. Only one interview was conducted with each participant. Although the participants represented various leadership roles ranging from manager to senior leaders in diverse types of acute healthcare facilities, the small sample size does limit the strength of the emerging themes. The narratives of the participants that served as data for the study was self-reported and is subject to recall bias and reinterpretation, especially considering the pandemic was several years prior to data collection.

Generalizability is limited and intrinsic in the qualitative research design of the study but may be further restricted by the timing of the study, respecting that over the course of several years since the event, participants have been exposed to multiple variables that might alter their interpretation of their experience. The lack of prior research on how nurse leader experience during the pandemic should specifically influence baccalaureate nurse leadership curriculum limits the ability to establish strong recommendation for change.

5. Conclusions

This study explored the lived experience of nurse leaders in acute care settings during the pandemic. The purpose of the study was to better understand nurse leader sense of shared vulnerability with staff and patients with the goal of applying these findings to the development of the leadership curriculum of undergraduate, baccalaureate nursing programs.

Final analysis of the data revealed four interrelated major themes: Life Changing Experience/The Emergence of a New Unit Culture, Critical Leadership Functions for Supporting and Sustaining the Nursing Workforce, Managing Patient/Personal/Political and Professional Boundaries, and The Essentiality of C-Suite Contribution to Operations.

These four themes were considered in crafting several suggestions for adapting the current approach to baccalaureate nursing leadership training. These suggestions acknowledge the requirement to continue to train student nurses on core competencies of nurse leadership but encourage a shift from didactic and perhaps stagnant pedagogy to a more robust, participatory, experiential model and one that affords students leadership clinical placements and both role modeling and short-term mentorship experiences.

This dynamic approach to student learning should include a competency-based model of instruction and assessment, utilization of experiential learning to help students apply theoretical knowledge to practice and student engagement in exercises in reflection towards developing self-awareness. Role modeling and mentorship opportunities should be prioritized.

5.1 Suggestions for future research

Suggestions for future research include exploring the application of this study's finding to acute care setting new leader orientation programs. In addition, studies that evaluate the effectiveness of an enhanced student leadership curriculum by establishing clear metrics to measure the impact of the improved design when demonstrated by graduates would be very helpful in further evaluation of the findings of this study. Studies that measure the changes in leadership competence among nursing students after participating in the new curriculum as compared to prior student performance would help confirm the value added of curriculum changes.

The opportunity to study the implementation and impact of an enhanced leadership curriculum to inform future program adjustments and to validate the value added of curriculum changes based on outcomes is valuable.

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DATA SHARING STATEMENT

No additional data are available.

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