



Nurses Leading the Way: A Qualitative Study of Nursing Leadership, Innovation and Opportunity in Primary Care During a Public Health Crisis

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Abstract

Introduction: Nurses in primary care play critical roles during public health crises; however, nursing leadership was underutilized during the COVID-19 response. This study explores nurses' leadership roles during the pandemic and their perspectives on the value of nursing leadership in primary care.

Methodology: We conducted qualitative interviews with 76 nurses across four Canadian regions. Participants described their roles and the barriers and facilitators encountered during the COVID-19 pandemic. We used thematic analysis and examined themes relevant to leadership.

Results: Three themes emerged: actualizing leadership, leveraging leadership experience and the value of nursing leadership. Nurses demonstrated leadership competencies, including educating teams and developing care delivery strategies. Participants emphasized the importance of involving nursing leadership in decision making and policy development.

Conclusion: Sustaining and leveraging nursing leadership post-pandemic is essential to enhance collaboration and strengthen healthcare systems. Involving nurses in decision making can address system challenges and improve responses to future public health crises.

Introduction

Leadership is an entry-level competency (i.e., a skill required by all nurses to provide safe, competent and ethical care) for all nursing designations. In Canada, primary care is commonly delivered in an office or clinic setting by teams of healthcare providers (Glazier 2023) that include nurse practitioners (NPs), registered nurses (RNs) and/or licensed practical nurses/registered practical nurses (LPNs/RPNs) (CCPNR 2019; CCRNR 2019, 2023). Competencies were developed

to help articulate the unique contribution of NPs and RNs in primary care, including their roles as leaders (CCRN 2023; CFPNA 2019). Nursing leadership in primary care is enacted at the societal or system level (e.g., advocating for primary care reform and social justice) and at the team level (e.g., sharing knowledge with peers to support evidence-based practice and developing practice policies and/or guidelines) (CFPNA 2019; Mathews et al. 2021a). Nursing leadership may involve formal positions (supervisor, manager) and/or engagement in different roles/skills in everyday practice. All nurses, regardless of regulatory designation, are expected to apply leadership competencies in some capacity to contribute to high-functioning primary care. Primary care nurses are well-positioned to undertake leadership roles such as facilitating care coordination; leading health education, prevention and health promotion programs; advocating for patients and effective resource use; sharing knowledge; problem-solving; developing healthy public policies; and mentoring (Canadian Nurses of Ontario 2023; Guibert-Lacasa and Vázquez-Calatayud 2022; ICN 2024; Lamb et al. 2018; Lukewich et al. 2021; Mathews et al. 2021a).

Existing research on nursing leadership is predominantly focused on the enactment of leadership in hospital-based settings or in managerial roles (Cummings et al. 2021; De Brún et al. 2019; Guibert-Lacasa and Vázquez-Calatayud 2022). Systematic reviews have reported on the critical role that nursing leadership plays in improving patient and health system outcomes (Cummings et al. 2021). Strong nursing leadership is also linked with high levels of job satisfaction, motivation and performance among the nursing workforce (Cummings et al. 2010; Germain and Cummings 2010). In primary care, where the role of the nurse as a leader has often been overlooked and underutilized, nurses have demonstrated critical leadership in care coordination, staff supervision, quality improvement and team-based planning, leading to enhanced quality, greater efficiency and reduced costs (ICN 2024; Smolowitz et al. 2015). Within primary care, the lack of formalized leadership positions or opportunities for nurses to actualize their leadership skills could impact quality of care and team collaboration (Severinsson and Holm 2012). This knowledge gap can be attributed to the reliance on traditional models of care that reinforce physician-led decision making and hierarchies within the healthcare system (Fernandopulle 2021); lack of understanding that leadership is within the nursing scope of practice (CCPNR 2019; CCRNR 2019, 2023; Lukewich et al. 2021); absence of well-defined nursing leadership within primary care (De Brún et al. 2019); and environmental and systemic factors, including clinic type and funding models (Mathews et al. 2021a).

During a public health crisis, such as the COVID-19 pandemic, nursing leadership is vital for shaping the delivery and quality of healthcare services (Wymer et al. 2021). Existing research regarding the ways in which nursing leadership

was leveraged during the COVID-19 pandemic largely focuses on hospital-based settings (Hayes and Cocchi 2022; Salminen-Tuomaala and Seppälä 2022). During the COVID-19 pandemic, within primary care, nurses had to rapidly adapt their roles in response to changing guidelines and public health policies (Mathews et al. 2023a, 2023b). Nurses enacted leadership competencies to support the pandemic response, including providing necessary patient care, enacting infection prevention and control measures, advocating for resources, participating in supply chain management, communicating policies and procedures and educating patients/the public (Aquilina et al. 2020; Fowler and Robbins 2022; Simonovich et al. 2021; Wymer et al. 2021). Despite these critical leadership roles, the prioritization of nursing leadership is not well-incorporated into pandemic response guidelines, particularly with respect to nurses in front-line/clinical positions within primary care (Government of Canada 2018; Rosser et al. 2020). Therefore, the purpose of our study was to explore the leadership roles that nurses enacted in primary care during the pandemic and the perspectives surrounding the value of nursing leadership in primary care.

Methodology

Study Design

This analysis was part of a larger cross-provincial multiple mixed-methods case study (Mathews et al. 2021b) aimed at describing the roles of primary care providers during the different stages of the COVID-19 pandemic (Mathews et al. 2023c) as well as the facilitators and barriers associated with these roles. As part of this study, we conducted in-depth semi-structured qualitative interviews with primary care nurses from four regions in Canada: the Interior, Island and Vancouver Coastal health regions in British Columbia (BC); the Ontario (ON) Health West region; and the provinces of Nova Scotia (NS) and Newfoundland and Labrador (NL).

Study Participants

Nurses were eligible to participate if they were licensed to practise in primary care during the COVID-19 pandemic (March 2020 to January 2023). We excluded nursing students who were undertaking a clinical placement/preceptorship or nurses in exclusively academic, research or administrative roles.

Sampling and Recruitment

We used maximum variation sampling (Creswell 2014) to recruit nurses (i.e., NPs, RNs, LPNs/RPNs) across a wide range of demographic and practice characteristics, which have been shown to impact the enactment of nursing roles in primary care (e.g., community size, funding models) (Mathews et al. 2021a). We targeted nurses who worked in a range of clinic practice types, including general

family practices (i.e., those with a broad patient population) and focused practices (i.e., those that serve specific patient populations or medical conditions), and also accounted for the nature of nurses' roles within these clinics. Nurses' roles within a clinic may differ from that of the broader practice, with some nurses focusing more on specialized areas, such as chronic disease management or outreach work; therefore, clinic and nurses' nature of practice were examined separately. To recruit participants, research assistants e-mailed study invitations to nurses identified from practice lists and search portals of regulatory and professional associations. Recruitment invitations were included in the newsletters, e-mails and social media posts of professional organizations. Clinics employing primary care nurses were identified through website searches and an invitation was sent to the e-mail address listed for the clinic. Where permitted by regional ethics boards, snowball sampling was used, whereby we asked participants to refer us to other eligible colleagues who they believed could be interested. Recruitment continued until we achieved data saturation (Berg 1995; Creswell 2014).

Data Collection

In the larger case study, nurses were asked to describe the actual and potential roles, and barriers/facilitators with respect to performing these roles, that they carried out during the pandemic (Mathews et al. 2023b) (Appendix 1, available online at longwoods.com/content/27551). Slight modifications were made to interview guides to account for regional differences in nursing roles, health system contexts and pandemic epidemiology and response. Interviews were conducted by research team members (CV, GY, LM, LR, SS) through video conference (Zoom Video Communications Inc.) or telephone, depending on participant preference. Interviews were audio recorded, transcribed verbatim, verified for accuracy and de-identified.

Data Analysis

We used a descriptive thematic analysis approach to analyze interview transcripts (Guest et al. 2012) using a robust coding template developed collaboratively by research team members. To develop this template, an experienced member of the research team in each region (LR, DR, SS, DB) independently coded one interview from their region and developed a draft template using an inductive approach to identify recurring ideas and themes. Team members then coded a selected set of transcripts from each province and met to compare themes, refine the meaning of each code and develop a unified template with consistent labels and descriptions. This process continued until all team members were satisfied with the appropriateness and applicability of the unified template. Each regional team then used the unified coding template to code all transcripts from their own regions using NVivo 12 software (QSR International) to facilitate the process.

Any disagreements in coding were resolved through discussion among the team members. We used inductive thematic saturation relating to leadership themes during the analysis stage. For the current paper, we analyzed coded excerpts specific to leadership (i.e., a leadership code that described leadership roles and activities performed by nurses) as well as other codes related to leadership (i.e., those focused on organizational context, roles of staff and clinic team, interactions with management and educating/supporting organizations) and identified themes from the data.

Rigour and Positionality

We used rigorous methods in the study (Berg 1995; Creswell 2014; Guest et al. 2012), such as pre-testing interview questions, documentation of all procedures and decisions, the use of skilled interviewers and validation of meaning through participant interaction during interviews. We looked for negative cases and provided thick descriptions. This project was carried out by an interdisciplinary team of primary care researchers, including primary care providers involved in the pandemic response. Input from a larger team of experts, including nurses, public health officials and policy makers, helped with the development of the interview guide and the verification of interpretations.

Ethics

We obtained ethics approval from the research ethics boards for Simon Fraser University and the University of British Columbia (File: H20-02998), the Health Research Ethics Board of Newfoundland and Labrador (File: 20222815), the Nova Scotia Health Authority Research Ethics Board (File: 1027959) and the Western University Research Ethics Board (File: 120519).

Results

A total of 76 nurses completed interviews across the four study regions between May 2022 and January 2023. Interviews varied in length from 24 to 125 minutes (mean = 58 minutes). Participants consisted of 24 NPs, 37 RNs and 15 LPNs/RPNs (Table 1). The majority of nurses practised in a general family practice (90.8%) and had a broad role focused on the general patient population of the clinic (78.9%). Three overarching themes related to nursing leadership during the COVID-19 pandemic emerged: (1) actualizing leadership; (2) leveraging leadership experience; and (3) the value of nursing leadership.

Actualizing Leadership

The pandemic highlighted nurses' exceptional ability to adapt and lead in times of crisis and offered a window into nurses' leadership qualities and functions that may have gone previously unnoticed. Early in the pandemic when policies were

Table 1. Demographic characteristics of participants (N = 76)

Demographic characteristics	Ontario n = 27	Nova Scotia n = 20	British Columbia n = 13	Newfoundland and Labrador n = 16	Total n = 76
Gender, n (%)^a					
Man or non-binary ^b	1 (3.7)	1 (5.0)	2 (15.4)	0 (0)	4 (5.3)
Woman	26 (96.3)	19 (95.0)	11 (84.6)	16 (100)	72 (94.7)
Nurse type, n (%)					
LPN/RPN	9 (33.3)	8 (40.0)	2 (15.4)	5 (31.3)	24 (31.6)
RN	9 (33.3)	11 (55.0)	11 (84.6)	6 (37.5)	37 (48.7)
NP	9 (33.3)	1 (5.0)	0 (0)	5 (31.3)	15 (19.7)
Clinic nature of practice, n (%)^c					
General family practice	22 (81.5)	19 (95.0)	13 (100.0)	15 (93.8)	69 (90.8)
Focused practice	5 (18.5)	1 (5.0)	0 (0)	1 (6.3)	7 (9.2)
Nurse nature of practice, n (%)^d					
General family practice	20 (74.1)	19 (95.0)	11 (84.6)	10 (62.5)	60 (78.9)
Focused practice	7 (25.9)	1 (5.0)	2 (15.4)	6 (37.5)	16 (21.1)
Community size, n (%)^e					
Rural	10 (37.0)	11 (55.0)	1 (7.7)	6 (37.5)	28 (36.8)
Small urban	5 (18.5)	6 (30.0)	3 (23.1)	0 (0)	14 (18.4)
Urban	12 (44.4)	3 (15.0)	9 (69.2)	9 (56.3)	33 (43.4)
Mixed	0 (0)	0 (0)	0 (0)	1 (6.3)	1 (1.3)
Years in practice, mean (SD)	13.6 (10.1)	15.6 (11.3)	17.7 (11.2)	14.0 (9.8)	14.9 (10.3)

a Gender was asked as an open-ended question.

b Non-binary participants were grouped with men due to small cell size.

c Whether the clinic that the nurse works in serves a broad population or focuses on a specialized area, such as a specific patient population or medical condition (e.g., diabetes clinic, low-barrier walk-in clinic).

d Whether the nurse's role involves providing a broad range of services to the general population or focuses on a specialized area, such as a specific patient population or medical condition (e.g., chronic disease management, outreach work).

e Rural < 10,000 population; small urban = 10,000-99,999 population; urban > 100,000 population (Statistics Canada 2001); mixed = participants reported practising in more than one community that involved rural and urban populations.

LPN/RPN = licensed practical nurse/registered practical nurse; NP = nurse practitioner; RN = registered nurse; SD = standard deviation.

rapidly changing, nurses reported a lack of context-specific guidance and found it difficult to navigate communications. Nurses recounted enacting leadership skills to address gaps and inconsistencies with the communication of pandemic policies, protocols and public health guidelines. One nurse described how they took the lead within their clinic to seek out information and contextualize it to their own practice:

In some places, it was a challenge because for a while there was no guidance for primary care in the initial phases, it was only acute care. So, we did some adaptations, but we found everything online. (ON17 NP)

Another nurse recalled receiving limited communication and guidance, prompting her to take initiative:

So, there wasn't a lot of direct updates [for] us; we did a lot of asking: "Can we keep the mask mandate? Can we run COVID clinics? ... We think the community is asking for these things, can we do them? We think it would be helpful." (NS07 NP)

Leadership was demonstrated when nurses served as the primary source of knowledge for other staff/providers in their clinic. One RN participant assumed the responsibility of sharing knowledge with the physicians in the clinic, thereby ensuring they stayed up-to-date on COVID-19 guidelines and could focus their time on patient care delivery:

I was keeping the doctors up-to-date on what was going on. ... They're so busy just trying to keep their head afloat ... but I could focus on their patients and what was going on with the COVID updates and guidelines and things like that and what was changing. So, I would spread the information around. So, quite often they would come to me and say, "So what's going on today?" or, "What was the last update?" and I would be able to find that. (NS09 RN)

Another participant described sharing public health guidelines with peers: "I would help the other physician disseminate the new information that was coming through in terms of spread, protocols to protecting ourselves, screening" (ON26 NP). Nurses took initiative to provide education to other members of the clinic team. An NP participant stated:

... when the vaccines were coming out or we were discussing potential vaccines, helping to disseminate that information to people based on my weekly Health Unit updates that I was receiving ... [and] assisting with any questions between employees. (ON26 NP)

Similarly, an RN with vaccination experience developed a vaccination training program in an effort to educate other members of the clinic:

I took it upon myself to ensure that we had a training program to make sure that each of the nurses or whoever was going to be administering the vaccines was aware of it ... there [were] different little caveats that [were] very legislatively dictated that I ended up having to make sure I understood it, from an educational component, and then developed the appropriate program ... (NL08 RN)

Nurses demonstrated leadership by taking initiative to develop workflow protocols and policies within the clinic. An NP from ON stated: “So, as part of the COVID team, we actually developed a physical clinical flow” (ON17 NP). Another NP described how she led the development of a policy related to screening: “... I started to make some policy myself ... a little handout I made on how to do a swab and a little clip from YouTube, to actually show how to do it ... to test the right way” (ON22 NP). In addition, nurses developed and disseminated protocols to assist other community organizations. One RN described how, as part of her practice focused on harm reduction and the provision of low-barrier primary care services, she assisted community shelters with the establishment of protocols for implementing infection prevention and control procedures:

... we helped [the shelters] establish protocols for isolation. ... So, it was challenging in the sense to try to ... provide reassurance, try to set up plans, try to have a donning and doffing station, and show them how to wear the PPE [personal protective equipment] ... (NL19 RN)

Another participant recounted developing workflows related to daily clinic operations that were shared and adopted by other primary care settings:

It was us who [designed an electronic version of a clinic workflow]; the nurses did that. We didn't have any external support helping us do that. I designed that spreadsheet on my own time to help me and then we ended up making copies of it and sending it to the other districts. (NL01 RN)

Nursing leadership was also demonstrated through outreach activities at a system/population level. Participants reported engaging in outreach with organizations outside of their primary care clinic: “A lot of what we did in those early months was a lot of outreach to different organizations or different parts of [the Regional Health Authority]” (NL07 LPN). Nurses also described advocating for socially marginalized or medically at-risk patient groups who were facing additional barriers and disproportionately impacted by the pandemic, such as unhoused

individuals, those of low socio-economic status, those with pre-existing chronic diseases and the elderly. One LPN described liaising with different community organizations to advocate for patients with limited resources: “We had elderly people come in who, you know, relied on food banks or they didn’t have a whole lot of money or they didn’t have someone to go to the store for them” (NL07 LPN). Another LPN described advocacy to support safe patient care:

And there was no real process in place for [patients] at this point. So, we kind of had to reach out to the opioid treatment centre, recovery centre ... [and] really do a lot of digging around in how we can get these patients their necessary medication, but also trying to keep everyone safe in the process. (NL07 LPN)

Nurses recognized and understood patient and health system needs and took the lead in filling perceived gaps. In the absence of formalized guidance, nurses were tasked with making their own decisions around how to adapt changes to their practice due to the time-sensitive nature of the unfolding pandemic:

So, we just start[ed] making the changes [to clinic operations] ourselves. Like we didn’t really wait until [management] came down with it, you know what I mean? Because it takes a little longer to get their policies written up ... (NS05 NP)

Given the lack of clear direction or actionable guidelines specific to primary care, nurses assumed leadership roles and made decisions around the safest course of action for implementing certain protocols. One RN describes stepping up to help the clinic with issues related to staffing shortages and devising how to keep the clinic operational in the face of staff members contracting COVID-19 or requirements to quarantine after exposure: “... that was a big part of our role as the team leads here, was figuring out what to do [with staff shortages]. ... [I]t’s just figuring out ... what’s the safest way to do this and roll this out” (BC12 RN).

Leveraging Leadership Experience

Participants described how existing positions of leadership were leveraged during the pandemic. Many nurses in existing leadership roles prior to the pandemic, and often NPs in a perceived or actual position of leadership, took on specific positions that were pandemic focused and created in response to a critical need. Existing formal leadership roles consisted of designated positions within primary care that nurses had been officially appointed to, where they carried out leadership activities in an official capacity such as “manager” (NL05 RN) or “clinic supervisor” (BC12 RN). For instance, an RN with previous leadership experience was asked to take on additional activities to address a gap that had emerged in clinic leadership:

So, there ... [were] some changes in leadership and I do have a previous background in leadership, so I was asked to fill some roles that weren't normally mine. ... My manager asked and I agreed. I just ... stepped into the role and I think it made sense just because I did have that ... previous experience. (BC10 RN)

In many instances, nurses had pre-existing skills that made them well-positioned to take on key leadership roles. For example, nurses with existing experience in providing vaccinations were often asked to oversee COVID-19 vaccination clinics:

But definitely when I was helping lead the vaccine programs on a large scale, I was sort of more [involved] in managing, helping to manage I guess, the clinics themselves and I was basically the vaccine go-to person. (NL13 RN)

Another participant described a similar experience: "... I ran the immunization clinics in the evenings almost completely independently with just very minimal support" (NS07 NP).

NPs often found themselves in leadership positions and overseeing clinic operations due to their advanced education and the formal leadership associated with their positions. One NP participant elaborated on how leadership responsibilities would automatically fall on her: "... I'm the only nurse practitioner here and usually if we have something like that happen, like SARS or H1N1 ... I usually am the one sort of assessing what we might need here" (NS05 NP). NPs also tended to have greater access to information than other members of the team and frequently acted as leaders by disseminating pertinent knowledge: "So, the nurse practitioner ... she spearheaded a lot. ... They had their COVID committee ... and [the committee] were very good to make sure that we knew what was happening and what was going on" (ON21 RPN). Another NP participant recounted how their access to information led them to assume a leadership role in disseminating public health updates: "... there [are] two NPs in our program. We both are kind of leading it and help with the program but I would be involved in the weekly COVID-19 public health update" (ON26 NP).

The Value of Nursing Leadership

Participants expressed the importance of nurses in leadership roles during the pandemic and the unique contribution of these roles to primary care functioning. However, despite widespread agreement, some participants felt their leadership skills were not fully recognized. In particular, participants expressed that nurses were not granted the opportunity to effectively engage in leadership to the full extent of their capabilities, with their activities often being directed toward other

areas of the pandemic response that did not fully utilize their skills: “My gut says they were asked to do too much in some capacities ... and not given opportunity to do enough in other areas, like more leadership-type roles” (BC08 RN). In some cases, a lack of recognition toward the contributions of nursing leadership could hinder a nurse’s ability to fully optimize these roles. An RN expressed a desire for a more prominent role in pandemic planning, particularly around the clinic organization and flow, but was hindered by the inability of those in leadership positions to recognize the value of this contribution:

So, I think even us taking on a bit more of a planning role would be beneficial. ... I certainly wouldn’t mind doing more of that if the need arose again, but like I said, the [managers in the] clinic didn’t see the benefit in letting us go to do that. (NS10 RN)

Participants also voiced concerns about the limited representation of nurses in leadership and emphasized the importance of nurses being more involved in decision making, with one RN noting: “... I saw a lot of scenarios where I thought, oh, if nurses had been involved in this decision, I don’t think it would have gone this way. ... [W]e could have moved nurses, I think, into more leadership roles” (BC08 RN). Nurses expressed concern that those tasked with creating policies often lacked insight into the distinctive role and perspective of nurses in primary care. A nurse expressed the need for greater inclusion of nursing expertise in policy development: “I think especially the input into how the system is developed. ... I think that input into what’s feasible and practical would have been a helpful contribution” (NS03 NP). Likewise, an RN participant articulated the need for front-line providers to have their voices heard, as they are well-positioned to speak to the day-to-day clinic operations and unique functions of primary care:

I think that [decision makers] could have ... listened a bit more to the front-line workers and had some of those front-line people involved in some of those meetings. I feel like sometimes with leadership, it’s a very, you know, “here’s our ideas,” but ... it’s difficult for them to know day-to-day how the operation will ... look and the nuance of that. It really does a disservice to the clients [when decision makers are] not really listening to the people who are doing the actual work and not getting input from them. (BC10 RN)

Despite the underutilization of nursing leadership in some instances, the pandemic highlighted the value of developing new leadership roles and opportunities for nurses. In these cases, nurses made valuable contributions to overall primary care functioning and showcased their leadership. For example, an LPN reflected on how she and her colleagues were able to demonstrate their leadership capabilities by overseeing assessment clinics:

Not to toot my own horn or anything, but me and another LPN that I worked with ... we were ... running some of the COVID clinics. When our managers weren't there, they were like, "You need to make sure everything is running smoothly today." And, you know, we're capable of doing that ... (NL07 LPN)

Similarly, some participants took on new leadership roles to ensure that trainees were receiving appropriate guidance. For example, an NP described accepting a position that involved overseeing newly graduated NPs:

I knew that innovation was coming because it had to. I knew that we, our systems, were getting overwhelmed, and I knew that there would be a lot of change for NPs. I don't know that I would have been as willing to take [a new leadership position] had the last two years not been as challenging for me, because all I could think was, if this was this challenging for me, how did the new grads feel? And so, I realized I had to take a role in supporting, and in some ways protecting [new graduates] by helping to guide what [transition to practise for new NPs] should look like and what the key ... pieces would be to include and change. (NS08 NP)

Some participants expressed that nursing voices within leadership roles appeared to be more valued after their critical contributions were exemplified during the pandemic. One RN noted that the display of effective leadership by nurses during the pandemic led to an increased appreciation for the nursing role in primary care: "I believe that the [primary care nurse] role, we became more of a leader. ... I actually think they treat me different[ly] now after COVID. ... [They show m]ore respect" (NS09 RN). Another participant described a shift in viewpoints regarding the importance of nurses in leadership:

And [the pandemic is] also, in a funny way, helping nurse practitioners to have a lot more credibility with the public, with other health providers, with leaders, because they really can and should be stepping into lots and lots of innovation ... (NS08 NP)

The pandemic highlighted nursing leadership capabilities that may have been previously unrecognized and underutilized. As one participant expressed:

... I think my being a nurse was significant because there are other sites that didn't have nurse managers and did not respond in the same [way]; like it was very, definitely challenging [for them]. ... So, I think the role of nursing was very much highlighted and I think the flexibility and fluidity of the role of the nurse too, because every day I'd say to the staff, "Okay,

now we're doing this, now we're doing this." ... But I think leadership was huge; our team lead was a nurse and that person was running the show every day and everyone knew it. (BC08 RN)

Discussion

This study describes the leadership roles that nurses demonstrated or adopted during the COVID-19 pandemic and nurses' perspectives on the value and need for nursing leadership in primary care. Prior to this study, there was scant evidence to inform nursing leadership roles during a public health crisis (ICN 2024; Rosser et al. 2020). Our study demonstrated that pre-existing leadership competencies were made visible by nurses across all regulatory designations (NPs, RNs, LPNs/RPNs) and ensured the ongoing provision of patient care in rapidly changing circumstances.

Nurses in our study identified situations where they enacted leadership competencies that were not necessarily embedded in routine primary care practice, including creating and implementing policies and clinic workflows, managing and advocating for resources, educating clinic team members and providing outreach to community organizations. Many of these are identified as leadership roles within the Canadian competencies (CCPNR 2019; CCRNR 2023; Lukewich et al. 2020). Our findings also align with previous research on nursing leadership, as well as leadership in healthcare more broadly, during a pandemic. For example, an international review of evidence found consensus on 10 leadership imperatives to serve as a guiding framework for health leaders during a pandemic (Geerts et al. 2021). Nurses in our study engaged in a number of these essential leadership imperatives, including maximizing team, organizational and system performances; managing the backlog of paused services and considering improvements; providing regular communication and engendering trust; and consulting with public health and fellow leaders to improve care and emergency preparedness (Geerts et al. 2021). These leadership imperatives could be incorporated into future primary care-focused pandemic plans using concrete examples of what we have learned from the experiences of primary care nurses during the COVID-19 pandemic. In another study, Aquilia et al. (2020) studied nursing leadership across different healthcare settings in the US, highlighting nurses' roles in adapting to novel situations and effectively leading pandemic response efforts through informed decision making. It is anticipated that the increased leadership responsibilities acquired during this crisis are unlikely to diminish with the waning of the pandemic (Wymer et al. 2021). These opportunities should be effectively leveraged to sustain and empower nurse leadership engagement, particularly as a means to enhance capacity in team-based primary care.

Evidence suggests that a lack of: clearly defined roles, recognition of leadership functions, opportunities to work at a strategic level and position/authority within organizations are considered barriers to nursing leadership advancement (Hughes 2018). In our study, nurses identified similar factors that hindered their ability to enact leadership, including a lack of clear direction or actionable guidelines, rapidly changing policies, capacity and staffing issues and a lack of recognition and inclusion in policy development and decision-making processes. Participants in our study perceived that health leaders (often non-clinical individuals with minimal understanding of the front-line nursing experience) overseeing pandemic response planning lacked a comprehensive understanding of primary care and the value of nursing within this setting (e.g., the scope of practice, the nature of longitudinal care, etc.). Similar to prior research highlighting the lack of prioritization of primary care and the limited representation of primary care voices in decision making broadly (Mathews et al. 2023d; Roe et al. 2022), this oversight affected the healthcare system's capacity to fully leverage nursing expertise. Consequently, this resulted in negative impacts on patient care, resource allocation and workforce management.

Implications for Nursing Leadership

A report by the World Health Organization (WHO 2020) recommends that healthcare systems take action to strengthen leadership roles within the nursing profession. Similarly, a recent report by the International Council of Nurses (ICN 2024) emphasizes the critical role of nursing leadership in advancing primary care and advocates for the empowerment of nursing leadership through their active participation in policy development. We recommend that, during pandemic planning and future public health crises, governments leverage nursing knowledge and expertise directly. The Canadian Nurses Association requested greater nursing engagement during the pandemic (CNA et al. 2020), prompting the Government of Canada to reinstate the chief nursing officer position in an effort to increase nurses' contributions and to increase their involvement in healthcare decision making (Government of Canada 2022). The prioritization of leadership is fundamental to advancing the nursing profession (Institute of Medicine [US] Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine 2011), and there is a clear and consistent need for decision makers to involve nurses during healthcare crises, specifically concerning resource allocation and workforce management to improve patient care. By leveraging nursing leadership, many health system challenges can be addressed and a more robust and timely pandemic response can be coordinated.

Limitations

Interviews were conducted across four regions in Canada; our findings may not reflect the experiences of all nurses or those in other Canadian regions.

Our interview guide consisted of semi-structured questions related to roles and barriers/facilitators that nurses encountered during the different stages of the pandemic. While participants were not asked specifically about their enactment of leadership roles, these themes arose organically and probes were employed to further explore these concepts. Lastly, interview data, as with all self-reported data, are subject to recall and social desirability bias (Bergen and Labonté 2020; Coughlin 1990); however, this was mitigated through the use of experienced interviewers who provided descriptions of each pandemic period to enhance recall and the use of consistent probes to encourage self-reflection.

Conclusion

Research informing leadership roles and opportunities for nurses in primary care is limited. Challenges arising from the COVID-19 pandemic allowed for increased visibility of these roles and opportunities for nurses to enact new leadership roles in primary care. Findings provide direction for health leaders and decision makers about the importance of directly involving nurses in pandemic planning and decision making during future healthcare crises. Nurses' leadership competencies should be leveraged to improve patient care experiences and address challenges facing health systems, especially in times of crisis. Future research should explore strategies for the intentional and effective integration of nurses into leadership positions in primary care settings, including assessing the impact of this integration on patient outcomes, healthcare delivery and organizational effectiveness.

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