S evere acute respiratory syndrome coronavirus 2 (SARS-CoV-2), also referred to as novel coronavirus (COVID-19), is a newly identified pathogen with no known existing human immunity that can cause respiratory distress and complications (Centers for Disease Control and Prevention, 2020a). The COVID-19 pandemic was first identified in the United States in January 2020 (Centers for Disease Control and Prevention, 2020b). Within 5 days of the first confirmed case in New Jersey, a state of emergency was declared on March 9, 2020 (New Jersey Department of Health, 2020). In less than a week’s time, a surge in critical COVID-19 patients in our large, teaching hospital created two main challenges: an abundance of patients who required critical care nursing skill sets and a demand for education and training that far exceeded our 16 nursing professional development (NPD) practitioner department. The situation necessitated the need for nurse leaders to make prompt but consequential decisions on strategies to best care for patients. The operational changes caused a shift in workflow for the NPD team. The department was split into three teams to meet the demand for education and training of frontline staff. Team 1 was responsible for orientation of new hire employees and travel nurses. Team 2 was responsible for training staff to a different unit or role because of low census in their employed clinical area. Team 3 was responsible for real-time education and support of all staff on the clinical units. A summary of each team’s primary role and respective responsibilities is listed in Table 1.

**THE UPSWING**

In late February 2020, the NPD practitioners were implementing education plans and beginning annual competency assessments. During this time, the Infection Control Department began to report updates about COVID-19 to our organization. Education on COVID-19 was assigned to all employees from our healthcare system’s corporate team. For the NPD team, this necessitated weekly huddles for dissemination about national and state trends. Led by the Director, transparency during huddle was critical for planning the NPD practitioner’s role if our organization were to be hit with a surge.

During the week of March 8, 2020, the hospital experienced an increase in admissions of patients with respiratory distress accompanied by a fever. On the following week, the organization began data collection, and patients were identified as persons under investigation (PUIs). On March 23, 2020, the PUI census was 93, and the COVID-19-positive census was 9. Six days later, on March 29, 2020, pending COVID-19 tests resulted, and there was an abrupt spike in confirmed positive cases. The PUI census was 48, and the COVID-19-positive census was 152. As the daily COVID-19 census climbed and the turnaround time for COVID-19 test results shortened, elective surgeries were canceled, nursing students were restricted from continuing clinical rotations, and visitors were no longer permitted on campus.

At the peak of the pandemic in mid-April, house-wide, we had an overall census of 598. There were 292 COVID-19-positive patients and 55 PUIs. COVID-19-positive
TABLE 1 Team Role and Responsibilities

| Team     | Primary Role                          | Responsibilities                                                                 |
|----------|---------------------------------------|----------------------------------------------------------------------------------|
| Team 1   | New hire and travel nurse orientation | • Create and distribute virtual education                                         |
|          |                                       | • Conduct in-person skills teaching and validation                                 |
|          |                                       | • Facilitate clinical orientation                                                 |
|          |                                       | • Facilitate respirator fit testing completion for travel nurses                  |
|          |                                       | • Distribute personal protective equipment to all orientees                         |
| Team 2   | Orientation for current staff to new units | • Facilitate orientation of repurposed staff                                     |
|          |                                       | • Develop competency assessment tools                                             |
| Team 3   | Just-in-time education on the units   | • Function as a resource                                                         |
|          |                                       | • Create a COVID-19 resource book for each unit                                   |
|          |                                       | • Perform just-in-time training, inservices, and real-time skills demonstration and return demonstration |
|          |                                       | • Provide direct patient care                                                    |

patients and PUIs made up 58% of our patient population. Eight units were converted to COVID-19 intensive care units (ICUs) for a total of 10 ICUs. On April 15, 2020, the ICUs had 81 PUI/COVID-19-positive patients, of which 78 were ventilated. There was a cumulative total of 185 COVID-19-positive deaths. All units, with the exception of the neonatal ICU, labor and delivery, and a clean medical-surgical unit for immunocompromised patients, consisted of COVID-19 patients.

The NPD leaders collaborated with key stakeholders, including the Chief Nursing Officer; Quality and Standards, Infection Control, Operations, Finance, Human Resources, Laboratory, and Physician leadership; and other multidisciplinary department heads. The NPD practitioner collaborated with unit leaders, charge nurses, preceptors, nursing recruiters, and security. In light of this upswing in COVID-19 patients, it became evident that all department workflow required an immediate switch in gears. The NPD department began daily huddles on March 9, 2020.

THE HUDDLE

Daily huddles began at 9:00 a.m. The huddle started with personal protective equipment (PPE) distribution. PPE was preordered by the Director for each NPD practitioner and distributed by need. Standing agenda items included PUI/COVID-19-positive admissions and death rates, unit infrastructure changes, changes to the nurse staffing model, and education to be immediately conducted in real time. The NPD practitioners shared concerns and brainstormed ideas. The Director formed three teams to direct focus on specific education needs. Each team member reviewed and understood their role for the day.

As social distancing became a standard, the huddle became more challenging to conduct. For the safety of the NPD practitioner and adherence to the social distancing guidelines, huddles occurred once per day for each team. Each team’s focus was to provide education and support to the frontline nursing staff. Daily objectives and learning needs were reviewed. Any new education plans were outlined and delegated for design that day. Any previous plans were evaluated for continued need, and adjustments were made based on new information and changing protocols. Needs were prioritized, and resources were identified. The huddle ended with the team members ready to perform their respective duties. NPD leadership communicated with the nurse leaders from other departments to share each NPD team’s focus. The open and transparent communication ensured that all NPD efforts were aligned with the organization’s daily strategic plan.

THE THREE TEAMS

The strategy was developed to implement a three-team approach to meet the needs of the staff, organization, and patients. The three teams were responsible for orientation, training of repurposed staff, and real-time education and support, respectively. The three teams were managed by department leadership. Each team was staffed with four to five NPD practitioners. Instructional modalities implemented by the NPD practitioner included the use of effective communication, innovation, technology, audiovisuals, demonstration and return demonstration, resource books, and just-in-time training.
Team 1 conducted an intense hybrid onboarding and orientation for new hire employees and travel nurses. Hybrid orientation consisted of three components. The first component was assigned through our learning management system and had to be completed prior to arriving on-site. This virtual portion of orientation was composed of presentations, audiovisual tools, and a webinar conducted by the nursing informatics team on the electronic medical record. The second component was conducted on-site and varied by employment status. The NPD practitioner facilitated respirator fit testing completion and PPE distribution. This was followed by a skills laboratory that assessed knowledge, skills, and attitudes through teach-back and demonstration and return demonstration. The third component was clinical orientation that occurred in the practice setting with a preceptor.

For travel nurses, the second component was often ad hoc because of timeliness with arrival to our state and medical clearance notification. A main focus was to orient travel nurses to the crisis nursing standard of care (American Nurses Association, 2020). The skills laboratory shifted away from traditional nursing orientation, as it covered the most current critical topics and skills needed to safely care for the COVID-19 patient population. Although the third component of clinical orientation for new hire nurses occurred for several weeks, the travel nurse immediately cared for an assignment with the designated preceptor. The designated preceptor evaluated and documented the nurse’s clinical competence on the provided competency assessment tool. The three-part hybrid orientation provided training to travel nurses working on medical/surgical, telemetry, critical care, emergency, and hemodialysis specialties. The quick turnaround in training provided support to patient care demands during unprecedented nurse staffing needs. Including new hires, a total of 107 nurses were onboarded within 28 days, and 90.1% of travel nurses successfully completed orientation.

Team 2 remained on the units to facilitate orientation of repurposed staff. Repurposed staff is defined as staff with former clinical experience in an in-patient setting but, at the time, was employed in the out-patient setting or on a low-volume unit. The training focused on educating repurposed staff to practice in designated roles on units with an influx of COVID-19 patients. It was important that the NPD practitioner designed the training experience to be efficient and completed in the shortest amount of time to meet patient demands. Staff were trained to be competent in one of five roles: critical care registered nurse (RN; 17), medical/surgical and telemetry RN (19), medical/surgical and telemetry support staff (9), emergency RN (3), and hemodialysis RN (4). A competency assessment tool with specific skills was designed and utilized for each role. For example, the Critical Care RN Competency Assessment Tool included clinical skills identified by the critical care NPD practitioner. The critical care NPD practitioner verified the skills were aligned with the scope and standards of practice and COVID-19 patient care and management recommendations by the American Association of Critical-Care Nurses (2020). Depending on the individual clinical experience of the repurposed nurse, the length of training ranged from 1 to 3 days. After the nurse was identified to be repurposed, the NPD practitioner orientated the nurse to the environment and reviewed the equipment on the unit. The amount of time the NPD practitioner spent with each nurse depended on the learning need of that nurse. The NPD practitioner was flexible and provided education in real time. The remainder of the orientation and transition time was with an assigned preceptor. The NPD practitioner followed up with the repurposed staff and the preceptor to provide any additional necessary education. A total of 52 staff were repurposed.

Team 3 functioned primarily on the units as a resource. The NPD practitioners working on the off-shift and night shift functioned primarily on this team. Their role was to ensure the frontline staff was equipped with the knowledge and skills to provide optimal care. The NPD practitioners supplied every unit with a COVID-19 resource book. They updated the resource book daily on the units with new hospital guidelines, policies, and evidence-based practice. They facilitated just-in-time training, inservices, real-time skills demonstration, and return demonstration and assisted with any call to our department. The NPD practitioners remained fluid in adapting to the needs of the nurses and the patients. Team 3 also engaged in direct patient care. Every hand on the unit was a needed one, including the NPD practitioner.

The three-team strategy became paramount as education demands grew during the peak of the pandemic. It was the backbone of our departmental structure for functioning effectively.

**TEAMWORK**

Aside from functioning in individual team roles, the NPD practitioners worked together to accomplish shared objectives. The practitioners collaborated with the Respiratory Department to film, edit, and upload videos on ventilator settings and alarms, high-flow oxygen, and bilevel positive airway pressure. The videos were uploaded to our internal intranet page for immediate staff access in real time. House-wide inservicing was accomplished on the units utilizing competency assessment tools. Inservices were completed on donning and doffing PPE for 1,142 staff and nasopharyngeal swab collection for 648 staff. Just-in-time education was provided on postmortem care for 223 staff and COVID-19 critical care patient management for 97 staff. The topics taught at the bedside included arterial line management, endotracheal tube and ventilator care, bispectral index monitoring, sedation and neuromuscular...
| Team | Team 1: New Hire and Travel Nurse Orientation | Team 2: Orientation for Current Staff to New Units | Team 3: Just-in-Time Education on the Units | Teamwork |
|------|---------------------------------------------|-----------------------------------------------|---------------------------------------------|----------|
| Education | • Nurse-sensitive indicators | • Emergency equipment | • COVID-19 resource book | • Infection control |
| | • Blood and blood product administration | • Oxygen and respirator support | • Hospital guidelines | • Donning and doffing personal protective equipment |
| | • Chemotherapy spill | • Endotracheal tube and ventilator care | • Policies | • Nasopharyngeal swabs |
| | • Medication administration | • Troubleshooting alarms | • Evidence-based practice | • Postmortem care |
| | • Pain management | • Critical care pharmacology | • New protocols | • Feeding pumps (enteral feeding) |
| | • Moderate sedation | • High-risk medications | • Updates with equipment | • Activating rapid response and the code team |
| | • Organ and tissue donation | • Blood and blood product administration | • Proning | • Electronic medical record (documentation) |
| | • Specimen labeling | • Arterial line management | • Tracheostomy care | • Patient assessment |
| | • Sepsis | • Telemetry | • Direct patient care | • Education videos |
| | • Infection control | • Venous access devices | • Ad hoc education as needed for unit structural changes |
| | • Intravenous pumps | • Bedside blood glucose management | | |
| | • Communication for patient safety | • Temperature management and troubleshooting | | |
| | • Critical thinking | • Hourly intake and output | | |
| | • Wound management and documentation | • Activities of daily living | | |
| | • Bedside blood glucose management | • Patient education and discharge teaching | | |
| | • Insulin protocol | | | |
| | • Heparin protocol | | | |
| | • Patient controlled analgesia | | | |
| | • Restraints | | | |
| | • Central line blood draw | | | |
| | • Safe patient handling | | | |
blocking agents, and peripheral nerve stimulation. Cumulatively, just-in-time education was provided for 2,110 staff members. A summary of the education conducted by each team and collectively is summarized in Table 2.

**CHALLENGES**

During the pandemic, arguably our greatest unprecedented challenge was remaining current with the rapidly changing recommendations and guidelines. Disseminating the most current recommendations to the staff during training, orientation, and inservices posed the risk of staff not retaining the information because of the abundance of education provided in a short period. This risk was mitigated by providing just-in-time education and teaching the same skill multiple times to the same staff. There were times that the NPD practitioner had to assess the circumstances and determine if the need was for education or a supportive hand. Another challenge was the NPD practitioner’s ability to be updated as quickly as protocols evolved. Streamlining the updates and latest education plans to off-shift practitioners added to the challenge. This challenge was overcome by ad hoc afternoon huddles, clear communication, and an end-of-shift handoff between practitioners. Social distancing was a challenge. Each activity the NPD practitioner planned had to follow social distancing guidelines. Orientation and training sessions were limited to a maximum of 10 individuals in a closed space setting. At times, huddles were held virtually for some members of the team to maintain adequate social distancing. Department leadership recognized the importance of identifying fears, providing flexibility, and adjusting roles to maintain NPD performance. A challenge many NPD practitioners are still facing is meeting the needs of pandemic-related stress and resiliency of nurses and healthcare providers, including themselves.

**THE HAT TRICK**

The hat trick is when a single player achieves three goals in a single game. The single player was our NPD team that achieved three goals in the COVID-19 pandemic. The three goals achieved during the pandemic were (a) onboarding new hire employees and travel nurses to meet nurse staffing needs, (b) repurposing nursing staff to support operational shifts because of supply and demand, and (c) NPD practitioner support on the units for education updates and a caring hand. By having defined teams but still remaining flexible, each NPD practitioner knew their purpose. This allowed for optimizing team performance. The NPD department and practitioners achieved the hat trick through the formation of focused, flexible, strong functioning subteams during the height of the pandemic.

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