MASTER'S THESIS

# Leaders in emergency: an analysis of leadership processes of long-term care facilities leaders during the COVID-19 pandemic in Norway

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## Declaration of oath

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## Abstract

The aim of this study was to understand the leadership behaviours and processes emerging in healthcare leaders when facing a major crisis. In particular, the following research question guided the work: "*how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis?"*

Micro-level leaders working in nursing home facilities in Norway were chosen as the study subject, and their experiences in the first months of the COVID-19 pandemic as the time period of focus. LTCF facilities faced demanding challenges especially at the beginning of the pandemic, and leadership is especially important in disruptive situations, including at the micro-level. The COVID-19 pandemic was a unique event to be studied and rich of possible insights for future learning in the healthcare sector.

14 leaders from Norwegian nursing homes participated in one-to-one interviews, which were coded and then analysed through framework analysis. Transformational leadership and sensemaking theories were used to analyse the findings. The focus was on ascertaining if transformational and sensemaking approaches emerged in the leaders in order to manage the COVID-19 crisis.

Findings showed that leaders preferred transformational approaches, centred on personal influence, openness to communication and inputs, focus on the staff's individual needs and positive performance, rather than tradeoff-based approaches. Transformational leadership traits seemed to promote sensemaking approaches, aimed at building collective understanding and narratives around the new, unforeseen emergency.

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# 1. Introduction

Since December 2019, the world has been dealing with the COVID-19 pandemic. After the first reports of a cluster of viral pneumonia cases in the Wuhan region in December 2019, the virus spread around the globe quickly, leading to a full on public health crisis and to WHO classifying it as a pandemic on March 11th, 2020. Europe has been severely hit as well: after the first case was confirmed in late January, the region became the epicentre of the pandemic in March and from there the first wave of the disease stretched into the summer and continues to this very moment (WHO, 2020).

In this scenario, the residents of long-term care facilities (LTCF), already a vulnerable population per se, have been particularly so due to COVID-19. "Coronavirus disease (COVID-19)-related deaths in LTCF residents represent 30–60% of all COVID-19 deaths in many European countries" (Danis et al., 2020, p. 1). Long term facilities include "nursing homes, skilled nursing facilities, retirement homes, assisted-living facilities, residential care homes or other facilities that take care of people requiring support who experience difficulties living independently" (Danis et al., 2020, p. 1).

## 1.1 Aim of the study

The aim of this research project was to shed light on what was done and what we can learn from the very first response to COVID-19 in the first, most vulnerable lines. That is, long term care facilities. LTCF were chosen as the main focus because of their emblematic nature, as structures particularly exposed to COVID-19 due to the vulnerability of their residents, and the importance of appropriate and timely response management.

In such centres, the first-line respondents, those taking the key decisions, were the leaders. Leaders were tasked with the challenge of managing the health crisis as well as keeping staff's morale and energies up, while also caring for the residents' well-being (Hordnes, Løland, & Bovim, 2020; McGilton et al., 2020). According to an US Institute of Medicine study, nursing management and leadership is a central factor in the provision of high-quality care (McGilton et al., 2020).Thus, investigating leadership processes of leaders in LTCF

during the peak of the first COVID-19 wave could provide valuable insights on leaders' approaches to crisis. The focus was on top-level («head administrator») and middle-level leaders (usually called «head nurse» and/ or «head of development») (Ågotnes, 2017).

Norway was chosen as the geographical focus of this research, given the similarity of its LTCF situation with other heavily hit European countries. As of May 2020 Norway, even if with lower COVID-19 incidence and related deaths compared to other European countries, reported that 61% of all COVID-19-related deaths happened in LTCF, a significant figure in line with other European States (Danis et al., 2020).

Given the above, this study wanted to answer the following research question: "*how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis?"* The COVID-19 crisis offered a unique and significant situation to analyse in order to create additional knowledge on top of the already existing literature. The literature mainly focuses on past crises or on other aspects, levels and geographies of response management in crisis: top-level managers, emergency managers by trade, public-health system level and mostly USA, Canada and China to name a few. This study wanted to take a closer look at crisis management at the micro-level, in smaller organisations, involving leaders that are not specifically trained in emergency response. The ultimate aim was to understand the leaders' processes and thoughts during the COVID-19 pandemic and learn from their insights. The previous literature was analysed and significant theories were chosen in order to provide a coherent framework of analysis to this work, which will be presented and discussed in the following chapter. In the paragraphs below, some background information on the situation is specified to better understand the context of the research, then an overview of the next chapters will follow.

## 1.2 Background of the problem

### 1.2.1 A brief overview of the Norwegian healthcare system

Norway has a universal and nationalised healthcare system. Health coverage is funded primarily by general taxes and by payroll contributions split between employers and employees. Enrolment is automatic and the covered services include primary, ambulatory,

mental health, hospital care and selected outpatient prescription drugs (Tikkanen, Osborn, Mossialos, Djordjevic, & Wharton, 2020). All inhabitants, regardless of social or economic status and geographical location have the right to equal access to services (Sperre Saunes, Karanikolos, & Sagan, 2020).

The national government is responsible for providing healthcare as well as for regulating, funding, and overseeing its provision. However, the system is semi-decentralised as the administration of care is shared with the municipalities (Tikkanen et al., 2020). Specialist care is the central government's responsibility, and it is delivered through four regional health authorities (RHAs), which own 20 hospital trusts. Primary care is delegated to municipalities, including nursing home services and long-term care. Municipalities often collaborate with counties on public health initiatives (Sperre Saunes et al., 2020).

#### 1.2.1.1 Long-term care and nursing homes in Norway

As mentioned above, organisation and provision of long-term care (LTC) in Norway is the municipalities' duty and often integrated with other local health and social services. LTC is provided in three kinds of settings: patients' homes, nursing homes and sheltered housing. Nursing homes care for residents who require a high degree of medical attention as well as help with everyday activities. Short-term rehabilitation departments can be located within some nursing homes, where for instance patients can stay after hospital discharge. Sheltered houses offer the same services as home care and are often close to the municipalities' long-term nursing homes. As a matter of fact, the distinction between nursing homes and sheltered houses is not always clear-cut (Sperre Saunes et al., 2020 ). Nursing homes in Norway can be public, private non-profit and private for-profit. Most of them consist of both long-term beds and short-term (or rehabilitation) beds (Ågotnes, 2017).

The number of management and caring staff depends on the size of each nursing home. All nursing homes have a head administrator (*enhetsleder* in Norwegian). Usually larger nursing homes have one or several middle management positions (*avdelingsleder*) placed between head administrator and unit nurse. In the same way, there are specific positions for finance and other administrative tasks in larger institutions, while smaller ones divide these tasks

between head administrator and unit nurse. The caring staff is generally made of registered nurses with minimum three years of university/college education, assistant nurses with at least a two-year secondary education and assistants without a nursing-home specific education (Ågotnes, 2017).

### 1.2.2 The COVID-19 pandemic

"The coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus" (WHO, 2021a). Most of those infected with it experience mild to moderate respiratory illness and no special treatment is needed for recovery. However, COVID-19 can lead to a serious illness for older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer (WHO, 2021a).

The disease spread quickly around the world and was declared a pandemic by WHO on March 11th, 2020 (WHO, 2020). Since its outbreak, COVID-19 has put healthcare systems to the test, as well as society, on a global scale. At the moment of writing, we are still dealing with the virus, even though the quick development of vaccines seems to give some prospects of closure.

As of June 1st, 2021, the status of the pandemic was the following:

- Number of confirmed cases: 170,363,852
- Number of reported deaths: 3,546,870 (WHO, 2021b).

#### 1.2.2.1 In Norway

The Norwegian National Institute of Public Health (NIPH) started testing for COVID-19 on January 23rd, and the first incidence was registered on February 26th, while the first death caused by COVID-19 on 12 March 2020 (Ursin, Skjesol, & Tritter, 2020).

The most important COVID-19-related regulations adopted to combat its spread during the first months included advice on hygiene routines and social distancing, limitation of gatherings and quarantining rules, limitations on travelling and public transports, closure of kindergartens, schools, colleges and universities, sport and cultural facilities as well as all

commercial activities except for grocery stores and pharmacies (Norwegian Government, 2020, cited in Christensen & Lægreid, 2020). In the following year government restrictions had been periodically tightened and loosened. Starting May 27th, 2021, a period of looser regulations started in Norway, with for example the reopening of sport and cultural venues, restaurants and bars including alcohol serving, and the loosening of limitations for number of participants in indoor and outdoor private and public events ("The next step of the reopening," 2021)

The NIPH has published daily reports since 12 March 2020. As of June 1st, 2021, cumulative figures collected since February 2020 report:

- Total people tested: 5,783,142
- Reported cases: 125,071
- Deaths: 783 (FHI, 2021).

#### 1.2.2.1 In Norwegian nursing homes

As mentioned above, nursing homes all over Europe were severely hit by the pandemic and at the vulnerable frontline of the response, with residents at high risk of both infection and severe outcomes from it.

In Norway, hospitals were given authority to cancel planned activities and reallocate beds in order to increase the number of ICU beds, while little attention to the COVID-19 response came from primary care, apart from restrictions on visits and no reallocation of work or staff. The Norwegian Directorate of Health recommended for nursing home patients to not be transferred to intensive care in hospitals because of the high mortality rates (Husebø 2020). Nursing homes were provided centralised guidelines as well as urged to develop their own response plans by central authorities, such as the NIPH and the Norwegian Health Directorate (FHI, 2020; Helsedirektoratet, 2019). The demand for personal protective equipment (PPEs), such as facemasks, gloves and face shields, was high. Many hospitals and health care facilities had very little of such equipment at the beginning of March, therefore orders and distribution were centralised to enable prioritisation of facilities with the greatest need (Helse Sør-Øst, 2020; Ursin et al., 2020).

### 1.3 Chapters overview

The answer to the research question *"how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis?"* and the processes leading to it are described in the following six chapters. The following, that is the theoretical framework chapter, provides an overview of what is already known in the extant literature and describes the two main theories chosen as a basis to my work: transformational leadership theory and sensemaking theory. Then, the research methods chapter identifies the overall setup and approach of the study, which is qualitative, and the means of research, semi-structured interviews, as well as the study sample. The fourth chapter, results, shows the data collected during the research in a systematic way. Then, the discussion of such findings in relation to the theory is in the fifth chapter. Finally, the last and sixth chapter provides an overview of the work as its conclusion.

# 2. Theoretical framework

## 2.1. Analysis of the literature on leadership in emergency management

This work's research would naturally locate itself in a theory encompassing leadership and emergency management. However, after a first review of the literature on the topic, I realised that such theory does not exist in an univocal, coherent form. Before diving into the specifics of such preparatory research on emergency management and leadership, some key terms ought to be defined.

### 2.1.1. What is emergency management?

For emergency and emergency management, the definitions provided by the US Federal Emergency Management Agency (FEMA) will be used. Emergency is "any occasion or instance- such as a hurricane, tornado, storm, flood, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, fire, explosion, nuclear accident, or any other natural or man-made catastrophe- that warrants action to save lives and to protect property, public health, and safety" (FEMA, n.d., p. 3). It follows that emergency management is defined as "the managerial function charged with creating the framework within which communities reduce vulnerability to hazards and cope with disasters" (FEMA, 2007, p. 4).

The term "crisis" often accompanies or substitutes the term emergency, even though they are not strictly interchangeable in meaning. Crisis is defined as "an unstable or crucial time or state of affairs in which a decisive change is impending. Especially : one with the distinct possibility of a highly undesirable outcome" (Merriam-Webster, n.d.). Crisis is thus the time shortly preceding emergency. Even though their interchangeability is not strictly correct, for convention the literature still uses both terms equivalently, and so this paper.

### 2.1.2. What is leadership?

This work adopts Northouse's definition of leadership. The most important aspect of such definition is that it treats leadership "as a complex process having multiple dimensions"

(Northouse, 2019, p. 32). That is, there are no static traits attributable to the leader only, but leadership is an *interactive event* occurring between a leader and the group of followers he interacts with. Thus, leadership is defined as "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2019, p. 43). Leaders, unlike popular opinion, are not "born" so: they evolve within a specific framework of motivation, values and goals (Burns, 1979). In addition to it being a process, it is important to emphasise that leadership involves:

- *Influence*, so how leaders affect followers and use power on them (Handy, 1994);
- *Groups*, where the leadership can take place. Leaders cannot exist in a vacuum, but are so when in relation to a group of followers;
- *Common goals*, that is leaders and followers have a common purpose (Northouse, 2019).

In this work, the term staff, followers and subordinates will be used interchangeably to indicate employees, those whose work is primarily directed and evaluated by the leader (Yukl, 2010). In the literature these terms are often connoted slightly differently, but such classification goes beyond the scope of this work.

#### 2.1.2.1. Leadership and management

Many authors draw a clear distinction between leadership and management. However, leadership processes do overlap significantly with managerial ones. They both involve exerting influence, working with people and achieving common goals. On the other hand, management is often qualified as primarily concerned with planning, organising, staffing, and controlling (Fayo, 1916, as cited in Northouse, 2019), while leadership is more concerned with change (Kotter, 1990).

To be effective, an organisation needs both good management and good leadership. The majority of the literature today seems to agree that in modern organisations, success in managing and administrating also involves leading (Yukl, 2010). Both such processes are fundamentally concerned with guiding a group towards set goals: "when managers are involved in influencing a group to meet its goals, they are involved in leadership. When leaders are involved in planning, organizing, staffing, and controlling, they are involved in

management" (Northouse, 2019, p. 55). In this work the focus will be on leadership rather than management. However, the two terms will be used interchangeably, following Yukl's (2010) reasoning: the terms manager and leader will be used to indicate "people occupying positions in which expected to perform a leadership role, but without any assumptions about their actual behavior or success" (p.27).

### 2.1.3. Summary of the analysed literature on the topic of crisis management in healthcare

When focusing the first explorative research and analysis on the literature about leadership in emergency management and healthcare, at a first glance the found literature presented no overarching theory or framework. Many of the available publications mainly considered the macro-level response (government, inter-organisation and/or public health system) of leaders who are specifically trained and employed in emergency management (Adini et al., 2016; Caro, 2015; Demiroz & Kapucu, 2012; Kahn & Sachs, 2018; Kapucu, 2009; Khan et al., 2018; Sell et al., 2018; Sun et al., 2018; Thompson, 2020). Moreover, their geographical focus was predominantly centred on the USA, Canada or China (Caro, 2015; Gordon, 2001; Kahn & Sachs, 2018; Khan et al., 2018; Sell et al., 2018; Sun et al., 2018). All these publications referred to the management response to a natural and/or public health disaster.

However, two aspects were found on which researchers converged in their findings. First, the crucial role of leaders at all levels in public health emergency response (Caro, 2015; Khan et al., 2018; Sell et al., 2018). Indeed, leadership (and governance) is essential public health preparedness and response (Khan et al., 2018), and the latter's efficacy is found to be tied to leadership and governance structure (Sell et al., 2018). Moreover, the examined literature emphasised the same common trends in successful leadership in emergency, which can be reflected and coherently summarised in transformational leadership theory. This theory has a particular relevance in the studies of Caro, Urby and McEntire, and Rose-Smith, all focusing on the characteristics needed in emergency management leaders (Caro, 2015; Rose-Smith, 2012; Urby & McEntire, 2015). Also other analysed publications report leadership characteristics and styles in emergency which can be traced back to transformational

leadership theory (Demiroz & Kapucu, 2012; Khan et al., 2018; Owen, 2014; Sell et al., 2018). The works of Veenema et al. and Xue et al. depart from the ones above as they focus on nurses and nursing managers, but do reach consistent results as the other studies mentioned (Veenema, Deruggiero, Losinski, & Barnett, 2017; Xue, Shu, Hayter, & Lee, 2020).

The characteristics observed about emergency leadership can be roughly summarised and categorised as encompassing:

- *personal qualities,* such as dynamism, stress management, intuitive foresight, values, decision-making, calm;
- *interpersonal qualities:* empathy, mentoring and psychological support abilities, coordination, team development, trust, communication and clarity;
- *strategic qualities:* situational awareness, flat and bottom-up structure, political skills and social competence, logistical strategizing, innovation and creativity, lead-by-example (Caro, 2015; Kahn & Sachs, 2018; Khan et al., 2018; Owen, 2016; Sell et al., 2018; Thompson, 2020; Veenema et al., 2017; Xue et al., 2020).

Such categorisation is provisional and aimed to synthetising the literature findings in a coherent manner. It provides a set of concepts which serve a double aim: first, they point to the direction of transformational leadership theory, which was thus chosen as part of the theoretical foundation of this work. It is presented in the following paragraphs. Second, these concepts will be used as a reference point to analyse the findings of this research work in the discussion part.

### 2.2. Transformational leadership

"The transforming leader looks for potential motives in followers, seeks to satisfy higher needs, and engages the full person of the follower" (Burns, 1978, p.4). Transformational leadership centres on emotions, values, ethics, standards and long-term goals. It focuses on assessing followers' motivation and their needs (Northouse, 2019). Transformational leadership is set aside from other styles by its focus on processes that change and transform people, leaders included. "It includes assessing followers' motives, satisfying their needs, and

treating them as full human beings" (Northouse, 2019, p. 263). Transformational leadership results into influencing both the relationship and the resources of those involved, increasing commitment and capacity to achieve common goals (Burns, 1978). According to Bass (1985, as cited in Northouse, 2019), such leadership style leads followers to exceed expectations by: raising their awareness on common goals, getting them to transcend their own self-interest in favour of the collective's, addressing higher-level needs.

Four factors are identified as specific to transformational leadership (Northouse, 2019):

1. Idealised influence (or charisma)
2. Inspirational motivation
3. Intellectual stimulation
4. Individualised consideration

### 2.2.1 Idealised influence (or charisma)

Transformational leaders act as strong role models, while followers want to emulate them in return. Followers usually have high degrees of trust in them and consequently share their leaders' vision and sense of mission (Northouse, 2019; Stewart, 2006).

### 2.2.2 Inspirational motivation

It describes leadership styles which are successful in clearly communicating high expectations to followers and making them follow through by increasing motivation and team spirit (Northouse, 2019; Stewart, 2006).

### 2.2.3 Intellectual stimulation

It is a characteristic of leaders who challenge their followers and their own beliefs and values as well as enable them to be creative and innovative. Such leaders usually support new approaches and innovative solutions to deal with organisational challenges and see problems in new ways (Northouse, 2019; Yukl, 2010).

### 2.2.4 Individualised consideration

Transformational leadership involves being attentive to the needs and diversity of each individual, by creating a supportive environment for followers. Constant communication and interactions are important to keep leaders up-to-date with individual concerns and necessities (Northouse, 2019; Stewart, 2006).

In his book, Yukl (2010) derives from the theories on transformational leadership a set of guidelines for leaders seeking to apply this style in their work. Such guidelines are considered a relevant summary of some actual key behaviours to observe in leaders and appraise their use of transformative methods. The guidelines are as following:

- Articulate a clear and appealing vision.
- Explain how the vision can be attained.
- Act confident and optimistic.
- Express confidence in followers.
- Use dramatic, symbolic actions to emphasize key values.
- Lead by example (p.291).

However, a critique often attributed to transformational leadership theory is that it lacks conceptual clarity and clear boundaries - the theory does not really indicate a defined set of assumptions on how it is best for leaders to act and be successful (Northouse, 2019). It can be said that transformational leadership theory provides a general direction on leadership and on *how* to act, but not on *what* to do.

Given that leadership is not a fixed state and set of attributes, but a continuous process, this study aligns with Bass' theory that transformational leadership does not exist in isolation, in a single ad hoc continuum, but in relation to other leadership styles. Specifically, transactional leadership. Transactional and transformational leadership exist on the same continuum and even if distinct, they are not mutually exclusive (Northouse, 2019). Many leadership styles can coexist in the same individual leader at the same time. Thus, defining transformational

leadership and using it to analyse and understand collected data without framing it in correspondence to transactional leadership styles would probably give an incomplete picture of reality. Therefore, a description of what characterises transactional leadership in opposition to transformational will follow.

### 2.3 Transactional leadership

Transactional leadership focuses on those leaders' tactics based on the exchanges that occur between leaders and followers. Such exchanges are meant to drive forward the leaders' and followers' agenda (Northouse, 2019). Four elements characterises transactional leadership behaviour:

1. making rewards contingent to performance;
2. correction of problems actively when problems arise (management by exception – active);
3. refraining from interrupting performance and intervening only after standards have not been met (management by exception – passive);
4. laissez-faire approach towards change in the organization (Banaszak-Holl, Nembhard, Taylor, & Bradley, 2012)

In Northouse's classification (2019) and in newest theories, the laissez-faire approach is a separate leadership approach, distinct from transactional and transformational leadership, and it is characterised as absence of leadership. However, Yang (2015) argues that laissez-faire leadership may not be the absence of leadership, but a strategic behavioral choice instead, in order to decrease followers' dependency, while increasing their self- determination, self-competence, and autonomy. Whether the laissez-faire approach is to be considered as its own leadership style or an extreme characteristic of transactional approaches, it is beyond the scope of this work.

## 2.4 Sensemaking in organisations

Sensemaking theory was deemed as a good additional theory for this framework, for two reasons. First, transformational leadership is mainly concerned with change, and so is sensemaking theory, both endogenous and exogenous. “Transformational leaders set out to empower followers and nurture them in change” (Northouse, 2019, p.280): they encourage change and guide followers in change. Sensemaking allows people to create shared meanings and narratives, so as to be able to connect to the change (Kezar, 2013) - sensemaking creates and shares meaning about change.

Second, the choice was inspired by the reading of Karl E. Weick’s work on the Mann Gulch disaster, which was found during the preliminary research on crisis management. The parallels that can be drawn between the crew trying to face a natural disaster, that is the unexpected growth of a wildfire, and healthcare leaders dealing with a never-seen-before pandemic are quite significant, even if the outcomes are divergent. The unexpected nature of the emergency, its complete disruption of expectations, the initial inability to understand it and react promptly, the lack of previous experience of it, are all elements drawn upon by Weick’s analysis which are significant also for the current COVID-19 pandemic and the healthcare sector’s response to it (Weick, 1993a). Thus, this work will draw upon sensemaking theory and some of the classic works of Weick on the topic as a relevant framework for better understanding the challenges of the COVID-19 crisis in the healthcare sector, and how leaders in LTCF coped with it.

Sensemaking is defined as “the process through which people work to understand issues of events that are novel, ambiguous, confusing or in some other way violate expectations” (Maitlis & Christianson, 2014, p. 57). It “involves turning circumstances into a situation that is comprehended explicitly in words and that serves as a springboard for action” (Taylor & Van Every, 2000, as cited in Maitlis & Christianson, 2014, p. 81). In his 1993 paper, Weick contrasts sensemaking versus decision-making. As the latter is characterised by strategic rationality attempting to remove ignorance (Daft & Macintosh, 1981), sensemaking is about contextual rationality. “It is built out of vague questions, muddy answers, and negotiated agreements that attempt to reduce confusion” (Weick, 1993a, p. 635).

There is no single, unitary theory of sensemaking. This work adopts the definitions of the part of the literature which emphasizes its ongoing nature: that is, sensemaking as a continuous process of social construction (Berger & Luckmann, 1971). Such process aims at creating an intersubjective meaning of new, disruptive situations, through interpretation and explanation of the cues present in the environment, typically during a situation of change. Thus, sensemaking occurs in the individual as well as in groups (Maitlis & Christianson, 2014) and it is a fundamental activity within organisations.

Sensemaking is triggered by events that are ambiguous and with uncertain outcomes. They disrupt people's understanding of the world and often lead to uncertainty on how to act in response. The COVID-19 crisis, which is at the centre of our analysis, is an external, environmental shock, a category which has been the object of sensemaking analyses since its earliest days (Maitlis & Christianson, 2014).

Weick identified seven specific characteristics of sensemaking processes:

- *ongoing:* its continuous nature, through feedback processes between the individuals and the environment they interact with;
- *retrospection*, as "remembering and looking back are primary source of meaning" (Weick, 1993b, p. 17);
- its *social* nature;
- extraction of *cues* from the environment, to build narratives through comparison, expectations, interpretations;
- its focus on *identity* as context to action and frame of reference to work from;
- *enactment*, that is taking action and producing structures and opportunities that were not present beforehand;
- *plausibility* over accuracy (Weber & Glynn, 2006; Weick, 1988, 1993b, 2005).

Some of such characteristics will be addressed more in depth in the following paragraphs.

Central to sensemaking is the construction and attribution of meaning to a new condition. Such process takes place both at the individual and the collective level. In the first case, individuals advocate for a particular view and try to influence others to build a shared, collective understanding. When the process unfolds between individuals, mutual engagement

around a joint issue builds intersubjective understanding (Maitlis & Christianson, 2014). Sociability is  a pillar to sensemaking. It has been observed that in crisis, even when stakeholders act following the "golden triangle" of trust, self-respect and honesty, if social support is lacking, efforts are compromised (Weick, 1993a).

Communication and taking action are the processes that help building such intersubjective meanings. Through discussion, managers use language to share perceptions and intuitions to gradually define or create meaning (Weick, 1995).  Building narratives and metaphors helps create order in unfamiliar situations. In his 1993 analysis of the Mann Gulch disaster, Weick reaches the conclusion that lack of communication is often a key element in crisis degenerating in disasters (Weick, 1993a).

On the other hand, action has a key role in sensemaking as it both enables stakeholders to test their previous sensemaking, as well as providing new sensemaking inputs through understanding the new cues generated by that action. However, it is not possible to know for certain which action is the most appropriate to take until it is actually taken, and consequences are assessed. Actions determine the situation, to the point that actions fundamentally influence the trajectory of crises. In a crisis, taking action can be a risk, but it is also a means of acquiring feedback, learning and understanding unknown situations – reluctance to act can lead to more confusion and mistakes (Weick, 1988).

Finally, who shapes sensemaking in organisations? The literature agrees that leaders have a key role in it, together with organisational stakeholders. It has been found that leaders influence the form of sensemaking process adopted in the organisation to various degrees in how they share such influence with staff and other stakeholders Maitlis & Christianson, 2014).

Given the above, I expected the data collected to be in line with the previous literature and with transformational and sensemaking theories. In particular, I presumed leaders to have adopted transformational approaches and perhaps also behaviours ascribable to sensemaking processes. Such expectations were guided not only by the previous empirical findings in the analysed literature, but also by the content and context of the theories presented above.

Indeed, they are both strongly concerned with change management at a leadership and organisational level.

# 3. Research methods

## 3.1 Methodological approach

Given the complexity of the research questions, which aims at describing and understanding a multi-faceted, new and still occurring situation, a qualitative approach was deemed as the most appropriate to use for this work. Indeed, "the main focus in qualitative research is to understand, explain, explore, discover and clarify situations, feelings, perceptions, attitudes, values, beliefs and experiences of a group of people" (Kumar, 2011, p. 82). That is the exact aim outlined by the research questions at the basis of this work: to collect and analyse experiences.

## 3.2 Study design

The following is a descriptive-interpretive study. As a matter of fact, the study is guided by open-ended, exploratory research questions, funded on collection of verbally reported experiences or observations. To understand their meaning and value to the field, such observations were systematically analyzed and organized in conceptual frameworks within a coherent narrative, in order to come to a descriptive-interpretative understanding of them (Elliott & Timulak, 2021). The interpretive approach aims at understanding human behaviour and the world, from the point of view of the participants in it (Green & Thorogood, 2004).

### 3.2.1 Data collection

Data were collected through semi-structured interviews with top and middle-managers in Norwegian nursing homes. Semi-structured interviews allow the participants to develop their own, in-depth narrative and emphasize the themes most relevant to them, with the researcher following mainly the participants' input as well as his/her own agenda in terms of topics to be covered. Such type of interview gives a loose structure, which helps the interviewer to not lose sight of the research objectives, as well as the interviewee to stir the conversation around the most important of the information produced (Green & Thorogood, 2004).

Due to the COVID-19 pandemic, the restrictions mandated by the Norwegian government and the necessity to keep healthcare personnel safe, interviews were held digitally, using common video conferencing programmes such as Zoom and Google Meet. The meetings were voice-recorded, provided previous consent by the participants (see next paragraphs for more details on privacy treatment and appendix II and III). Each meeting lasted between 25 and 40 minutes.

### 3.2.2 Sample description

The study sample is constituted by nursing home leaders in Norwegian municipalities, selected according to their level of leadership in the organisation (middle- and top-management). Participants were recruited by obtaining the permission of the municipality of employment, then contacted through the information provided by the municipalities. 11 municipalities (in Norwegian, *kommune*) in Norway were contacted to take part. Of these, two municipalities in different areas of Norway agreed to participate. It is important to point out that in Norway a *kommune*, translated into English as municipality, can include different villages and towns. In the study, one municipality encloses a large urban area in Norway, the other is more rural and medium-sized. The sample size was not predetermined, but it responded to saturation criteria as well as response rate and availability. A total of 14 subjects offered to participate and were interviewed.

Treatment of personal data is in compliance with NSD (Norwegian Centre for Research Data) guidelines, which granted ethical approval to the project's privacy treatment protocol before its start (see appendix II). Participants' consent to treatment of personal data were collected through NSD-approved consent forms (attached in appendix III) and they were asked for consent to voice-record conversations beforehand, as well as informed of their right of withdrawal from the project at any time.

### 3.2.3 Limitations of the study

The main limitation of the study arose from the likely limited availability of respondents, given that the COVID-19 pandemic was still not over at the time of the study and workload was considerable in nursing homes.

Moreover, language and cross-cultural barriers were considered. Language is key to qualitative research work, as it is a means not only to collect facts, but also a window on how the subject perceives the world and the phenomena the researcher tries to get better insight on (Green & Thorogood, 2004). The participants were asked to be interviewed in English. The choice was made as the author is more fluent in the English language than in Norwegian, and considering that Norway has high English fluency levels (EF, 2020). This choice could have constituted a barrier to fluency and delivery of more complex concepts. This aspect was highly dependent on the proficiency level of the interviewee, but it is also likely that only proficient English speakers responded to the interview request in the first place. However, after recurring remarks of participants' on the hardships of expressing themselves in their non-native language, as well as the keen interests of some leaders to be interviewed, but in Norwegian, it was decided to proceed with the last seven interviews completely in Norwegian. This resulted in allowing participants to express themselves in their native language, lifting the barriers stemming from the use of English. However, given that the interviewer was not as proficient in Norwegian as in English, this constituted a barrier in return – tied to the lack of full understanding of nuances of language and of local expressions. However, such trade-off (more comfortable interviewees versus lessened language proficiency and versatility of the interviewer) was evaluated and deemed to be worth the results, given that more people accepted to take part in the study and could use a language they were more familiar with.

Other limitations of the study could have been recall bias and self-report, or social desirability, bias. As for recall bias, participants were asked to recall events, thoughts and feelings from one year prior, which could have led to problems remembering accurately. Indeed, some participants remarked that some details were hard to recall (Green & Thorogood, 2004). With regards to self-report bias, interviewees were asked to describe

themselves, their own work and relationships within their job environment during a difficult time, which did not lack controversies and criticism towards healthcare personnel too. Even though the study is not evaluative and this aspect was emphasised to the participants, it is natural for people to desire to appear "as a morally worthy person to the interviewer" (Green & Thorogood, 2004, p. 82). So, it must be considered that participants might have responded dishonestly to conform to expectations and to be positively perceived.
However, such limitations are intrinsic in the mode of research used and considered throughout the whole research process. Given the complexity of the subject and the focus of the analysis on elements such as personal interpretations, emotions and narratives, no other modality but interviews seemed more appropriate to fully capture the research subject. Other methods would have likely limited the possibility of expression of the subject, and also not have had the possibility to ask follow-up and clarification questions when needed. Moreover, the self-report bias could have been partly mitigated by the anonymisation processes adopted to secure the participants' privacy, of which the participants were informed.

### 3.3 How was the data analysed?

Framework analysis was considered as the most appropriate approach to analyse the collected data. Framework analysis is a common methodology in the field of qualitative research. It provides a systematic structure "to manage, analyse and identify themes, and is particularly useful with large volumes of text based data" (Hackett & Strickland, 2019, p. 6), which is the case of this research work. More specifically, framework analysis is "a content analysis method which involves summarising and classifying data within a thematic framework" (National Centre for Social Research, as cited in Green & Thorogood, 2004, p. 184). This approach has been selected also because of its relative adaptability, and the possibility to use a combination of both deductive and inductive approach, as the project relies on specific issues and theories to explore but also requires to leave space for discovering and explore the unexpected in the participants' narratives and meaning they gave to the phenomena (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Framework analysis consists of several steps – the first one is *familiarisation* with the material. That is, listening to recording and re-reading transcriptions to deepen the knowledge

of the data. This is followed by *thematic analysis* and the development of a coding scheme to classify data. The third step is the one of *indexing*, that is applying such codes to the whole data set. Then, *charting* allows for summarising and comparing data by rearranging data according to theme. The final stage involves finding the relationships between the codes by use of diagrams and tables (*mapping and interpretation*) (Green & Thorogood, 2004).

# 4. Results

## 4.1 Overview of organisational themes

The aim of the research work underlying this thesis is to find, analyse and explore those behaviours and characteristics which emerged in LTCF leaders during the COVID-19 pandemic, especially in the light of the available literature and theories on transformational leadership and sensemaking. The work of coding, analysis, theme formulation and mapping carried out on the collected material is presented in the following chapter in a schematic manner, through tables and maps, as well as with written explanations of the reasoning underneath the classification of data in different themes and subthemes. Selected transcribed quotations from the participants are also reported for better exemplification. Quotations were selected for inclusion on the basis of how well they highlighted the common themes generated through the recorded data. The main, organising themes that were identified, which reply to the question *"how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis?"*, are :

- Information and communication;
- Cooperation;
- Sensemaking;
- Relationship with staff;
- Creativity;
- Learning;
- Strategy;
- Personal leadership traits.

For those themes, some basic sub-themes were identified as particularly stressed by the participants in the data. Such structure is better understood in the form of a network map, showing the first two levels of themes developed:

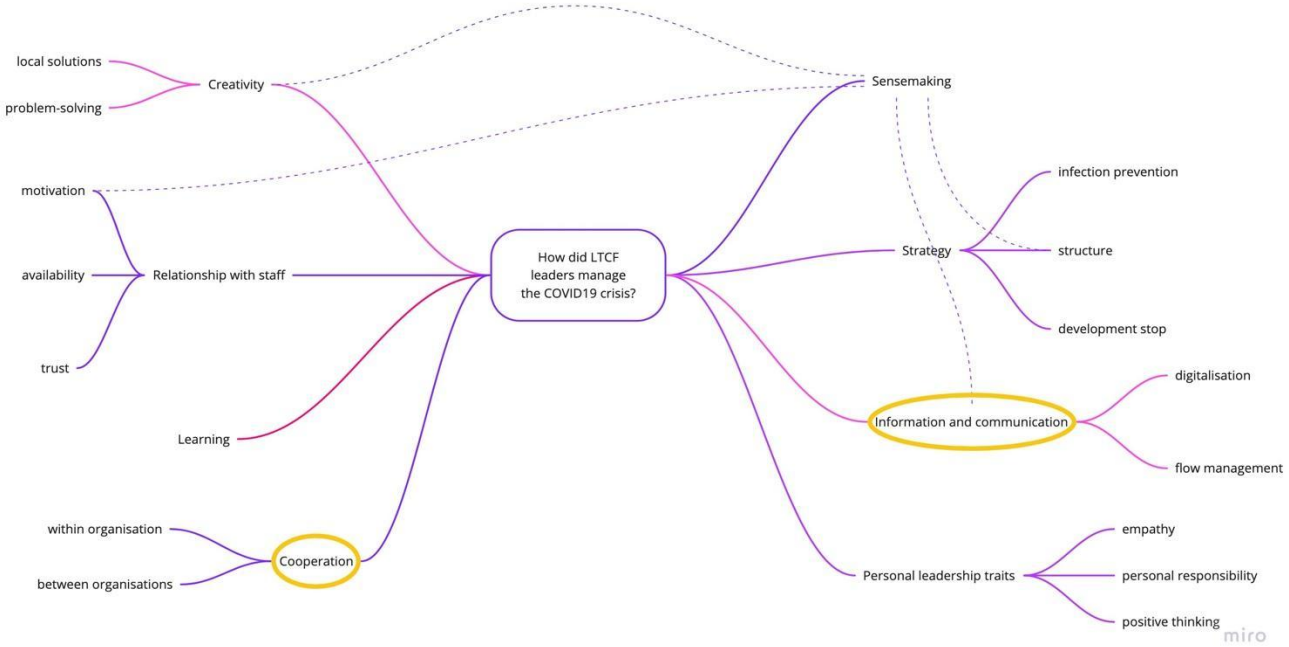


*Figure 1: Network map with organising and basic themes.*

Figure 1 illustrates the main organisational themes and relative basic themes, which will be examined in the following paragraphs. The map also graphically shows two elements which emerged from the analysis of the data, and which are important to specify before delving into them in more detail.

1. The two yellow circles emphasise the themes of *cooperation* and *information and communication*. These themes are particularly important for our following discussion because they emerged as pervasive and all-encompassing. They are stand-alone categories of data, yet respondents signal how they are the foundational stone for any other element of crisis leadership. Thus, the yellow markings seemed appropriate to set those two themes aside from the other six.
2. The dotted lines represent the links between sensemaking and creativity, motivation, communication and structure. All the themes and subthemes are indeed connected, and such connections will be explored in the discussion part of this work, but the link between those categories emerged as very evident in the data, thus the need to show it on the main network map.

## 4.2 Presentation of main themes

In the following, the main themes will be broken down and some quotations from the transcribed interviews will be provided as examples. For an overview of every theme and sub-theme, or a more thorough list of various examples for each mentioned theme and code, please refer to figure 2 at the end of this chapter, and table 1 in appendix I.

### 4.2.1 Information and communication

The main focus of all the respondents' was communication, and how to convey the massive flow of information they were receiving on a daily basis to their staff as well as within the leader group. Their responses gravitate mainly around:

- (information) *flow management*;
- *digitalisation.*

All the leaders interviewed were struggling with managing the amount of information they were receiving. Especially, many were grappling with *uncertainty:*

> *"One day remember, 9 o'clock, I came rushing to my employees: we have to use gloves in every occasion! At 11 o'clock, I rush into my employees, don't use that many gloves! At 1 o'clock, sometimes we have to use gloves! So it was very frustrating to always change direction"* (lines 41-44, participant E)

The other concern related to *modality and frequency* for conveying such information. The respondents emphasised the need to give information fast and in an accessible manner. Many and frequent meetings were organised, either in person or through other options.

> *"I understood that the most important things for me to do was to give the staff here good information. If they had information, they could do almost everything."* (lines 31-34, B)

> *"And also this with being precise in communication, that is information, information,*

*information. It's really a very simple thing, but I think we're constantly forgetting how important information is."* (lines 159-161, I)

In addition *digital communication*, massively introduced in work life by the COVID-19 pandemic, occupied a key role in the reflections of all the study participants. Digitalisation was considered both as an *advantage*:

*"(digital communication) It is very useful, for instance for part of the meetings one saves time by not having to travel. You can actually have several meetings and meeting points, and you still save time. You are in a way protected from infection and yet you get to meet people. So I think it's been great."* (lines 164-167, M)

As well as an obstacle to the leaders' work during the crisis:

*"the reflections you get when you sit in a group and you have a physical meeting, all the new technology can't replace that."* (lines 99-100, H)

### 4.2.2 Cooperation

Another recurring pattern was cooperation, both *within the organisation* as well as *between organisations.* The first is very significant, as all leaders have signalled in their responses how *teamwork* is essential for any other tasks within the organisation, and of course for crisis management. Without a strong team, an effective response would not have been possible.

*"I have staff that is hardworking and they step up if we need them to. In Norwegian we call it dugnad [...] I think everybody felt this dugnadsånd, if something happens we will be there and we will participate and we will stand up for our patients and for our colleagues."* (lines 156-157 and 162-164, G)

*Dugnad* is a very important concept in Norwegian society, which can be translated in English as "voluntary work, service" (and *dugnadsånd* as "spirit of service").

Such cooperation was also characterised by the *flat structure* in which leaders said they work in, and which they leveraged during the crisis:

> *"I am not that kind of leader who has a top-down attitude, I have been concerned with being inclusive and working together on it (the pandemic). It is not the case that I sit in the office, it is also those who know how it is in practice."* (lines 87-89, L)

The cooperation *between organisations* does not emerge as relevant as organisational teamwork, however it is a recurring theme among several leaders:

> *"Also many nursing homes have already contracted the infection, and they have shared their experiences with us about what is the right thing to do."* (lines 147-148, P)

#### 4.2.3 Sensemaking

This theme groups together those instances in which the respondents emphasised the group effort required to analyse, understand the situation and take action, in spite of limited information. The term sensemaking has a broader meaning which could potentially include some elements of other organisational themes, but it has been limited to facilitate clearer classification. However, such links are not ignored, and will be explored in the following chapter.

As a matter of fact, many leaders emphasised how, when faced with uncertain information and need to communicate and understand it, they had to group together with colleagues, discuss, create a narrative and assign meaning to the situation:

> *"we had to walk things through because, a recommendation could be ... different colours, and how we understand it, so we have to have a lot of discussion what does this really mean what does it mean for us, and how do we communicate it for people."* (lines 47-49, A)

*"the questions that have come up, we have raised together, so that we have landed them together. So that we could go out with the same information and be able to act as similarly as possible in terms of concerns"* (lines 102-106, L)

### 4.2.4 Relationship with staff

The main recurring theme of all interviews was how leaders described and valued their relationship with their staff, at the time of the crisis as well as on a more general level. Indeed, a leader's work is mainly concerned with staff management. In particular, the participants narrated their relationship with staff according to three main sub-themes:

- *motivation;*
- *availability;*
- *trust.*

During the COVID-19 pandemic, keeping focus and motivation was key. Leaders did so especially by providing *praise*, as well as focusing on the reassurance of *small things* and rituals. In addition, they fuelled the *sense of belonging* to a group on a specific mission.

*"And the way I think I can motivate them in everyday life is to praise, and see the good things that they do, and support them when they need it."* (lines 80-81, N)

*"we talked a lot about the pride that we have in doing something important."* (line 64, O)

Leaders also reported their primary concern with being *available* and present for the staff, even if it hindered their work day and lead to long hours. In particular, some leaders expressed that during the crisis they *focused* a lot *on the individual staff members*.

*"The main thing in that period of time was that my employees knew that I was available for questions 24/7."* (lines 31-32, E)

*“(I think it is important) to pay really attention, as a leader in a crisis, to the individual as a whole,  more empathy."* (lines 200-201, C)

Finally, *trust* emerged as a basic requirement in the leaders’ relationship with their staff no matter which situation, but especially in a crisis. Many leaders mentioned it explicitly.

*"what is important to act well in a crisis is to have a good foundation, with good cooperation and good relations, to stand together. And trust  in each other, help each other"* (lines 157-159, I)

### 4.2.5 Creativity

The crisis that the interviewed leaders had to face was unprecedented. New problems require new solutions and creative thinking, and this is a recurring theme in the interviews. Leaders and staff, according to the participants, showed *problem solving* and especially focused on *local solutions*, that is institution-specific.

*"we have also learnt the necessity of quickly make our local variants of routines."* (lines 127-128, E)

*“At the beginning we didn’t have enough of the equipment we needed, that was for the whole city, but the staff found other solutions, why don’t we do like this and we can try... Yeah I think they were innovative and found solutions."* (lines 140-143, G)

### 4.2.6 Learning

Several leaders remarked how impressive and important *learning*, especially if fast, has been. This includes learning from experiences, training sessions, others, etc. Learning is characterised both as an instrument used for navigating the COVID-19 pandemic, as well as for acquiring skill to better deal with future crises, or just everyday work tasks in a more efficient manner.

*"I think that all the leaders and all the employees have become a lot more skilful on the pc and the computer meetings, skills that we will take with us afterwards"* (lines 151-153, A)

*"Fortunately, all our patients are vaccinated, but I notice that all the routines have been incorporated now, so after such a long time, we are experienced, we have clear messages and everything is much clearer now."* (lines 123-125, F)

### 4.2.7 Strategy

Several interviewees expressed shared objectives and described similar tactics and strategies aimed at containing the crisis. First, all leaders reported that *infection prevention* was at the core of their actions and decisions.

*"my main focus was to avoid to get this virus inside [...] our institution"* (lines 59-60, A)

*"we thought of course infection control was first and foremost"* (line 20, N)

Aside from preventing the actual infections, many participants reported their use of *structure* for their response. Structure was ensured especially through *planning*, which some leaders emphasised as the first thing they did when the crisis began, and *role assignment*, perceived as a safety in a highly uncertain situation.

*"the first thing  I was thinking about was to make a plan, crisis leadership plan, so we made that so we could put in every day new decisions that we make and I was very opptatt (concerned) on this plan"* (lines 29-31, B)

Finally, a part of such strategic focus on infection prevention and on the immediate demands of the crisis, was that any other plan or project was set aside. Leaders mention it as a necessity, as well as a source of frustration, since the desire of many is to move on and distance themselves from the COVID-19 pandemic.

*"(the pandemic) it has meant that we have had to put other work aside. When we focus on one thing, we become good at it, but we become less good at what we do not focus on."* (lines 119-121, L)

### 4.2.8 Personal leadership traits

Many leaders were hesitant to talk about themselves and their leadership styles. However, three specific *personal leadership traits* emerged in several conversations when interviewees were asked about their personal thoughts and leadership approaches during the pandemic. Many leaders stressed their *positive thinking* attitudes as well as their use of *empathy* when interacting with staff and colleagues.

*"Now we can control it, it gives us more room to focus on the patient and use our time with our work. So it was very important to find the bright side of the new routines always."* (lines 111-112, E)

*"You have to be close, physically as well. [...] we chose to be present. And I notice that employees appreciate, even if it is recommended home office and such, it is important to be present"* (lines 50-52, F)

One very interesting point, which is part of many of the interviewees' narratives, is the emphasis on *personal responsibility*, as the will of leaders to step up, take on the challenges which are part of their job, and protect employees. In some instances of the literature this tendency is called *heroic leadership,* that is hiding one's weaknesses to be a model to employees and shield them from extra stress. However, other leaders have also emphasised the need to be open about one's insecurities and show vulnerability.

*"I've never said or shown my employees that I was stressed, sometimes also afraid. But I told them if that happens we go like this, if that happens we go like that, we have a plan."* (lines 99-102, C)

*"One has to put on a mask and act calmer than you really are"* (lines 83-84, O)

*"I've learnt that it's ok to be worried, it's ok to talk about my feelings as well to my staff, so they see that I'm not a "over person", I'm also insecure, that we together can find solutions."* (lines 146-148, D)

### 4.3 Summarising map

The results described above are developed around eight main themes, some of which present one or two extra layers of basic themes and codes. To make understanding easier, they are graphically represented in the network map in the next page.

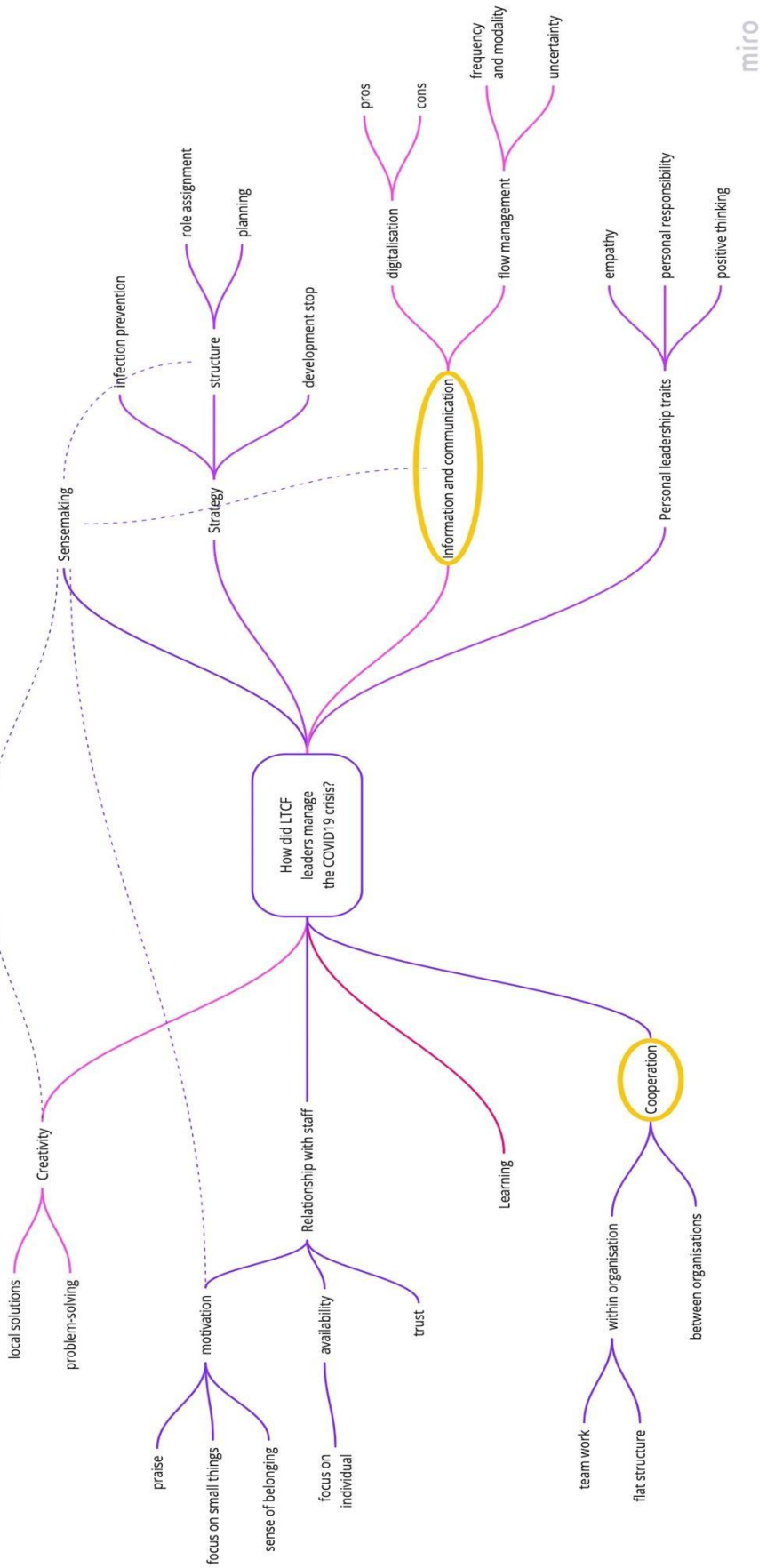


*Figure 2: Summarising network map.*

# 5. Discussion

This chapter continues with a discussion on the main findings presented in the previous section. In particular, results were analysed using the theoretical framework and the relevant literature presented in the second chapter. Such analysis was carried out in the light of the research question at the basis of this work: *"how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis? "*

Overall, the findings provide an answer to the research question which is in line with the analysed literature and the chosen theoretical framework, as well as my own expectations. The interviewed micro-level leaders who are not emergency response professionals showed similar approaches and behaviours as the high-level, crisis response-trained leaders analysed by the previous literature. Such approaches were matching for the most part to transformational and sensemaking ones, with some unexpected or divergent results, which will be addressed in the relevant paragraphs.

This chapter is structured around the two main theories chosen as framework, transformational leadership theory and sensemaking theories.

## 5.1. Transformational and transactional leadership

The interviewed leaders' reports on their reactions to the COVID-19 pandemic present distinct references to transformational leadership theory. In general, the leaders were focusing mostly on their staff, their individual needs, how to communicate with them effectively and on how to foster group work. The needs of each individual worker were a priority for the leaders also during the crisis time, so as to enable them to push towards the higher, urgent needs of the pandemic. As a matter of fact, transformational leadership centres on emotions, values, ethics, standards and long-term goals. It focuses on followers as all-around individuals and on assessing their motivation and needs especially (Northouse, 2019).

Transformational leaders are also described as future-oriented, with long-term goals and focus on high-level needs (Bass, 1985, as cited in Northouse, 2019). However respondents needed to set their focus on short-term, immediate needs and objectives linked to preventing infection spread in their institutions. This was dictated by urgency and necessity, and some leaders indeed complained about how the pandemic put a stop to any other type of development and focus. Such focus on practical demands can be reconducted to a more transactional approach, but the boundaries between the two leadership styles are very nuanced.

Transformational leadership theory is built around four core principles:

### 5.1.1 Idealised influence (or charisma)

> *"Idealized influence describes leaders who act as strong role models for followers; followers identify with these leaders and want very much to emulate them. These leaders usually have very high standards of moral and ethical conduct and can be counted on to do the right thing."* (Northouse, 2019, p. 270)

All the interviewed leaders, in different ways, expressed how they calibrated their behaviour and leadership style in order to provide guidance and support to their followers during the COVID-19 pandemic. First, they all emphasised how frequent and precise communication, paired with strong planning, was at the centre of their concerns in order to reach out to employees, maintain their trust and empower them, and show them that their leaders were actively engaged in the response.

Within the leaders' responses there are many parts linked to the sphere of *influence,* but the *idealised* element is more elusive. Many leaders emphasised that they did not act top-down: while roles were still clear-cut, the overall sentiment was that leaders and staff acted together and leaders were involved in the daily work. The sentiment of personal responsibility for their role and actions was strong, but being a role model "with very high standards of moral and ethical conduct" meant different things to different people (Northouse, 2019, p. 270). Some leaders showed indeed a tendency towards "heroic leadership", as they avoided

showing to their staff their feelings of confusion, anxiety and fear. One leader explicitly mentioned it as “wearing a mask”, to hide one’s weaknesses and be a model to employees while shielding them from extra stress. “Transformational leaders can use idealised influence to portray a leader who is not panicking. A leader who is concerned but calm, who is decisive but not impulsive, and who is clearly in charge can inspire the confidence and trust of followers” (Bass & Riggio, 2006, p. 57). However, other leaders shared that, sometimes after struggling with such a need to deal with everything alone, they realised the need to involve the staff and open up about their feelings. Such openness was seen as part of fostering mutual trust and teamwork.

### 5.1.2 Inspirational motivation

> *“This factor is descriptive of leaders who communicate high expectations to followers, inspiring them through motivation to become committed to and a part of the shared vision in the organization. In practice, leaders use symbols and emotional appeals to focus group members’ efforts to achieve more than they would in their own self-interest. Team spirit is enhanced by this type of leadership.”* (Northouse, 2019, p. 271)

When solicited about keeping motivation during the crisis, many leaders did mention team spirit. Belonging to the same group, going through a hard time together while also doing something vital for society as a whole, not only the single institutions, was a leverage for leaders in order to keep spirits and productivity up. As part of those symbols and emotional appeals mentioned in Northouse, it emerged that leaders resorted to “small things” to connect with staff. That consisted of preparing food and sharing it together, showing up for small, daily activities and making time for small talk and everyday problems. It is possible that, within such extraordinary times, leaders and staff were seeking out for normality and routine.

The interviewed leaders did not emphasise having and/or communicating high expectations to their followers. It emerged that the focus was more on positive feedback and great value placed on good work.

### 5.1.3 Intellectual stimulation

> *"This type of leadership supports followers as they try new approaches and develop innovative ways of dealing with organizational issues. It encourages followers to think things out on their own and engage in careful problem solving."* (Northouse, 2019, p.272)

Many leaders did mention creativity and problem-solving, especially coming from the staff's side, as central to the pandemic response. In uncertainty and lack of resources (both material as well as informational), leaders and staff joined forces to adapt government guidelines to their institutions, deal with PPEs shortages, and use the new routines as inspiration to improve workflow also for non-emergency times. New skills were learned and many respondents believe they will persist in the future (for example the massive push towards digitalisation).

However, more than being active "agents of change", leaders described themselves as "passive enablers" - leaders made sure to create trusting and safe spaces and forums where staff could come up with input and new ideas independently.

### 5.1.4 Individualised consideration

> *"This factor is representative of leaders who provide a supportive climate in which they listen carefully to the individual needs of followers. Leaders act as coaches and advisers while trying to assist followers in becoming fully actualized."* (Northouse, 2019, p.272)

Many leaders emphasised in their responses how focused they were on the staff and the single individuals, everyday as well as in crisis. Many leaders expressed their engagement in checking regularly on each employee, getting to know them and sparing time for addressing the challenges they were facing during the pandemic. Therefore, frequent communication was key to achieve such an objective - frequent communication is indeed key in individual consideration (Northouse, 2019; Stewart, 2006). However, some leaders did complain about

the physical distancing and home office as a barrier to that, as digital means reduced small talk and limited body language understanding.

Also the conscious focus on keeping a flat structure and setting aside time (often outside working hours) for meeting and/or talking with employees apparently allowed leaders to be as available as they could and give staff individual consideration. Such availability seemed to be especially of the emotional kind, with leaders supporting staff as well as fellow leaders throughout the most demanding times, discussing complex feelings such as guilt and fear, and exercising empathy.

As mentioned above, transactional approaches seemed to have emerged solely with regards to the immediate needs created by the pandemic. That is, the need of preventing infection and of preparedness in case of actual infection into the institution. This reflects the "two-factor theory", where transformational leadership builds on transactional: the latter deals with the basic needs within the organisation, while the first aims at higher needs and lasting change (Avolio & Bass, 2002). Also, it had to be noted that according to the theory presented in the dedicated chapter, transactional and transformational leadership do exist on the same continuum, and they are not easily distinguishable from one another (Northouse, 2019).

### 5.2 Sensemaking

The choice of sensemaking theories as a framework for this work seemed appropriate as it includes theories on how people in organisations rationalise and respond to events that are ambiguous and with uncertain outcomes (as the COVID-19 pandemic). I deemed it interesting to use at least part of this very vast set of theories to see if it can shed more light on crisis responses within healthcare management.

The data are pervaded with mentions to sensemaking processes. The interviewing process could be classified as a sensemaking attempt as well. Indeed, sensemaking is a social, ongoing and retrospective process (Weber & Glynn, 2006; Weick, 1988, 1993b, 2005). By looking back at their actions, thought processes and feelings one year from the beginning of

the pandemic, leaders had to build a narrative around their experiences in order to communicate them to an external person, the researcher.

To delineate what elements of sensemaking emerged during data collection, Weick's seven characteristics of organisational sensemaking were used (Weber & Glynn, 2006; Weick, 1988, 1993, 2005):

- As anticipated by the theory, all the leaders mentioned processes involving discussion, speculation and brainstorming about the pandemic situation and the necessary measures which always involved some level of *sociability*. Some leaders even suggested that, after a period of trying to solve problems independently, they realised they needed their staff as a counterpart. Indeed, sociability is a pillar to sensemaking (Weick, 1993a). This was enabled by the attention of leaders towards creating possibilities for frequent and open communication.

- Continuous communication allowed also for extracting *cues* from the environment, through comparison, expectations, interpretations. Leaders exchanged ideas with leaders above and below them, sought advice from other institutions and staff, interpreted and adjusted guidelines.

- Appealing to *identity* as a source of structure and motivation was a tactic often mentioned by leaders when asked about their strategies to maintain a positive staff morale. In the previous chapter it was also mentioned that the theme of structure found within the data was linked to sensemaking, which in turn can be linked to the identity aspect of sensemaking. Respondents put a lot of stress on the effort used on clarity in defining new roles and procedures, in order to ensure that everyone was on the same page. Indeed, if we take Weick's 1993 Mann Gulch disaster analysis paper, it is interesting to note that the lack of structure and the loss of the group's role system lead to its downfall (Weick, 1993a).

- Many leaders navigated the measures to take together with colleagues and staff through testing new solutions, adapting guidelines, and revising their routines. This is defined in sensemaking theory as *enactment*, that is taking action and producing structures and opportunities that were not present beforehand. Indeed, "Action and

cognition are [...] recursively linked: action serves as fodder for new sensemaking, while simultaneously providing feedback about the sense that has already been made" (Maitlis & Christianson, 2014, p. 84). Another aspect of enactment is learning: many leaders placed value on the lessons learned during the pandemic, both for the immediate and the far future. Sensemaking is indeed critical for learning from error (Maitlis & Christianson, 2014).

- The use of *plausibility* over accuracy - given the uncertainty leaders had to navigate, often they were faced with having to give answers they did not have, improvise and make adjustments as time went by. Sensemaking, according to Weick, is a compromise between confusion and rationality, resulting in "vague questions and muddy answers" (Weick, 1993a, p.636). However, it is to note that while many leaders did indeed compromise with not having "all the answers", also many mentioned accurate planning, which probably provided the limits of such improvisation.

In particular, given what emerged in the results, the part of sensemaking theory focusing on the use of *language and narratives* appears to be the most relevant for the analysis. As already mentioned above, communication was a pillar in crisis response according to leaders. The creation of shared narratives is even equated to sensemaking itself by some researchers (Maitlis & Christianson, 2014). Leaders described themselves the situation has highly uncertain and with different implications for different people, as they needed to see "the different colours" of recommendations and had "a lot of discussion what does this really mean what does it mean for us, and how do we communicate it for people" (interview A, lines 47 - 49).

However, it could be interesting in further research to investigate how the relatively new digitalisation trend, which gained huge momentum during the pandemic, could have influenced the building of narratives, since the means of communication were hugely impacted by it. Many leaders had to shift towards using mainly communication via SMS or online conferencing systems, especially in the very first weeks of the pandemic. It was surprising how many leaders stressed the role of digitalisation and its effects in their

accounts. Many reported aspects such as increased availability, immediateness, the greater possibility of misinterpretation and the lack of body language and small talk, as influencing the quality of communication both for the better and for the worst.

### 5.3 Crossovers between transformational and sensemaking theory

By reading the lines above, it is likely that the reader noticed how overlapping and similar transformational leadership and sensemaking principles are. They both rely on communication processes, staff/stakeholders focus, identity building and role assignment, creative action and improvisation. Sensemaking is built on communication and collaboration with others to build shared meaning and embrace change, and transformational leaders are as such when focusing on individual collaborators and their growth to promote and navigate change. Both transformational and sensemaking approaches seem to emerge in proving, disrupting times for organisations.

The data and their analysis seem to suggest that the characteristics of a transformational leader (idealised influence, inspirational motivation, intellectual stimulation, individualised consideration) are a fitting springboard for sensemaking processes in crisis. The availability for dialogue, openness to the frequent input of staff, attention to praise and individual needs, consciousness on identity and roles, offer a basis for the cooperation and trust needed for construction of narratives and meaning, as crises ask of sensemaking leaders. The two processes support and nurture each other in demanding leadership situations. Moreover, an interesting implication would be that since transformational leadership theory is more concerned with the *how* of crisis management (cf. chapter 2, page 18), sensemaking can supplement what transformational theory lacks, that is in explaining *what* can be done and achieved during a crisis. That is, transformational approaches could be a premise for sensemaking objectives to happen, which are aimed at understanding new situations, building and sharing collective meaning.

### 5.4 Summary of key takeaways and implications for research

The results of this research are overall consistent with the characteristics shown by emergency managers in crisis literature, which in turn are largely attributable to transformational leadership theory. One of the aims of this work was to investigate whether this was true also for micro-level managers, as it showed to be. Such managers expressed a focus on dialogue, staff's needs as workers as well as whole human beings, creative thinking and change, learning and exemplary behaviour, corresponding to many key aspects of transformational leadership. The main feature that diverged from the theory was that leaders focused on more practical, short-term goals and did not stress on high standards for their staff, focusing instead on positive feedback on the work already done. Such behaviours were due to the most pressing demands of the pandemic, and could be traced back to transactional leadership styles, but the distinction is not clear-cut in practice as it is in theory.

Moreover, in their accounts leaders described processes linked to sensemaking theories. In particular, the focus on communication between colleagues and staff to create a coherent narrative around the pandemic situation appeared at the centre of their sensemaking processes. Leaders focused on creating shared meanings to foster more harmonious action within the organisations. They promoted creativity and testing of new solutions to get an understanding of the situation, and embraced improvisation, however within the limits of accurate planning and preparedness plans. The impetuous process of digitisation seemed to be particularly interesting, as it changed communication and sensemaking processes both for the better (efficiency, immediacy, accessibility) and the worst (misunderstandings, partiality, lack of spontaneity).

From the data it emerged that transformational and sensemaking processes can be seen as complementary and supporting each other during emergency management. A transformational leadership approach opens for dialogue, continuous exchange of ideas, individual consideration and embracing of change, thus providing a basis for sensemaking processes to occur effectively and handle crises.

Overall, this work shows that transformational and sensemaking approaches emerge in leaders when facing crisis. This confirms the previous literature and expands its findings to different levels of healthcare as well as to a new situation, the COVID-19 pandemic. The

relevance of these findings lies in the learning possibilities that it opens up for current and future leaders who might have to face similar crises themselves, and who are not emergency response professionals. This study was set in Norway in the LTCF sector, but the inputs and considerations deriving from it could be extended to other countries and sectors with similar systems. Moreover, both transformational and sensemaking approaches can be taught, according to the literature (Ancona, 2012; Bass & Riggio, 2006), and the analysis of key real-life examples can be used to enrich learning and training. Moreover, there are authors who directly argue for the need of transformational leaders to navigate crises and stressful situations (Bass & Riggio, 2006).

It would be extremely interesting for future research to continue studying leadership in emergency response at the micro-level, perhaps in other countries and still within the healthcare sector and its response to the COVID-19 crisis. Future research could expand current knowledge by adopting different methods, for example quantitative approaches, and attempting to measure how performance is linked to transformational and sensemaking strategies in emergency situations. In addition, the new digitalisation trends that have been greatly pushed forward by the 2020 pandemic will inevitably influence leadership processes and thus also emergency management, and will probably require ad hoc attention in further research.

### 5.5 Considerations on the limitations of the study

Predictions on the possible limitations arising during the study were mentioned in chapter three. After the carrying out of the interviews, data mapping and analysis, I have a clearer picture of these limitations, how I acted to prevent or limit them, and how they might influence the research results.

First, due to the preparatory work of research done before starting the study, I naturally had expectations on what might have shown up in the interviews. The human factor in research, especially qualitative, is impossible to completely wipe out, and every researcher brings their own background to the work. Being aware of such influence, a lot of attention was put into the interview guide as well as in reviewing my questions and feedback after each interview,

to take advantage of continuous learning and self-reflection. Indeed, “rather than aspire to an unachievable goal of “objectivity”, it is better to simply be honest and transparent about one’s own subjectivities, allowing readers to draw their own conclusions about the interpretations that are presented through the research itself.” (Austin & Sutton, 2014, p.437). Moreover, given that I am a student and external to the Norwegian healthcare system, no personal interest towards any specific outcome was brought into the study.

Then, barriers arising from language and cultural differences were considered from the very beginning. Its implications were largely explored in chapter three. While this resulted in a longer time needed for transcription and translation work for those interviews carried out in Norwegian, the language difference did not constitute a major barrier to the researcher’s or the participants’ understanding. On my part, my language proficiency and the other available instruments for translation were enough to navigate the interviews, however challenging due to the use of dialects by some participants. On the participants’ part, they were told from the very beginning that I was not a native speaker, and the meetings were carried out in an informal, friendly manner: if there were misunderstandings, participants were encouraged to speak out. Still, there is the possibility that some misunderstandings could have not been avoided, despite both parties’ attempts. However, letting interviews be carried out both in English and Norwegian allowed for more participants to join and be comfortable with the interviewing language, which is a good tradeoff.

Self-reporting bias, that is the desire of participants to be viewed in a positive manner, probably played a role in their narratives. However, participants were informed on anonymisation procedures tied to the work and on the confidentiality of their data, as well as that the study was not evaluative in any way. A possible way to counter-balance such an effect could have been to carry out observational research on top of interviews, or also to include nursing staff in individual interviews or focus groups. However, given the hardships tied to finding a sample in the COVID-19 situation, as well as the limited amount of time available, it was deemed more appropriate to involve only leaders.

Lastly, data saturation, that is the point at which no new information is obtained, or it is negligible (Kumar, 2011) was close to be met, participants did indeed show similar repeating

patterns, but a bigger sample would have been beneficial for deeper understanding. Moreover, the sample recruitment was stalled and obstructed by the COVID-19 pandemic.

## 6. Conclusions

This paper was inspired and motivated by one main objective: learning. With two implications: first, to learn how to use a new method of research and deepen my personal knowledge of the nursing homes sector. Second, to take advantage of the uniqueness of the COVID-19 pandemic to further the knowledge of leadership processes in emergency situations. In particular, given that the identified previous literature focused on leaders at the macro-level, and/or specifically trained in crisis response, and/or in the United States, China and Canada, this study partially filled in the gaps by looking at micro-level leaders who are not emergency management professionals, in Norway. The focus on nursing homes was dictated by, in addition to personal curiosity, the significant and difficult role this sector had especially at the very beginning of the pandemic.

The research question: *"how did long-term care facilities (LTCF) leaders manage the COVID-19 crisis?"* drove the work forward. Two main theories were chosen to frame the analysis and discussion, both dealing with change management and attribution of meaning to disruptive situations: transformational leadership theory and sensemaking theory. The participants were eager to share and be heard, and they provided great insights on their work and thoughts during the pandemic. Transformational leadership traits emerged clearly, and such focus on availability, communication, openness, lead-by-example, creativity, paved the way for sensemaking processes aimed at understanding the pandemic and making sense of its implications both on the short as well as long term. The interviewed LTCF leaders expressed a great deal of attention to open communication, empathy, compassion (towards employees, patients and relatives), as well as to safety and rigorous procedures.

As mentioned above, learning was the main reason for this work as it is its main outcome. The intention is to learn from joining together the inputs from the theory, from previous crises and from the research on current events. Learning from topical examples and practical experiences could benefit current and future leaders, who are likely to face similar situations in the future. It could enlighten them on good practices, approaches and tactics to face very critical situations. The leaders' testimonies were collected only one year after the beginning of the pandemic, which is still ongoing at the moment of writing, so that memories and

impressions could be as fresh as possible, even though biases linked to social pressure, self-reporting and language barriers must be taken into account.

This work inserts itself in a long line of research with the intent of expanding from others' works, as well as of inspiring others to go in new directions. Continuing research on emergency management on the micro-level, taking advantage of the lessons learned during the COVID-19 pandemic, could be highly rewarding, since crisis response is made not only by macro-level leadership, but also by localised response. In addition, the attention given by leaders to the impact of new communication technologies on their work and emergency management itself could prove to be a very interesting as well as topical theme for future research.

In conclusion, this work showed how leaders, when faced with emergencies and unfamiliar, stressful situations, prioritise traits ascribable to transformational leadership and sensemaking objectives in order to deal with crisis. Such traits emphasise frequent and open communication, focus on staff individuality and needs as whole human beings, provision of a personal example to guide and calm followers, use of creativity, improvisation and shared rationalisation. On top of this, teamwork and empathy are carrying leaders in their daily work and prove to be fundamental for succeeding even in tougher times.

## References


Ågotnes, G. (2017). *The Institutional Practice: On nursing homes and hospitalizations* Cappelen Damm Akademisk.

Adini, B., Ohana, A., Furman, E., Ringel, R., Golan, Y., Fleshler, E., . . . Reisner, S. (2016). Learning lessons in emergency management: the 4th International Conference on Healthcare System Preparedness and Response to Emergencies and Disasters. *Disaster and Military Medicine, 2*(1), 16. doi:10.1186/s40696-016-0026-3

Ancona, D. (2012). Sensemaking : framing and acting in the unknown. *The handbook for teaching leadership : knowing, doing, and being*, 3-19.

Austin, Z., & Sutton, J. (2014). Qualitative research: getting started. The Canadian journal of hospital pharmacy, 67(6), 436-440. doi:10.4212/cjhp.v67i6.1406

Avolio, B. J., & Bass, B. M. (2002). *Developing Potential Across a Full Range of Leadership TM : Cases on Transactional and Transformational Leadership*. Mahwah, N.J.: Psychology Press.

Banaszak-Holl, J., Nembhard, I., Taylor, L., & Bradley, E. H. (2012). Leadership and Management: A Framework for Action in Health Care. In L. R. Burns, E. H. Bradley, & B. J. Weiner (Eds.), *Shortell and Kaluzny's Health Care Management*: Delmar Cengage Learning.

Bass, B. M., & Riggio, R. E. (2006). Transformational leadership (2nd ed. ed.). Mahwah, N.J: L. Erlbaum Associates.

Berger, P., & Luckmann, T. (1971). *The social construction of reality : A treatise in the sociology of knowledge* (Pelican books). Harmondsworth: Penguin.

Burns, J. (1979). Leadership (Harper Perennial Political Classics). New York: Harper Perennial Modern Classics.

Caro, D. H. J. (2015). Code orange: Towards transformational leadership of emergency management systems. *Healthcare Management Forum, 28*(5), 195-201. doi:10.1177/0840470415588657

Christensen, T., & Lægreid, P. (2020). Balancing Governance Capacity and Legitimacy: How the Norwegian Government Handled the COVID-19 Crisis as a High Performer. *Public Administration Review, 80*(5), 774-779. doi: https://doi.org/10.1111/puar.13241

Daft, R., & Macintosh, N. (1981). A Tentative Exploration into the Amount and Equivocality of Information Processing in Organizational Work Units. *Administrative Science Quarterly, 26*(2), 207-224. doi:10.2307/2392469

Danis, K., Fonteneau, L., Georges, S., Daniau, C., Bernard-Stoecklin, S., Domegan, L., . . . Schneider, E. (2020). High impact of COVID-19 in long-term care facilities, suggestion for monitoring in the EU/EEA, May 2020. *Euro Surveill, 25*(22). doi:10.2807/1560-7917.Es.2020.25.22.2000956

Demiroz, F., & Kapucu, N. (2012). The Role of Leadership in Managing Emergencies and Disasters. *European Journal of Economic and Political Studies, 5*(1), 91-101.

EF. (2020). EF EPI 2020 - EF English Proficiency Index. Retrieved from https://www.ef.no/epi/

Elliott, R., & Timulak, L. (2021). *Essential of Descriptive-Interpretive Qualitative Research: a Generic Approach*.

FEMA. (2007). Principles of Emergency Management Supplement. Retrieved from https://www.fema.gov/media-library-data/20130726-1822-25045-7625/principles_of_emergency_management.pdf

FEMA. (n.d.). Glossary of Terms. Retrieved from https://www.fema.gov/pdf/plan/glo.pdf

FHI. (2020). Råd til sykehjem under covid-19-pandemien. Retrieved from https://www.fhi.no/nettpub/coronavirus/helsepersonell/sykehjem-og-smittevern-mot-covid-19/

FHI. (2021). *Daily report and statistics about coronavirus and COVID-19* Retrieved from https://www.fhi.no/en/id/infectious-diseases/coronavirus/daily-reports/daily-reports-COVID19/

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1), 117. doi:10.1186/1471-2288-13-117

Gordon, E. M. (2001). Leadership commitment to strong emergency management. *The Spectrum /, 74*(4), 9.

Green, J., & Thorogood, N. (2004). *Qualitative Methods for Health Research*. London: SAGE Publications.

Hackett, A., & Strickland, K. (2019). Using the framework approach to analyse qualitative data: a worked example. *Nurse Researcher, 26*(2), 8-13. doi:10.7748/nr.2018.e1580

Handy, C. (1993). Understanding organizations (4th ed., Penguin business management). London: Penguin.

Helse Sør-Øst. (2020). Smittevernutstyr. Retrieved from https://www.helse-sorost.no/nyheter/smittevernutstyr

Helsedirektoratet. (2019). *Koronavirus – beslutninger og anbefalinger* Retrieved from https://www.helsedirektoratet.no/veiledere/koronavirus

Hordnes, K., Løland, K. K., & Bovim, E. (2020). [Not Available]. *Tidsskr Nor Laegeforen, 140*. doi:10.4045/tidsskr.20.0316

Kahn, M. J., & Sachs, B. P. (2018). Crises and Turnaround Management: Lessons Learned from Recovery of New Orleans and Tulane University Following Hurricane Katrina. *Rambam Maimonides Med J, 9*(4). doi:10.5041/rmmj.10354

Kapucu, N. (2009). Leadership Under Stress: Presidential Roles in Emergency and Crisis Management in the United States. *International Journal of Public Administration, 32*(9), 767-772. doi:10.1080/01900690903017025

Kezar, A. (2013). Understanding sensemaking/sensegiving in transformational change processes from the bottom up. *Higher Education, 65(6)*, 761-780. doi:10.1007/s10734-012-9575-7

Khan, Y., O'Sullivan, T., Brown, A., Tracey, S., Gibson, J., Généreux, M., Bonny, H., Schwartz, B. (2018). Public health emergency preparedness: a framework to promote resilience. *BMC Public Health, 18*(1), 1344. doi:10.1186/s12889-018-6250-7

Kotter, J. (1990). *A force for change : How leadership differs from management*. New York: Free Press.

Kumar, R. (2011). *Research Methodology: a step-by-step guide for beginners* (3rd ed.): SAGE Publications Ltd.

Maitlis, S., & Christianson, M. (2014). Sensemaking in Organizations: Taking Stock and Moving Forward. *Academy of Management Annals, 8*(1), 57-125. doi:10.5465/19416520.2014.873177

McGilton, K. S., Escrig-Pinol, A., Gordon, A., Chu, C. H., Zúñiga, F., Sanchez, M. G., . . . Bowers, B. (2020). Uncovering the Devaluation of Nursing Home Staff During COVID-19: Are We Fuelling the Next Health Care Crisis? *Journal of the American Medical Directors Association, 21*(7), 962-965. doi:10.1016/j.jamda.2020.06.010

Merriam-Webster. (n.d.). Crisis - In Merriam-Webster Dictionary. Retrieved from https://www.merriam-webster.com/dictionary/crisis

Northouse, P. G. (2019). *Leadership : theory and practice* (8th edition.; International Student edition. ed.). Los Angeles: SAGE.

Owen, C. (2016). Leadership, Communication and Teamwork in Emergency Management. In C. Owen (Ed.), *Human Factors Challenges in Emergency Management*.

Sell, T. K., Shearer, M. P., Meyer, D., Chandler, H., Schoch-Spana, M., Thomas, E., . . . Toner, E. (2018). Public Health Resilience Checklist for High-Consequence Infectious Diseases—Informed by the Domestic Ebola Response in the United States. In (pp. 510-518). Frederick, MD :.

Sperre Saunes, I., Karanikolos, M., & Sagan, A. (2020). Norway: Health system review. *Health systems in Transition, 22(1)*, i-163. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/331786/HiT-22-1-2020-eng.pdf

Stewart, J. (2006). Transformational Leadership: An Evolving Concept Examined through the Works of Burns, Bass, Avolio, and Leithwood. *Canadian Journal of Educational Administration and Policy*(54). Retrieved from https://cdm.ucalgary.ca/index.php/cjeap/article/view/42735

Sun, M., Xu, N., Li, C., Wu, D., Zou, J., Wang, Y., . . . Hao, M. (2018). The public health emergency management system in China: trends from 2002 to 2012. *BMC Public Health, 18*(1). doi:10.1186/s12889-018-5284-1

The next step of the reopening will be implemented on 27 May. (2021). [Press release]. Retrieved from https://www.regjeringen.no/en/aktuelt/neste-trinn-i-gjenapningen-skjer-27.-mai/id2850347/?expand=factbox2850353

Thompson, S. (2020). Beyond traditional leadership: Re-defining emergency management core competencies. *Haznet - The Magazine of the Canadian Risks and Hazards Network*. Retrieved from

http://haznet.ca/beyond-traditional-leadership-re-defining-emergency-management-core-competencies/

Tikkanen, R., Osborn, R., Mossialos, E., Djordjevic, A., & Wharton, G. A. (2020). Norway. *International Health Care System Profiles.* Retrieved from https://www.commonwealthfund.org/international-health-policy-center/countries/norway

Ursin, G., Skjesol, I., & Tritter, J. (2020). The COVID-19 pandemic in Norway: The dominance of social implications in framing the policy response. *Health Policy and Technology, 9*(4), 663-672. doi:https://doi.org/10.1016/j.hlpt.2020.08.004

Veenema, T. G., Deruggiero, K., Losinski, S., & Barnett, D. (2017). Hospital Administration and Nursing Leadership in Disasters. In (pp. 151-163). Frederick, Md.

Weber, K. E., & Glynn, M. A. (2006). Making Sense with Institutions: Context, Thought and Action in Karl Weick's Theory. *Organization Studies, 27*(11), 1639-1660. doi:10.1177/0170840606068343

Weick, K. E. (1988). Enacted sensemaking in crisis situations. *Journal of Management Studies, 25*(4), 305-317. doi:https://doi.org/10.1111/j.1467-6486.1988.tb00039.x

Weick, K. E. (1993a). The collapse of sensemaking in organizations: the Mann Gulch disaster. *Administrative Science Quarterly 38*(4), 628-652.

Weick, K. E. (1993b). Sensemaking in Organizations: Small Structures with Large Consequences. In J. Keith Murnighan (Ed.), *Social Psychology in Organizations: Advances in Theory and Research* (pp. 10-37).

Weick, K. (1995). *Sensemaking in organizations* (Foundations for organizational science). Thousand Oaks, Calif: Sage.

Weick, K. E. (2005). Managing the Unexpected: Complexity as Distributed Sensemaking. In R. R. McDaniel & D. J. Driebe (Eds.), *Uncertainty and Surprise in Complex Systems: Question on Working with the Unexpected* (pp. 51-65). Berlin, Heidelberg: Springer Berlin Heidelberg.

WHO. (2020). Timeline of WHO's response to COVID-19. Retrieved from https://www.who.int/news/item/29-06-2020-covidtimeline

WHO. (2021a). Coronavirus. *Health topics.* Retrieved from https://www.who.int/health-topics/coronavirus#tab=tab_1

WHO. (2021b). WHO Coronavirus (COVID-19) Dashboard. Retrieved from https://covid19.who.int/

Xue, C. L., Shu, Y. S., Hayter, M., & Lee, A. (2020). Experiences of nurses involved in natural disaster relief: A meta-synthesis of qualitative literature. *Journal of Clinical Nursing, 29*(23-24), 4514-4531. doi:10.1111/jocn.15476

Yang, I. (2015). Positive effects of laissez-faire leadership: conceptual exploration. Journal of Management Development, 34(10), 1246-1261. doi:10.1108/JMD-02-2015-0016

Yukl, G. (2010). *Leadership in Organizations* (7th ed.): Pearson Education, Inc.

## Appendix

Appendix I : Table 1 (list of each theme, sub-theme and examples of corresponding codes)
Appendix II: NSD approval
Appendix: III: Consent form
Appendix IV: Interview guide

**Appendix I: Table 1 (list of each theme, sub-theme and examples of corresponding codes)**

| INFORMATION AND COMMUNICATION |
| --- |
| **flow management** |
| **1) modality and frequency** |
| "we've become more aware of the way we communicate, absolutely, the way we communicate and how much, how often, we have to say the same things over and over again […] in Norwegian we call it *relasjonel ledelse*, it's a focus on communication with people (149-150 and 160-161, A)<br><br>"I understood that the most important things for me to do was to give the staff here good information. If they had information, they could do almost everything. They were calm and everything went smooth after I understood how important that was" (31-34, B)<br><br>"I was always at work and always checking mail and always walking around trying to update employees on the latest news. [...] necessity to bring information out quickly has been very demanding but also a safety" (28-29 and 86-87, E)<br><br>"we have to talk the same language, we have to agree, we have to work together to assemble our workers." (185-186, G)<br><br>"And also this with being precise in communication, that is information, information, information. It's really a very simple thing, but I think we're constantly forgetting how important information is." (159-161, I)<br><br>"And the flow of information was very important. The staff needed lots and lots and lots of information. In relation to what is happening and how we should work at the nursing home. We worked very well in teams so that everyone would get the same information. I think that was very wise." (19-22, L)<br><br>"we create information that everyone has to read every time they come to work [...] Therefore, everyone must read to know the latest news, [...] I have to check that people read the information that I put there, or I have to go and ask them if they have read" (111-114, P) |

### 2) uncertainty

"One day remember, 9 o'clock, I came rushing to my employees: we have to use gloves in every occasion! At 11 o'clock, I rush into my employees, don't use that many gloves! At 1 o'clock, sometimes we have to use gloves! So it was very frustrating to always change direction" (41-44, E)

"There are many things we were unsure of at first, if we had understood it correctly. And if employees asked, I was unsure too, so then we asked the nursing home superior and discussed." (58-60, F)

"There were a lot of messages and there were a lot of changes from day to day" (23-24, I)

## digitalisation

### 1) pros

"the way we communicate has changed now, I think. To the better, because the information goes easier. It's ... Now when I send an email to an employee, she will always answer in mail. That was not the case on year ago." (84-86, B)

"we also saw that everything that could not wait until the next shift was sent by email, everything that people had to know now by sms. So my employees got very frequent information about how to behave." (28-31, C)

"(digital communication) It is very useful, for instance for part of the meetings one saves time by not having to travel. You can actually have several meetings and meeting points, and you still save time. You are in a way protected from infection and yet you get to meet people. So I think it's been great." (164-167, M)

### 2) cons

"You've lost a lot of decision-making forums at the local level. So we're struggling a bit to build those up again. [...] I'm talking about philosophy of care for example. If there are new patients, you have to find new perspectives to deliver care. It's not a good reflection forum to do through teams. It's better to meet and look each other in the eye. Those forums are very difficult to find development for. [...] Complex development at the abstract level doesn't work through teams or zoom in a way." (144-155, E)

"the reflections you get when you sit in a group and you have a physical meeting, all the new technology can't replace that." (99-100, H)

"(on SMS use) So it has been in a way challenging, and written information can be easily misinterpreted. Some interpret it that way and some interpret it that way." (88-89, N)

# COOPERATION

## within organisation

### 1) team work

“I have staff that is hardworking and they step up if we need them to. In Norwegian we call it dugnad [...] I think everybody felt this dugnadsånd, if something happens we will be there and we will participate and we will stand up for our patients and for our colleagues." (156-157 and 162-164, G)

"So standing together for something and working towards the same goal, working in the same direction, supporting each other, it is very important to make things happen. I have also learned that we can get a lot of energy from people, maybe more than when things are going well." (136-139, I)

"good collaboration in the management team, I think was very crucial" (18, L)

"And I've also learnt to value the great unity and team work we had." (175-176, M)”

### 2) flat structure

"We have a flat structure so ... yeah, me and my other leader team we are very involved in their daily work you know" (103-104, B)

"We talk to them (the staff), we have tested, tried and practiced how to put on the equipment and I join them when they do it." (103-105, D)

"I’m a type of leader who thinks that the lady who cleans the house is as important as I am." (143-144, H)

"I am not that kind of leader who has a top-down attitude, I have been concerned with being inclusive and working together on it (the pandemic). It is not the case that I sit in the office, it is also those who know how it is in practice." (87-89, L)

## between organisations

"but we received very good support from the nursing home's superior and the infection control team, so to speak. We received a lot of guidance and close follow-up from the municipal manager and such. There was a lot of good support" (23-25, F)

"I was part of such a leadership network for non-profit institutions. And we have regular team meetings. And to hear a little how others have it - it was others' nursing home that got infected - and to hear a little how they do it, how they meet relatives, how they inform their employees." (142-145, M)

"Also many nursing homes have already contracted the infection, and they have shared their experiences with us about what is the right thing to do." (147-148, P)

## SENSEMAKING

"we had to walk things through because, a recommendation could be ... different colours, and how we understand it, so we have to have a lot of discussion what does this really mean what does it mean for us, and how do we communicate it for people. […] you hold the answers you don't have (giggles) so someone has to give these answers and … your answers one week after, two weeks after, you take the consequences if you said something wrong." (47-49 and 61-63, A)

"we had to meet to ... discuss what do we do now, how do we act, how to we inform all the employees, all the families to our patients" (29-30, D)

"There was a little of trial and error in the start"
"There are many things we were unsure of at first, if we had understood it correctly. And if employees asked, I was unsure too, so then we asked the nursing home superior and discussed together" (32-33 and 58-60, F)

"we had to discuss how we're going to do this, how we're going to react, how we're going to get all the equipment we need"
"but I didn't have all the answers, so I often sent the questions back, what do you think, what would you have done" (87-88 and 150-152, G)

"the questions that have come up, we have raised together, so that we have landed them together. So that we could go out with the same information and be able to act as similarly as possible in terms of concerns" (102-106, L)

## RELATIONSHIP WITH STAFF

### motivation

#### 1) praise

"we also have focused on what we had achieved you know." (139, B)

"to encourage and tell them what's going well with them, the good work they do, and that I'm very grateful" (80-81, C)

"And the way I think I can motivate them in everyday life is to praise, and see the good things that they do, and support them when they need it." (80-81, N)

### 2) focus on small things

"We have also been good at making a cake and serving them, buying some fruit, for Christmas we had a cosy time during Advent." (82-84, C)

"we also bought lunch for all the employees in the beginning. Each day they got lunch from the cafeteria. It was my way to show them that I appreciated that they knew the new routines and we didn't have any infections into this unit at all." (76-79, D)

"They (the staff) called me a lot of times, I had a bunch of phone calls every day and that was ok. We solved many of those small issues through the telephone and that was ok." (134-136, G)

### 3) sense of belonging

"Yes, we motivated each other. But that's what we can do, we make it happen, we make progress, we solved this. We make a plan, we stand together" (73-74, I)

"The staff felt that they were taken seriously, and that they were not alone in the insecurity they felt" (35-36, L)

"We motivated them more by talking to them and saying that we can do this together, that we can get through it together" (111-112, M)

"we talked a lot about the pride that we have in doing something important." (64, O)

## availability

"it's important to be not too authoritative, because you want them to know that they can call you every day, in the weekend, in the afternoons" (98-99, A)

"The main thing in that period of time was that my employees knew that I was available for questions 24/7." (31-32, E)

"I think it is important to have an open relationship with employees, that they can face an open door, that they can come to me if there is something, and say what they mean, and I can say what I mean." (40-42, N)

"It is one of the things we have really prioritized over the last year to also take difficult meetings even if there is no time, even if you feel you do not have time. " (121-123, O)

### 1) focus on the individual

"(I think it is important) to pay really attention, as a leader in a crisis, to the individual as a whole, more empathy." (200-201, C)

"They often come to my office to talk. Sometimes it's about job and sometimes it is personal stuff" (90-91, D)

"I know whom among my staff gets more easily stressed out, and the corona situations was extra stressful. So I sat down with them and took out extra time for them" (83-84, L)

## trust

"In fact the corona pandemic had increased the level of trust in some ways." (80-81, E)

"what is important to act well in a crisis is to have a good foundation, with good cooperation and good relations, to stand together. And trust in each other, help each other" (157-159, I)

"I think we have a mutual relationship of trust. We have earned it." (48, L)

"we have an open environment, where we can bring things up, we can disagree but we can still work together, we are loyal to the same thing, even if we do not always completely agree. " (76-77, P)

# CREATIVITY

## local solutions

"even though we have routines from the FHI ... we had to make changes in our institutions" (line 79, B)

"we have also learnt the necessity of quickly make our local variants of routines." (lines 127-128, E)

"we have adjusted routines gradually, if they (the staff) reported back that this does not work in practice, then we updated the routine" (lines 31-32, L)

## problem-solving

"At the beginning we didn't have enough of the equipment we needed, that was for the whole city, but the staff found other solutions, why don't we do like this and we can try... Yeah I think they were innovative and found solutions." (140-143, G)

"It is important for the employees to get to contribute with their input on how to do things. (It is important) that you are together to get things done" (107-108, F)

"So we ask people to provide input, and if they provide input, we try to get those things done, or test them out." (92-93, M)

"Then I ask them. I do not try to come up with all the solutions myself. Because I know that many together, there are often very good suggestions, all so different, I think it is very good (92-94, P)

# LEARNING

"I think that all the leaders and all the employees have become a lot more skilful on the pc and the computer meetings, skills that we will take with us afterwards" (151-153, A)

"Fortunately, all our patients are vaccinated, but I notice that all the routines have been incorporated now, so after such a long time, we are experienced, we have clear messages and everything is much clearer now." (123-125, F)

"a lot of the people who work here digitally have increased their competence. And a lot of the learning new routines are on the computer. And I do believe this crisis has prepared anybody a bit better, in that, a bit safer in how to do that." (92-94, H)

# STRATEGY

## infection prevention

"my main focus was to avoid to get this virus inside [...] our institution" (59-60, A)

"at the same time, much else was set aside so that we concentrated very much on working against the corona crisis." (33-34, I)

"we thought of course infection control was first and foremost" (20, N)

"we tried to stay focused on doing the right things and being strict with the routines." (33-34, O)

## structure

### 1) role assignment

"we had these people that have responsibility when people are coming to visit." (76, A)

"I collected some of my staff in a group and called it infection control group" (50-51, B)

"If three people get ill this weekend, we do this and this. They also get a list every week, who from the leadership has homeoffice, who is going to be here, who should you call. So they have a list every week and they know all the time how they can get one of us." (101-104, C)

"Creating good plans and routines so that the staff knows what to do in connection with different situations." (28-29, L)

### 2) planning

"the first thing I was thinking about was to make a plan, crisis leadership plan, so we made that so we could put in every day new decisions that we make and I was very opptatt (concerned) on this plan" (29-31, B)

"We discussed various scenarios, crisis, who are the employees supposed to talk to" (34-35, D)

"But the most important thing, I think, was that we had good plans and that we had thought through "what if this happens". And we had made purchases in such a way that we had all the equipment. So routines were in place then, with some adjustments of course, when it happened. " (28-31, N)

## development stop

"we are going down to our freezing point where it’s this evolution things inside the organisation have been stopped. All focus and energy have become on this pandemic situation." (137-139, A)

"This year, everybody stopped. We’ve just been doing infection control ‘hygiene’. But it was ... every other focus went away" (125-126, C)

"(the pandemic) it has meant that we have had to put other work aside. When we focus on one thing, we become good at it, but we become less good at what we do not focus on." (119-121, L)

## PERSONAL LEADERSHIP TRAITS

### positive thinking

"Now we can control it, it gives us more room to focus on the patient and use our time with our work. So it was very important to find the bright side of the new routines always." (111-112, E)

"in my emails I try to encourage them to be positive" (145, G)

"We have a very good leader at the institution who has guided us leaders with a very steady hand, that is very clear and clear and calm and I also think that is one of my qualities, that I am very calm. That I take the staff seriously and do not "maximize" the crisis, if you understand. Do not think worst case all the time." (25-27, L)

### personal responsibility

"I've never said or shown my employees that I was stressed, sometimes also afraid. But I told them if that happens we go like this, if that happens we go like that, we have a plan." (99-102, C)

"I also get very calm when something like this happens, I think that is also my role as a leader, because all my workers were really stressed about this and didn't know what to think, what to believe, what's going to happen now, so we managed to stay calm" (53-56, G)

"One has to put on a mask and act calmer than you really are" (83-84, O)

I wish I had understood from the beginning how important it is to involve all the staff. Because the first weeks I was stressed so then I thought I had to deal with this on my own, but you can't. (lines 180-182, B)

"I've learnt that it's ok to be worried, it's ok to talk about my feelings as well to my staff, so they see that I'm not a "over person", I'm also insecure, that we together can find solutions." (lines 146-148, D)

### empathy

"(I think it is important) to pay really attention, as a leader in a crisis, to the individual as a whole, more empathy." (200-201, C)

"I've learnt that it's ok to be worried, it's ok to talk about my feelings as well to my staff, so they see that I'm not a "over person", I'm also insecure, that we together can find solutions." (146-148, D)

"You have to be close, physically as well. [...] we chose to be present. And I notice that employees appreciate, even if it is recommended home office and such, it is important to be present" (50-52, F)

"We talked a lot about guilt. Everyone was so scared of being the one that brought covid to the institution. So we talked a lot about this" (79-80, H)

# Appendix II : NSD approval



NSD NORSK SENTER FOR FORSKNINGSDATA

## NSD's assessment

**Project title**

Leaders in emergency: an analysis of leadership processes of long term care facilities leaders during COVID19 in Norway

**Reference number**

251558

**Registered**

18.12.2020 av Sofia Cecilia Dall'Osto - sofiacd@uio.no

**Data controller (institution responsible for the project)**

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

**Project leader (academic employee/supervisor or PhD candidate)**

Trond Tjerbo, trond.tjerbo@medisin.uio.no, tlf: +4722845362

**Type of project**

Student project, Master's thesis

**Contact information, student**

Sofia Cecilia Dall'Osto, s.c.dallosto@studmed.uio.no, tlf: 97328158

**Project period**

01.02.2021 - 31.08.2021

**Status**

10.02.2021 - Assessed

**Assessment (2)**

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**10.02.2021 - Assessed**

NSD has assessed the change registered on 09.02.2021.

We find that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 10.02.2021, as well as in correspondence with NSD. Everything is in place for the processing to continue.

The changes are that the sample will no longer be recruited from a single municipality, but from all over the country. The information letter and interview guide has been upgraded to reflect this.

FOLLOW-UP OF THE PROJECT
NSD will follow-up the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Jørgen Wincentsen
Data Protection Services for Research: +47 55 58 21 17 (press 1)

**22.12.2020 - Assessed**

Our assessment is that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 22.12.2020. Everything is in place for the processing to begin.

NOTIFY CHANGES
If you intend to make changes to the processing of personal data in this project it may be necessary to notify NSD. This is done by updating the information registered in the Notification Form. On our website we explain which changes must be notified. Wait until you receive an answer from us before you carry out the changes.

TYPE OF DATA AND DURATION
The project will be processing general categories of personal data until 31.08.2021.

LEGAL BASIS
The project will gain consent from data subjects to process their personal data. We find that consent will meet the necessary requirements under art. 4 (11) and 7, in that it will be a freely given, specific, informed and unambiguous statement or action, which will be documented and can be withdrawn. The legal basis for processing personal data is therefore consent given by the data subject, cf. the General Data Protection Regulation art. 6.1 a).

PRINCIPLES RELATING TO PROCESSING PERSONAL DATA
NSD finds that the planned processing of personal data will be in accordance with the principles under the General Data Protection Regulation regarding:

- lawfulness, fairness and transparency (art. 5.1 a), in that data subjects will receive sufficient information about the processing and will give their consent
- purpose limitation (art. 5.1 b), in that personal data will be collected for specified, explicit and legitimate purposes, and will not be processed for new, incompatible purposes
- data minimisation (art. 5.1 c), in that only personal data which are adequate, relevant and necessary for the purpose of the project will be processed
- storage limitation (art. 5.1 e), in that personal data will not be stored for longer than is necessary to fulfil the project's purpose

THE RIGHTS OF DATA SUBJECTS
Data subjects will have the following rights in this project: transparency (art. 12), information (art. 13), access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18), notification (art. 19), data portability (art. 20). These rights apply so long as the data subject can be identified in the collected data.

NSD finds that the information that will be given to data subjects about the processing of their personal data will meet the legal requirements for form and content, cf. art. 12.1 and art. 13.

We remind you that if a data subject contacts you about their rights, the data controller has a duty to reply within a month.

FOLLOW YOUR INSTITUTION'S GUIDELINES
NSD presupposes that the project will meet the requirements of accuracy (art. 5.1 d), integrity and confidentiality (art. 5.1 f) and security (art. 32) when processing personal data.

If you are using a data processor in the project, the processing must meet the requirements under the General Data Protection Regulation arts. 28 and 29.

To ensure that these requirements are met you must follow your institution's internal guidelines and/or consult with your institution (i.e. the institution responsible for the project).

FOLLOW-UP OF THE PROJECT
NSD will follow up the progress of the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Data Protection Services for Research: +47 55 58 21 17 (press 1)

# Appendix III: Consent form

## Participant Information Sheet

### Participation in research study on "Leaders in emergency: an analysis of leadership processes of long term care facilities leaders during COVID19 in Norway"

Thie research study is a Master's thesis project in the programme "Healthcare economics and management" of Universitetet i Oslo.

The aim is to collect and analyse leaders' response to crisis situations by looking at their thought-processes, techniques, reflections and emotions, and compare with previous findings in the relevant literature. Their testimony can help in identifying tools and techniques to facilitate leaders' emergency response work.

You are invited to take part in a study on leadership behaviours of leaders in nursing homes during the COVID19 pandemic.

Please take time to read the following information carefully and discuss it with others if you wish. Please contact the lead investigator for any questions or further information. Take time to decide whether or not you wish to take part.

### Purpose of the study

The study is a Master's thesis project focusing on the discipline of healthcare management. The goal is to collect data in order to inform reflection on what leadership characteristics emerge and are needed in emergency, and how to promote them. This study is not in any way meant to be evaluative, but it will about your personal experience as a leader. Approximately, the study is expected to be carried out from February until June 2021, and completed by August 2021.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep.

### Why have I been chosen?

The study sample is made by middle- and top-level leaders in your municipality's long-term-care facilities (sykehjem, helsehus), selected through the information made available by the municipality.

### Do I have to take part?

The participation in this study is voluntary. You don't have to give a reason if you don't want to take part. If you do want to take part now, but change your mind later, you can pull out of the study at any time without experiencing any disadvantage.

## How and when will the data be collected?

You will be asked to participate in one personal interview held by the Master's student, which will be held in English. The interview will be held either in person or digitally, and will last around 30min.

## Recording, storage and deletion of data

The interview will be documented through notes and through voice recording, provided you give consent to it, which you can do in the Consent Form below. If applicable, the voice recording will be transcribed, in order to ensure that the research is as thorough as possible and give the possibility to the researcher to go through and analyse key concepts repeatedly during the research.

Only the graduate student and the project supervisor will have access to the unpublished data. Your data will anonymised, that is the removal of information in the data set that identifies an individual. I will replace your name and contact information with a code that is stored in a separate name list separate from other data. Any recording will be stored in a safe device (that is, with restricted access and not connected to external servers) and not shared with any third party. All collected unpublished data will be deleted by the end of the project August 2021.

## What are my rights?

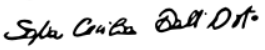
You have the right to withdraw your consent at any time. You have the right to request access to and rectification or erasure of information about yourself obtained via this study. You will not own any intellectual property that may arise from any future research.

Any complaints can be addressed to University of Oslo's data protection officer or to the Norwegian Data Protection Authority.

## What will happen to the results of the research project?

The data is collected as part of a Master's thesis project as part of the Master's programme "European Programme in Healthcare Economics and Management". As part of the final graduation examination, the project outcomes will be presented to an evaluation committee within the programme.

## Who do I contact for more information or concerns?


| | | |
|---|---|---|
| Master's Student: | Sofia Cecilia Dall'Osto | Signature: |
| Email: | s.c.dallosto@studmed.uio.no |  |
| Telephone: | +47 97328158 | |
| Project supervisor: | Associate Professor Trond Tjerbo | Signature: |
| Email: | trond.tjerbo@medisin.uio.no |  |
| Telephone: | +47 22845362 ; | |

Data protection officer: personvernombudet@uio.no
University of Oslo

If you have questions related to NSD's assessment of the project, you can contact:
NSD - Norsk senter for forskningsdata AS by email (personverntjenester@nsd.no) or by phone: 55 58 21 17.

# Informed Consent Form

## Declaration by participant

I hereby consent to take part in this study. By signing below, I confirm that:

- I have read and understand the Participant Information Sheet
- I understand that taking part in this study is voluntary and that I may withdraw from the study at any time
- I consent to the research staff collecting and processing the statements I make/information I give during interviews
- I understand that my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study, unless otherwise explicitly stated.
- I consent to the research staff to voice record my statements and transcribe them:
  Yes ☐ No ☐

Participant's name:

---

Signature: Date:

---

## Appendix IV: Interview guide

INTERVIEW GUIDE

"Leaders in emergency: an analysis of leadership processes of long term care facilities leaders during COVID19 in Norway"

The interviews will be carried out as semi-structured interviews. The interviewer will ask input questions, take notes and record the conversation to be transcribed soon after the interview has been completed. New follow-up, clarification questions might be asked to get better insights on a specific theme or statements done by the interviewee.

Input questions

1. Let's go back to the very beginning of the pandemic, when cases were rising and there was more confusion than now. Considered the overall situation, what was your reaction as a leader?

2. Which leadership attributes you think were important at the time? Why? Do you still think that now?

3. What was important to you when it came to the relationship you had with staff, patients and their families, and other fellow leaders?

4. As a leader, how did you handle conflict, with patients, families and staff? How was that different from non-emergency times, if it was?

5. In retrospective, is there anything you feel you could have done better as a leader, and why?

6. Which external factors do you think would have helped you to better perform as a leader? Education, training, resources, central guidance, etc.?

7. What did you learn as a leader?