Healthcare Social Workers' Experiences of Distress During the COVID-19 Pandemic:

Organizational and Relational Levels of Care

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Organizational and Relational Levels of Care

By

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ABSTRACT

Healthcare social workers have been on the front lines of the response to COVID-19 since its early days. With an upsurge of social isolation, unemployment, and grief and loss, social workers are being met with new challenges and are required to adapt to new and heightened demands of their roles – while also navigating their own fears and anxieties during the pandemic. While social workers attempt to manage increasing caseloads of complex patient needs, they must navigate the constrained context of their workplace and the changes in patient care. This study used qualitative methods to capture the lived experiences of healthcare social workers amidst the COVID-19 pandemic. Specifically, I used qualitative interviewing to explore the reflections of nine hospital social workers in Hamilton, Ontario regarding their experiences of wellness and wellbeing throughout the pandemic. My research identified three key themes: 1) lack of professional agency and power 2) moral injury, and 3) respect and care – organizational and among colleagues. In the discussion section I reflect on the implications of these findings for the practice of social work during and beyond pandemic times.

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TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

In early spring 2020, the coronavirus disease (COVID-19) had rapidly spread across borders, evolving into a global pandemic that has drastically changed the way people experience the world and each other. As of 11 July 2021, globally, there have been 186,232,998 confirmed cases of COVID-19 and 4,027,858 deaths (World Health Organization, 2021). The effect of this pandemic has been profound on individuals, families, organizations, and communities internationally. Due to the implications of the virus on respiratory systems, healthcare systems have been particularly overwhelmed and burdened as the demand for resources (i.e., critical care beds, equipment, staff) have surpassed availability (Camillo, 2021). Strategies such as redeployment of healthcare staff, stringent healthcare policies and procedures, stay-at-home orders, physical distancing, vaccinations, and universal masking have been implemented across the province of Ontario in a great effort to reduce the spread of COVID-19. Unfortunately, the effects of this pandemic have been traumatic, distressing, and multifaceted on patients, families, and healthcare workers. The delivery of care to patients and families has been undoubtedly jeopardized as stringent policies and procedures in response to containing the spread of COVID-19 have depersonalized care (Miller & Reddin Cassar, 2021). Adverse effects on the delivery of patient and family care include "increased instances of isolation, loneliness, and adverse health consequences" as patients and their family members were involuntarily separated and isolated, including during end-of-life and moments of health crisis (Currin-McCullock et al., 2021, p.93-94).

Healthcare social workers have been on the front lines of the response to COVID-19 since its early days. In the interviews I did as part of this study, social workers described implementing creative and adaptive strategies to ensure patients and family members received

quality care as restrictions and regulations in response to COVID-19 created substantial barriers for many individuals and families. In response to visitor restriction policies, they developed creative strategies to connect patients and family members by facilitating window visits and virtual phone calls (i.e., Zoom, FaceTime). Healthcare social workers also utilized virtual platforms to facilitate the signing of critical documents, such as Power of Attorney (POA) forms, to ensure that the healthcare decisions and/or financial matters of patients were aligned with their wishes in the event of incapacity. Another example includes transportation services as many programs were paused in response to COVID-19 (i.e., Wheels of Hope volunteer drivers). Healthcare social workers advocated for alternative transportation services to ensure that cancer patients received critical treatment. Further, the role of supportive counselling increased dramatically for healthcare social workers as they held the hands of patients who were dying, critically ill, and coping with new diagnoses in isolation due to barriers imposed by COVID-19 regulations (i.e., no-visitor policies, paused in-person support groups). Additionally, healthcare social workers more frequently led spontaneous debriefings with their multidisciplinary team members to provide support during and after critical events. Supportive counselling expanded from patient care to providing support for team members, themselves, and their family members. In addition to these adaptive and creative strategies, healthcare social workers continued to do holistic assessments, risk assessments, discharge planning, counselling, connecting patients and family members with community resources, and advocating amidst dramatically changing conditions.

Without question, the global pandemic has had adverse effects on healthcare workers, and, specific to this research study, healthcare social workers. The adverse working conditions imposed on healthcare workers is well documented in emerging studies (Miller & Reddin

Cassar, 2021; Currin-McCullock et al., 2021; Lai et al., 2020; Greenberg, 2020, Banks et al., 2020, Ashcroft et al., 2021). Conditions including insufficient and scarce personal protective equipment, understaffing due to staff redeployment, overstretched and unavailable resources, and inadequate organizational training and support have contributed to harmful working conditions (Lai et al., 2020; Banks et al., 2020; Ashcroft et al., 2021). According to Lai et al. (2020), "healthcare workers feared contagion and infection of their family, friends, and colleagues, felt uncertainty and stigmatization, reported reluctance to work or contemplating resignation, and reported experiencing high levels of stress, anxiety, and depression symptoms, which could have long-term psychological implications" (p.2). Further, concerns regarding the "mental health, psychological adjustment, and recovery of healthcare workers" who provided care throughout the COVID-19 pandemic are rising (Lai et al., 2020, p.2). Throughout the pandemic, organizations and associations have recommended engaging in strategies that promote wellness and wellbeing to self-regulate and cope with the distress of the global pandemic (World Health Organization, 2020a; National Association of Social Worker, 2020). However, studies that explore healthcare social workers' experiences of distress, wellness, and wellbeing throughout the pandemic are only now emerging.

I undertook this study to explore the experiences of healthcare social workers in Hamilton, Ontario during the COVID-19 pandemic. My particular focus was on distress, wellness, and wellbeing. I sought to understand how social workers experienced care and support during moments of crisis in hopes of highlighting strategies that promote personal and professional wellness. I also hoped to understand how organizations shape workers' experiences of wellness, with the intention that these insights may create direction for more supportive organizational practices.

This research was prompted by my professional practice as a healthcare social worker, where I conduct holistic assessments with patients and families; provide emotional, practical, and informational support; navigate systems and structures, and advocate with patients and families in pursuit of quality care and social justice. Throughout my practice, I have developed questions about how healthcare workers care for themselves and are cared for by others when their work is especially difficult and demanding, and how their organizations affect their wellness and wellbeing (or lack of wellness and wellbeing). Issues that continue to arise within the practice of social work include a high rate of burnout and compassion fatigue. Specifically, "[t]he rate of burnout amongst social workers over the course of their profession is 75%" (Duschinsky, Lampitt & Bell, 2016, p.9). Researchers who examine the conditions of social work labour have pointed to managerialism eroding discretion and autonomy of workers (Baines et al., 2012). Therefore, understanding how social workers experienced wellness and wellbeing throughout pandemic may offer insight on how to sustain the practice of social work. Further, understanding how social workers experienced lack of wellness and wellbeing may offer direction for advocacy efforts related to persistent problems in the conditions of social work labour.

CHAPTER 2: LITERATURE REVIEW

Knowledge about the effects of the COVID-19 pandemic on healthcare social workers is only just evolving. Emerging studies indicate that the highly challenging working conditions during the pandemic place healthcare social workers at high risk of experiencing and developing mental health issues (Ashcroft et al., 2021; Greenberg, 2020). Constrained working conditions have altered and depersonalized the delivery of care, creating additional barriers for social workers to navigate. The main challenges faced by social workers include "a lack of resources to do their jobs, fear about their own health, guilt, shame, grief, exhaustion and a lack of guidance

and training to navigate their changing roles, which put front line workers at risk of moral injury" (Ashcroft et al., 2021, p.4). With worsening conditions during the pandemic, social workers are simultaneously combating wider social, health and justice issues while facing significant suffering and unjust practices within their own organizations (Ashcroft et al., 2021; Banks et al., 2020). The following review of literature has informed my research about the implications of the COVID-19 pandemic for the wellbeing of social workers.

Increased workload

The roles and responsibilities of healthcare social workers have broadened and extended to meet the increasing needs of patients, families, and colleagues during substantial health crises (Banks et al., 2020; Currin-McCullock et al., 2021; Ross et al., 2021). With an upsurge of social isolation, unemployment, and grief and loss, social workers are being met with new challenges and are required to adapt to new and heightened demands of their role – while also navigating their own fears and anxieties during the pandemic (Banks et al., 2020). For example, a palliative care team in Colorado reported a significant influx in referrals as their skills in pain and symptom management, navigating advanced directives and goals of care, and support for grief and loss are in high demand due to the gravity of COVID-19 (Curring-McCullock et al, 2021). In fact, "[a]t the height of the pandemic, the team met with an average of 30-35 families a day, an increase from the typical 15-20 cases daily" (Curring-McCullock et al, 2021, p.95). The challenge, however, is that social work demands surpass resource availability as COVID-related restrictions have decreased community services that practitioners would otherwise liaise with to adequately support patient needs. For example, cancer peer support programs and volunteer-run transportation programs have been reduced and/or temporarily cancelled during COVID, consequently creating additional barriers for patients and challenges for social workers as they

must adapt and prioritize new and complex needs (Banks et al., 2020). Oftentimes, these

complexities sustain the inequities and injustices for populations already on the margins of

society, raising many challenges for social workers in both their pursuit of social justice and

service to humanity (CASW Code of Ethics, 2005).

Depersonalization of care

       While social workers attempt to manage increasing caseloads of complex patient needs,

they must navigate the constrained context of their workplace and the changes in patient care –

particularly the depersonalization of care. In adherence to infection control, care settings have

implemented stringent policies in effort to protect public health. These policies included, but not

limited to, visitor restrictions, isolation measures, use of personal protective equipment, and staff

redeployment. Although necessary in some measures, there are debates about whether some

policies should have adapted more quickly to emerging knowledge, given their profound and

lasting effects on patients, families, and healthcare workers (Curring-McCullock et al, 2021).

These changes to patient care are further described by Curring-McCullock et al. (2021):

       "[w]ith COVID-19 emerging as an overwhelming burden on critical health care

       providers, the quality of care for patients and families has become, and continues to be,

       jeopardized. In addition to the jarring, societal gravity of COVID-19, maneuvering social

       distancing and adhering to quarantine restrictions has resulted in the depersonalized

       delivery of care to patients and families, as frontline staff struggle to overstretch limited

       resources while attending to the suffering of patients and their caregivers." (p.93)

The depersonalization of care creates substantial challenges for social workers as therapeutic

alliance is hindered from lack of face-to-face contact (Ashcroft et al., 2021). For example,

transitioning to virtual care and the use of personal protective equipment (PPE) (masks, goggles,

gloves, gowns) interferes with conducting assessments and therapeutic alliance as practitioners

are unable to use and interpret non-verbal cues (Ashcroft et al., 2021). Further, social workers

report that these measures have decreased access to services for some patient populations

(Ashcroft et al., 2021). Specifically, "virtual care has created barriers for for (i) children; (ii)

homeless populations and (iii) some older adults" (Ashcroft et al., 2021, p.13). Thus, standards

of practice for social workers are threatened as their commitment to delivering accessible

services and fair distribution of resources are greatly challenged (CASW Code of Ethics, 2005).

Additionally, social workers have had to quickly incorporate virtual care without adequate

training or access to reliable technology (Ashcroft et al., 2021). These instances have created

additional stress for practitioners as their value of professional integrity and competence are

hindered.

Redeployment to new settings

The process of staff redeployment was also a significant factor in how social workers

provided and experienced care. Redeployment was an organizational response to allocate staffing

resources to areas in need during outbreak (San Juan et al., 2021). Many social workers were

redeployed to areas that needed additional support, however this process often lacked flexibility,

appropriate training, consideration of professional skills, and consultation with departing and

receiving teams. While social workers develop transferrable skills overtime (risk assessments,

crisis intervention, interviewing, counselling, advocacy, resource allocation), they also develop

specialized knowledge and skills based on their setting and patient population. For example, a

social worker practicing in the pediatric clinic will have distinct knowledge from a social worker

practicing in the adult intensive care unit. Therefore, redeployment meant for some social

workers considerable change in their professional practice (Ashcroft et al., 2021). Social workers

reported feelings of loss and powerlessness from the redeployment process as patient care was affected in both departing and receiving units (Ashcroft et al., 2021).

Further, adequate training and resources were not always offered to redeployed staff given the state of crisis of receiving units. As social workers in receiving units were already overstretched with increasingly complex and urgent patient needs, they often did not have the capacity to train oncoming practitioners. Research by Miller & Reddin Cassar (2021) highlight the correlation between limited self-care practices of social workers and insufficient organizational support, including lack of training. Thus, the process of redeployment frequently contributed to the stress experienced by healthcare social workers in an already challenging practice.

Visitor restriction policy

Grief, loss, and bereavement are universal experiences shared by all throughout the trajectory of one's natural life. The COVID-19 pandemic, however, has exponentially increased these experiences as the likelihood of confronting death has raised exponentially since the beginning of 2020 (Murphy, 2020). Further, grief has been complicated by stringent policies and procedures intended to protect public health and safety. Most notably, visitor restrictions have involuntarily separated families during crucial moments of end-of-life as hospitals have banned and limited visitor presence. As stated by Murphy (2020), "[p]eople have died without the support of loved ones present; funerals have been conducted in a very different manner to the usual practice; and many people's experience of grief and bereavement has been challenging" (p.240). Grief and loss are now compounded with guilt and shame – leaving people at-risk for complicated grief and unresolved suffering (Murphy, 2020). Further, infection control measures have significantly infringed on the rituals associated with death and dying. Meaningful traditions

such as funerals, burials, parades, and family gatherings have been hindered by policies and procedures enacted by health officials. In absence of rituals and traditions, Murphy (2020) reflected on the challenges of processing bereavement as families are left with feelings of being overwhelmed and unsupported.

During these extraordinary measures, healthcare social workers have assumed the role of providing heightened emotional support for dying patients as family and friends are separated involuntarily. Practitioners have facilitated end-of-life conversations like never before as they have held iPads and phones – while fully donned in PPE – up to an isolated and dying patient in effort to connect patients and families during last moments (Murphy, 2020). Research indicates that "it is common for persons helping with response efforts to experience secondary traumatic stress, a stress response that can occur as a result of knowing or helping a person(s) experiencing trauma" (Wallace et al., 2020, p.73). Exposure of secondary traumatic stress has undoubtedly increased for social workers during the pandemic through their efforts of supporting patients and families in otherwise unjust situations.

In their research, Wallace et al. (2020) focus on the relationship between COVID-19 and the experiences of "anticipatory grief, disenfranchised grief, and complicated grief" for patients, families, and healthcare providers alike (p.70). Anticipatory grief is described as the mourning that precedes the death of a person (Wallace et al., 2020). Due to the gravity of the COVID-19 virus, healthcare practitioners are anticipating death at exponential rates – similarly to the experiences of folks watching the global spread on the news as they anticipate the virus moving closer to their proximity, subsequently increasing distress (Wallet et al., 2020). In addition to anticipatory grief, complicated grief is also rising at unprecedented rates as stay-at-home orders

simultaneously isolate and separate loved ones from one another during moments of fear, anguish, grief, and loss (Wallace et al., 2020). Symptoms of complicated grief include: "recurrent intrusive thoughts of the person who died, preoccupation with sorrow including ruminating thoughts, excessive bitterness, alienation from previous social relationships, difficult accepting the death, and perceived purposelessness of life" (Wallace et al., 2020, p.71). Previous research has indicated that complicated grief was significantly related to the "inability to say goodbye to family before death" – a common experience throughout the trajectory of the pandemic (Wallace et al., 2020, p.71). Additionally, experiences of disenfranchised grief are heightened as families are restricted from traditional and ritual practices of grief and bereavement (i.e., funerals, burials) (Wallace et al., 2020). As social workers play a crucial role in end-of-life, they carry with them these substantial instances of complicated grief (Wallace et al., 2020).

Ethical challenges

The pandemic has raised substantial personal and professional challenges for social workers. Ethical dilemmas are at the very core of these challenges as depersonalized care and practices experienced as uncaring and unjust conflict with core social work values of social justice, professional integrity, and service to humanity (Banks et al, 2020). Social workers have been advocating for flexibility within their workplace as stringent policies have placed public wellbeing over individual or family wellbeing, rights and freedoms (Banks et al., 2020). In their study, Banks et al. (2020) reported a variety of ethical challenges experienced by social workers including: 1) hindered therapeutic alliance (trust, empathy, privacy, confidentiality) via virtual care and use of personal protective equipment, 2) challenges in prioritizing new, greater, and

complex patient needs with limited resources, 3) balancing individual rights and freedoms with the wellness of greater society, 4) choosing between professional discretion and organizational policies when practitioners felt protocols were unjust, 5) balancing their own heightened emotions and fatigue while working in crisis situations, and 6) applying the lessons from current practice and rethinking the ways in which structures and systems could be improved on.

The six key ethical dilemmas demonstrated by Banks et al. (2020) suggests that social workers are at risk of experiencing moral distress during the COVID-19 pandemic. By definition, moral distress is the "physical or emotional suffering that is experienced when constraints (internal or external) prevent one from following the course of action that one believes is right" (Wallace et al., 2020, p.73). Constrained working conditions and depersonalized care have created significant issues for social workers while putting them at risk for burn out and compassion fatigue (Wallace et al., 2020; Banks et al., 2020; Greenberg, 2020). Core social work values, such as fair distribution of resources, have been challenged more than ever as demands have increased (both in volume and in complexity) while community resources have closed or decreased (Banks et al., 2020). Social workers have been critical of organizational and government policies that create unjust practices and have exhausted their advocacy efforts for flexibility and change (Banks et al., 2020). Moral distress was also created in situations where practitioners contemplated breaching policies as they weighed the needs of patients against possible health risks for all concerned (Banks et al., 2020).

The literature that was reviewed demonstrates the crucial role of healthcare social workers during the COVID-19 pandemic. Constrained working conditions and depersonalized care, in part from organizational and government policies, hindered practitioners' ability to

practice in accord with their core professional values. The experiences of ethical challenges, moral distress, heightened personal fears, anxieties, and loss, while also navigating increased demands and overstretched resources, threatens the wellness and wellbeing of social workers. This study contributes to the emerging literature on this topic, exploring the organizational and relational levels of care (or lack of care) experienced by hospital social workers. Specific tensions and conflicts are reviewed and have been organized into three key findings, which are further reviewed in the following sections.

CHAPTER 3: METHODS AND METHODOLOGY

In this study, I used qualitative methods to capture the lived experiences of healthcare social workers amidst the COVID-19 pandemic. Specifically, I used qualitative interviewing to explore the reflections of nine hospital social workers in Hamilton, Ontario regarding their experiences of wellness and wellbeing (or lack of wellness and wellbeing) throughout the pandemic.

Approach to the study: Theory, Methodology and Methods

This research was grounded in an interpretive framework with a phenomenological approach to inquiry. For the purpose of this study, interpretivism was used as an umbrella theory with phenomenology as a research methodology and tool to frame the research being conducted. Interpretivism is aligned with qualitative research with a main "focus on *meaning* rather than *measurement*" (Sherman, 1991, p.70). Interpretivism assumes that people are intentional and purposeful by nature and that reality and meaning is constructed by people based on lived experience (Sherman, 1991). As opposed to positivism where objective observation and measurable quantitative data are considered to be the 'gold standard' for validity, interpretivism

appreciates and values the diversity amongst people's experiences and knowledge of a similar or the same event or interaction (Nair & Prem, 2020). Key features of interpretivism that guided this research include: understanding reality as being socially constructed, the value of lived experience, utilizing an interactive and collaborative approach between researcher and participants, and the goal of understanding rather than explaining (Clarke, 2009). These tenets of interpretivism align with the ethical practice of social work as lived experience is valued as a rich and valid source of knowledge. As such, the voices and lived experiences of this study's participants were the foundation of this research.

Interpretivism understands the social world as constructed by human beings, where interpretations are dynamic and *subjective* (Sherman, 1991). The focus of interpretivism lends itself to "an empathetic understanding of individual's feelings and the meaning that they give to everyday life with the goal to gaining greater understanding of the individual's behavior." (Pulla & Carter, 2018, p.9). Therefore, rather than objectively observing human behavior, I collaborated with participants and valued their knowledge of lived experience throughout. Further, interpretivism understands life to be created by one's "reflexivity, positionality, privilege, situated knowledge and perceptions," as these intersecting factors "shape, define and redefine each other" (Pulla & Carter, 2018, p.9). Therefore, interpretivism understands that there are multiple truths to reality that are significantly influenced by one's social standpoint. As a researcher, I found myself compelled by this framework due in part to the focus on positionality and privilege. I acknowledge the importance of reflecting on the positionality and power within the working relationship between researcher and participants, as well as how these positions may influence the participants' role as social workers in the healthcare system. Utilizing open-ended questions and a semi-structured interview format also aligned with interpretivism as, according

to Clarke (2008), "[q]ualitative researchers are deeply involved in the data collection and must be sensitive and flexible to follow the thoughts of the person being interviewed to gain an in-depth understanding of the individual's experiences" (p.11). Thus, asking open-ended questions helped ensure that participants had the opportunity to deeply reflect on their experiences and take their answers to where they felt was important.

With an interpretivist framework guiding my research, I also used a phenomenological method to highlight the lived experiences of hospital-based social workers during the pandemic. According to Singer (2005), "[j]ust as different therapy models provide clinicians with certain assumptions and techniques that direct their practice, different research methods prescribe specific strategies to help researchers manage and organize their data and transform it into meaningful units" (p.272). With the goal of phenomenology being "to establish a close connection with another's experience in order to understand it better and to transform that experience into consensually validated knowledge," I anticipated that centering the lived experiences of healthcare social workers would provide depth and insight, towards understanding the phenomena of wellness and wellbeing for social works practicing during COVID-19 (Singer, 2005, p.272). Singer (2005) highlights an important objective of phenomenology, that is, "bracketing any preconceptions" to ensure that the research being conducted is made unbiased and unaffected by the researchers preconceived notions (p.272). Finlay (2011) clarifies, however, that bracketing is not concerned with objectivity but rather a researcher's ability to step away from "habitual ways of perceiving the world" and "to connect directly and immediately with the world as we experience it – as a opposed to thinking about it." (chapter 2) The phenomenological tool of bracketing was important in this study as I frequently used this tool to ensure that the

phenomenon was being met with openness and "in as fresh a way as possible" (Finlay, 2011, chapter 2).

As this study is intended to delve deeply into life events that otherwise may have been left unquestioned, it is align with phenomenology. Finlay (2011) describes phenomenological research as "…potentially transformative for both researcher and participant. It offers individuals the opportunity to be witnessed in their experiences and allows them to give voice to what they are going through. It also open[s] new possibilities for both researcher and researched to make sense of the experience in focus" (Finlay, 2011, para 1).

Recruitment and Ethics

Participants were recruited through Hamilton Health Sciences (HHS) at the following sites: Hamilton General Hospital, Juravinski Hospital, Juravinski Cancer Centre, St. Peter's Hospital, and McMaster Children's Hospital. HHS is an organization that services southwestern Ontario and provides expertise in areas such as cardiology and stroke, cancer care, pediatrics, and palliative care. As I was interested in how the workplace context shapes social workers' wellness and wellbeing, I sought participants from a single employer. However, I recruited from all HHS locations to ensure that workers in a range of care settings were included. With approval from the Hamilton Integrated Research Ethics Board (HiREB), recruitment was made possible by the social work professional practice lead at HHS. Once she determined that this research was suitable, she distributed an e-mail, including the letter of information and consent form (Appendix 1) to social workers across all HHS sites. Potential participants were informed of their right to withdraw at any point in time during the study as well as the steps on how to do so. Interested participants were encouraged to contact me directly by email or by phone and when

they did, I answered questions, reviewed the study with them, obtained their written consent, and chose a date and time to participate in a one-on-one Zoom interview.

Care was taken to ensure safety and confidentiality as the purpose and potential risks and benefits of this study were outlined in detail in the letter of information. However, two factors remained ethically complex for this research study. First, if participants had or continued to have emotionally difficult experiences during the pandemic, the interview could bring focus to these in an unhelpful or even harmful way. It was possible that questions and discussions relating to their experiences at HHS during the pandemic could trigger distressing memories and invoke feelings of discomfort. To mitigate this risk, participants were reassured that they did not have to answer questions that they did not want to answer or that caused them to feel discomfort or distress. Participants were also reassured that they could take a break during the interview and/or withdraw from the research study at any point. During the interviews, all participants reflected on emotionally challenging experiences during the pandemic. Participants either highlighted hope in light of these otherwise negative situations or reflected on the people and strategies that they used to cope and persevere during challenging moments.

Economic and social risks also posed ethical concern as they were invited to reflect on their perceived support from HHS and people at HHS during the pandemic. Articulating their perceived lack of support from HHS or people at HHS could create worry about others learning what they had said, with potential negative consequences in their work settings. To mitigate this risk, participants chose the name or pseudonym to be used in association of quotes used in this research study. Participants were informed in the letter of information, however, that stories can be identifying and that they may wish to alter the stories they share to mitigate the risk of being identified. Further, participants also had the choice of editing their interview transcript.

Interviews

Due to the COVID-19 pandemic, specific precautions were taken to ensure the safety and wellbeing of everyone involved in this research study. Face-to-face interactions were set aside in favour of alternative and virtual methods of communication, such as email and Zoom. The format of the interviews was semi-structured with questions to elicit conversation regarding experiences of wellness and wellbeing during the COVID-19 pandemic (Appendix 2). This approach created an open and flexible style of interview where the experiences of participants were the focus of conversation and thus direction could be changed based on what participants felt was most relevant to them. The interview questions were designed to guide participants to deep reflection of their experiences of wellness and wellbeing throughout the pandemic. Participants were asked to reflect on how they were and/or were not cared for at work when their work was really hard, if and how they cared for themselves during this time, and how the organization shaped their experiences of wellness. With permission from each participant, I recorded the Zoom interviews for the purposes of data analysis. To assure participant privacy and confidentiality, participants had the choice of editing their interview transcript and chose the name that they would like to be associated with the quotes used in my thesis.

Study Sample

This study utilized a convenience sample approach, where participants were recruited from a pre-determined population of healthcare social workers over a two-month period of time until the desired number of participants (at least five, and ideally 10) was obtained (Luborsky & Rubinestein, 1995). The study sample included nine HHS social workers, including eight female-identified and one male-identified participants. All participants identified as Caucasian. Participants were diverse in their areas of speciality, ranging from inpatient units to outpatient

clinics and varied in patient populations served (i.e., adult, geriatrics, pediatrics). All participants indicated that they worked fulltime with HHS.

Role and Positionality

Throughout this research study, I was reflective of my role and positionality in the research process. My 2019 clinical internship at Juravinski Hospital and role as a healthcare social worker at Brantford General Hospital means I carry 'insider knowledge' of healthcare systems and of the role of healthcare social workers. In acknowledgement of this, I was mindful and reflective of how my knowledge and experience may influence my interpretation of participant experiences. Specifically, I was aware that participants and I might share a set of assumptions about hospital social work, a kind of shorthand that could mean that I would not adequately explore their particular unique individual experiences, and/or that I would overlook the significance of or implications of certain themes because they are so familiar and taken-for-granted. Therefore, and discussed in more detail below, I committed to practicing reflective phenomenology as a researcher, trying consistently to move away from pre-determined and habitual ways of knowing and rather focusing closely on the *experiences* of the participants to guide this research. Further, with the guidance of my supervisor, I stepped away from the pre-defined terms of 'self-care' and 'coping' that I had used early on in the research process to create space for participant-defined experiences based on reflections of their own care needs and feelings throughout the COVID-19 pandemic.

Data Analysis

Once transcripts were finalized, I began analyzing each transcript by carefully reading and searching for salient themes and patterns. As I read through transcripts, I used both interpretive and reflective reading skills (Mason, 2002). Interpretive reading encouraged me to

move away from a literal or positivist approach of analysis, to rather focusing on the phenomena that the transcripts had the potential of leading to (Mason, 2002). This method of thematic analysis aligned with my epistemological perspective and my use of phenomenology as I focused on the interpretations of participants and how they made sense of wellness and wellbeing throughout the COVID-19 pandemic (i.e., social phenomena) (Mason, 2002). Additionally, reflexive reading encouraged me to be aware of and reflect on my positionality and role as a healthcare social worker and the knowledge that this has granted me, and to remain aware and self-critical about how I was interpreting the data. The results section presents the themes and patterns I deciphered from the collective voices of the participants in this study.

Importantly, I must note that while I had set out to conduct phenomenological research, critical theory also had substantial influence on this study as power differentials in the healthcare setting was frequently identified in discussions with participants. As reviewed in the results section, it became evident that systems of power greatly influenced the participants' experiences of personal and professional wellness and wellbeing. Thus, this study is grounded in both the experiences and feelings of participants (phenomenology) and the analysis of social and power dynamics in the relation between healthcare systems and social work practice (critical perspective).

CHAPTER 4: RESULTS

Themes were deciphered through my engagement with the experiences and reflections of participants and thus quotes from the interviews have been used throughout this section. This section attempts to convey the experiences of healthcare social workers pertaining to care and wellness (or lack of care and wellness) during the pandemic. Three key findings are outlined in detail: 1) lack of professional agency and power 2) moral injury, and 3) respect and care –

organizational and relational. Names and workplace settings have been changed in respect of privacy and confidentiality.

Theme 1: Lack of professional agency and power

During the pandemic, longstanding concerns about lack of professional agency and power became more visible and consequential for healthcare social workers. Issues of lack of professional agency became apparent through the redeployment process, and when social workers attempted to advocate for themselves and patients. Throughout our discussions, it became evident that lack of professional agency created distress among participants, in part because stringent policies and procedures impeded on the delivery of quality care and pursuit of social justice.

Powerlessness in the Redeployment Process

Concerns about lack of professional agency were well-demonstrated through the redeployment of healthcare social workers. The strategy of redeployment was used in healthcare systems to combat the surge of COVID-19 patients by allocating staffing resources to units experiencing outbreaks. However, participants reported that healthcare social workers were redeployed without adequate notice, consultation, or consideration of skill set.

Kim explained that the units receiving the most (and the most ill) COVID patients – the ICU, the emergency department, and COVID-designated units – were clear about the kind of staff support they needed:

> They were very vocal that they wanted and needed somebody who could 'hit the ground running'... that was very clearly asked: if people are going to be deployed they didn't have time to hand hold, they couldn't spend time training...

In her view and in the view of other participants, sending (for example) a pediatric social worker to the ICU or the emergency department "doesn't work" because they would not be able to

engage in the fast-paced decision making often needed in these areas and contexts as they are not

familiar with the key healthcare acts and policies (Substitute Decisions Act) relevant to the

patient situations that happen there. Rather, units in need should receive social workers familiar

with the patient population and the context. Yet as she reported,

> HR it seemed made decisions that didn't respect those wishes and people... ended up with staff that didn't meet the meet the criteria that they wanted, and that was very difficult for both sides, right? Because as a new deployed person you want to hit the ground running, or at least be able to perform and not need your hand held and 'where's this again and how do I do that?'… I think it was kind of disrespectful.

 Kim began this account by saying "a social worker is not a social worker is not a social worker,

right?" That social workers were treated as 'interchangeable' parts in a system, in her view,

failed to understand the work and was disrespectful of social work knowledge and skill. Elaine

also discussed the advanced knowledge and skills that social workers acquire while working in

specialized units and reflected on how "it would have been a much more rich process for

everyone involved" should social workers with relevant experience had been given the

opportunity of redeployment to units in need. Elaine further described how the redeployment

process made her feel like "just a number, a widget" rather than a respected professional with

distinct skills and knowledge.

     The lack of control social workers experienced – both those redeployed, and those

receiving redeployed colleagues – stood out in participants' accounts. As Sue put it,

> HR was making some decisions without consulting the people that it was affecting and that caused a lot of distress... for example, a social worker in an outpatient clinic was redeployed to ICU and had never / doesn't have any access to the computer, doesn't know how to document anything, was basically told you have to work these hours, she had childcare she had to make arrangements for and it was weekends and nights and so it just turned their lives completely upside down.

As a social worker on a unit that received redeployed social work colleagues, Penny highlighted a lack of control at her end as well:

> one day when I came to work a social worker appear at my door and I did not expect her, I didn't know she was coming, nobody knew she was here, it was very unwelcoming to the redeployed staff as well, because I didn't know what to do with a new redeployed social worker and when she did finally come I had nowhere to put her, I had no desk for her, I had no phone for her, I had no computer for her, and then they sent us two more so I had three redeployed social workers with me following me around…

In this case, the situation was "very unwelcoming" to the redeployed workers and not helpful (and likely burdensome) to the social worker in the receiving unit. Sue describes a social worker being 'basically told' to work in a setting she was not equipped to work in, and to work hours that completely upended her home life; Penny describes being 'sent' social workers she had no idea what to do with.

The lack of control and agency was felt personally as well as collectively in the redeployment process. As Penny noted, the social work practice council "you would think would be involved at some of these conversations, but they weren't…" As well, Sue went on to describe how respect for social work as a profession in the situation of redeployment would have gone a long way to ensuring the effectiveness of the redeployment process. As she noted, there were social workers prepared to step into positions in the ICU and emergency, but no one gave the social work staff the opportunity to organize their own redeployment:

> If they had asked there probably was a better solution and it would have made a lot more sense... you know, it would be different if nobody volunteers, nobody came forward, but there were people who felt capable and able to step in and really provide quality service to that area, that didn't happen.

Lack of agency in advocacy efforts

Sue describes how one manager attempted to facilitate a more rational and respectful redeployment process by reaching out directly to social workers in the system to describe the needs of their unit and request volunteers with matching skills, from units that could spare a social worker. The social worker heard that this leader had her "hands slapped" for this effort and reflected on how "that was disheartening." Similarly, participants described many instances of advocacy efforts from social workers across the organization to address the needs of workers, units, and patient care with alternative redeployment strategies. Yet, Penny, and other participants, report that their efforts were frequently rejected by leaders:

>…they would say that they would hear what we had to say and then they would placate us by telling us that they really appreciate all the efforts that we're doing… but when you're going through all of this at the frontline, you're trying to tell your leadership, you're trying to express your distress and they aren't really hearing it, they aren't here to see, it makes you feel like you're just completely abandoned by them, because they would nod and then they would not change anything about it…

Penny further stated that "it just made us feel very disposable" and "entirely abandoned" as social workers put their health and wellbeing on the line for patient care and yet their advocacy efforts to create a safer redeployment process were consistently rejected by leaders.

Individual social workers also described several instances in which they attempted to advocate for patients and families affected by COVID-related policies. While everyone understood the need for measures to control the spread of the virus, social workers attempted to bring about flexibility – and humanity – where they thought it was necessary and reasonable. However, their efforts were commonly refused or rejected. Sue described her concerns about patients who would in usual times have choices about what they received to eat, however had this choice withdrawn during the pandemic – and many could not eat what was put in front of

them. As a result, she said, many ate far less than they needed, to the point where some had to be

put on total parenteral nutrition (a method of feeding that gives nutrition through veins). Sue

described her consistent effort – both by conducting her own research on the matter and

consulting with management – to understand why outside food was restricted from patients:

> I kept trying to ask my manager, 'can you explain why food coming in is an
> issue? The things I'm reading does not back that up,' I was trying to advocate and
> understand the rule and the initial thing was basically 'stop asking, I've gone to
> my manager... and there's nothing we can do about it'

Sue spoke about what happened when she continued advocating for change in this procedure, or

at the very least an understanding of the rationale behind food restrictions:

> …there was a lot of conflict – there was huge conflict – with my manager around
> that issue because I wouldn't give it up, I was advocating, and I would not give up
> on that issue when I hear patients, not just one but the whole floor one way or
> another, was impacted by the no food on the floor brought in from outside.

Eventually, Sue reported, she was allowed to 'make the case' – to bring forward the research she

had found that confirmed that the risk of COVID transmission through food and packaging was

very low; she and her colleagues also documented the longer lengths of stay, which they

attributed to delayed wound healing from inadequate nutrition. As I highlight in the discussion,

the perseverance of healthcare social workers became evident through the stories they shared.

More specifically, social workers continued their research, risk assessments, and advocacy

efforts despite continuous rejection and refusal from leadership.

The visitor policy was another COVID-related measure that participants engaged

vigorously with advocacy for more flexibility. In effort to reduce transmission of the virus, HHS

implemented visiting policies where, at its most stringent, hospitals closed their doors to visitors

almost entirely. Participants independent from one another described their experiences of

advocacy in efforts to connect patients and family members in-person being rejected by

leadership. Ava reflected on the restricted visitor policy in the newborn intensive care unit,

where only one parent at a time was permitted to visit their unwell baby amidst rising COVID

cases. Ava recounted her persistent advocacy to unite unwell babies and their families, however,

she was ultimately overruled by leadership:

> I think the hardest part for me has been going to advocate to a higher level to the managers and kind of like the push back and just feeling like you want to be on the same page when there's been a lot of push-and-pull…but like I will be doing a disservice to my patients without even attempting to advocate… I think that even with other social workers like we're not happy with this, what can we do to be okay with it or try to advocate in a different way because there's been many days where we will come to the office just defeated, like I tried, but it didn't work out…

While advocacy is central to practitioners' daily practice, social workers reported feeling

'abandoned' and 'unsupported' by leadership as their advocacy efforts were frequently rejected.

These tensions created additional distress for workers in part because participants felt frustrated

with a system that they felt almost exclusively focused on the physical aspects of health. River

reflected on her frustrations of feeling unheard regarding equally important non-medical factors

of wellness and wellbeing: "[social workers'] concerns aren't going to be just for themselves, it's

going to be for either all social workers, allied health, their unit, the profession – like there's a lot

of shit that's going on outside of just medicine inside hospitals that people need to focus on".

Theme 2: Moral Injury

The crisis of uncertainty that was brought upon by the COVID-19 pandemic led to high-

stake decision making required from leaders within healthcare organizations. COVID-related

organizational decision making was often incongruent with social work values, which sometimes

resulted in moral injury. Historically associated with military personnel, moral injury is defined

as "the distress that arises in response to actions or inactions that violate our moral code, our set of individual beliefs about what is right or wrong" (Alexander, 2021, para 3). It is unsurprising, then, that the term moral injury is now being attributed to healthcare workers as the burden of the pandemic has overwhelmed and strained healthcare resources, ultimately complicating working conditions and the delivery of patient care (Ashcroft et al., 2021; Banks et al., 2020; Greenberg, 2020). Throughout our discussions, it became evident that participants experienced moral injury as organizational decisions moved them away from practicing in alignment with their professional values, consequently creating experiences of distress among participants.

Incongruence between organizational decision making & social work values

Ethical practice is the foundation of social work, and while social workers understand the measures that were taken to contain the spread of COVID-19, they also felt it had impeded on their ability to provide care in congruence with their professional values, in part due to the organization's stringent policy response. Most notably, participants reflected on how the visitor restriction policy and the clinical triage protocol (developed to decipher the distribution of critical care resources in anticipation of a surge in cases that overwhelmed hospital resources) challenged social work values of respecting the inherent dignity of individuals and families, service to humanity, and pursuit of social justice (CASW Code of Ethics, 2005).

Penny explained that when the visitation restrictions came into effect, the policies neglected to outline who would be responsible for assessing cases and determining exceptions. Consequently, she said, the teams would frequently look to social workers to make decisions about visitation:

> … we suddenly became the people making these decisions as to whether or not somebody could come to see their loved one die and that was not – that is not – what I became a social worker to do.

In her view, the sudden assumption of regulating visitations between patients and families

conflicted with her professional role (and values) as she was expected to transition from

advocating for patient rights to enforcing involuntary separation between families. Sue further

described the moral dilemma that arose from these expectations:

> …that was hard, people who were potentially end-of-life and families couldn't
> come in until they were going to die within the next 24 to 48 hours, so these are
> all ethically challenging as a social worker, because we know how important the
> time leading up to someone's death is – not just the last 48 hours, and while we
> could Zoom, we know that's nowhere close to being able to hold the hand of
> somebody who's dying.

In this case, Sue highlighted that although social workers developed creative strategies to

connect patients and families, she still felt the visitor restriction policy hindered her service to

humanity as the process of grief and loss were complicated and caused suffering.

In their discussions, the participants also talked how "policing" visitations was

contradictory to their helping profession. For instance, Penny discussed how her values of

compassion and empathy were challenged when she was expected to enforce the policy and

disallow family members from visiting their loved ones:

> …the whole purpose of social work healthcare workers is to be helpers right,
> we're there to help, we're there to have empathy, we're there to have compassion,
> so it's very contrary indicative to be the people who are saying, 'no you can't
> come'…

Penny highlighted the duality that the visitor policy created for the role of social worker, where

restrictive and enforcement measures were not in alignment with the values and visions of social

work practice. Kim talked about how the visitor restriction policy also affected rapport with

patients and families, as social workers' roles in preventing visiting affected supportive care

efforts:

34

> …it's hard to kind of play both roles at the same time because you're being heavy in terms of, 'no you can't come in' or 'it has to be one person, one person only' and then 'oh, by the way, we need to talk about this treatment decision and what we're going to do from here.'

From her perspective, establishing rapport with patients and families was hindered from the burden of enforcing visitation policies. Consequently, important conversations around goals of care, withdrawal of care, and grief and bereavement were jeopardized as patients and families may have not always trusted social workers as they usually would. From the interviews, it became apparent that the visitor restriction policy, and the sudden expectation of social workers to regulate and enforce visiting, created moral distress as practitioners felt the policy conflicted with their core professional values and principles. Most notably, enforcing visitor restrictions caused *suffering* for patients and families, where social workers usually strive to promote the *wellbeing* of patients and families.

Organizational decision making during the pandemic was evidently incongruent with social workers' pursuit of social justice, an important value of the social work profession. Participants identified many instances where policies and procedures created additional barriers for individuals and families to access services. Harper described how insufficient access to personal protective equipment led to the organizational decision of transitioning to remote work via telephone. She explained that this transition created additional barriers for her patient population as they often "don't have access to a phone or they have cell phones that they're not able to afford to top up every month." Similarly, Nicole highlighted that the transition to virtual platforms created barriers for people with hearing or visual impairments, and for folks without internet access. Participants unanimously acknowledged the increase of both social isolation and inequality projected onto individuals, families, and communities who are already on the margins of society, and how organization decision making sustained this inequity.

The clinical triage protocol draft was another plausible threat to the pursuit of social justice as social workers feared the possibility of patients being denied from critical care resources based on discriminatory criteria. This protocol was developed by the government with the purpose of responding to situations where the demand for critical care resources surpassed the availability within Ontario healthcare systems (Ontario Health, 2020). Drafts of the protocol have surfaced, though the final copy has not yet been made publicly accessible. In short, the protocol draft outlines both inclusion and exclusion criteria for critical care resource allocation, where both life expectancy and comorbidities influence eligibility criteria (Ontario Health, 2020). While social workers were not expected to allocate critical care resources, they were expected to support patients and families who were declined these life-saving measures. Camille reflected on the reality of social workers' role in the protocol as COVID cases were at their highest:

> … it was hard during the pandemic when the COVID numbers were really high and there was all that talk about the critical care triage and the limited ICU capacity, and how social workers would be involved with that, that was that was definitely a scary and very daunting time…

Participants voiced their concerns over the presence of significant human rights issues within the clinical triage protocol as many aspects violate people's right to equal protection without discrimination. For social workers, the pursuit of social justice is grounded in fairness and equity in the distribution of resources (CASW Code of Ethics, 2005). Thus, the plausibility of this protocol led to many social workers questioning their alignment with the healthcare system, in part, from the incongruence of their values and visions of patient care.

Implication for wellness and wellbeing

During the interviews, it became apparent that participants experienced increased grief and loss (for patients and families, for the changes in their professional and personal lives), fear

about potential health risks (for themselves, their loved ones, colleagues, and patients), guilt

(from feeling complicit in unjust practices), and betrayal (from organizational leaders).

Participants were especially distressed by situations that compromised patient and family rights,

specifically visitation and food restrictions. Further, perceived betrayal and inadequate support

from leadership during these situations hindered practitioners' experiences of wellness and

wellbeing as they felt powerless in their professional role.

Most notably, participants reported that the visitor policy was profoundly distressing.

Penny described the effects that her role in enforcing visitor policies had on her wellbeing:

> The visitation piece of it and in of itself, I can say, has caused me immediate
> trauma. It has caused nightmares, I couldn't sleep properly through the nights, I
> absolutely dreaded coming to work, many, many days. Lots of tears, lots of anger,
> lots of frustration, lots of feeling extremely failed by the [hospital] corporation…
>
> …it was extremely distressing, like traumatizing, this whole process has been
> traumatizing and a big piece of it does revolve around visitation for us because it's
> both physically and emotionally and like verbally, it has made us very unwell.

From her view, she felt betrayed by the organization as she was instructed to enforce and

regulate policies that impeded on her professional values. Apparent in her response, she

experienced significant distress from separating families in moments of crisis as she felt

complicit in actions that would have profound effects on patient and family wellbeing.

Additionally, Penny stated that she began to question herself on a personal level: "am I

terrible?", as both families and colleagues viewed her as "uncompassionate" in decision making

that was guided by "grey policies" from leadership.

River describes situations where, despite advocating for change, people at end-of-life

were still being restricted from visits with loved ones:

> My co-worker reached out to say like, 'we have people dying here without seeing
> their families and we're still limiting them when they're dying' and patients have
> brought this up too enough times; one patient told us, 'the one day I look out the

> window and I see this bus full of people getting off there, but only one son can visit me here while I'm dying at a time' – how the fuck do you respond to something like that?

In this quote, River seems to be highlighting two sources of distress: families were not allowed to be together when a family member was dying, and social workers were consistently countering patient and family distress and anger about the situation. Social workers had to respond to this distress and anger, and the strong sense of unfairness communicated by patients and families. The impossibility of this situation for social workers is reflected in the quote – "how the fuck do you respond to that?" River reflected on her experiences of guilt and shame from unjust practices (patient isolation) within her organization, and how this affected her ability to experience joy and wellness within her own personal life:

> How do you care for yourself but you're still taking home the fact that we are missing a lot of gaps here, how do I go home and do the things that I'm going to do while knowing that our patients are here isolated – they can't even see one another, so all that kind of plays into how you care for yourself, how you respond to your family members, your spouse as well, or lack thereof, because sometimes it's just nothing, sometimes it's being left alone, sometimes it's isolating, sometimes it's just being alone and I want to go to bed right now.

River, and all participants, were critical of organizational policies and procedures as they acknowledged and responded to (through advocacy) the heightened isolation and suffering of patients and family members created through COVID responses. Participants reflected on the challenges of maintaining an ethical practice during COVID, and consequently, the distress they suffered because of this.

A few of the participants reflected on situations that evoked strong reactions based on conflicting views with management:

> …I broke down about that, I mean, I broke down in front of my manager, I was crying because this makes no sense and you just keep telling me no and I'm like that's not acceptable, I need to understand why so I can go back and explain to the families and patients because they're not understanding this..." (Sue)

> …you want to be on the same page [with management] where there's been a lot of push-and-pull, which I think it's like they have to follow these rules, but I will be doing a disservice to my patients without even attempting to advocate, and I think that for me has created some distress. (Ava)

In the first quote, Sue reflected on the restriction of outside food from patients during the pandemic. After months of refusal from management to provide an explanation, she described breaking down in tears as she struggled to uphold the wishes and rights of patients and families in a measure that she felt warranted flexibility. The second quote described the distress experienced by Ava based on the conflict between her visions and that of management (regarding visitor policies). During this discussion, she stated that although she understood the difference in perspectives and decision-making, she felt "mortified" in knowing "the long-term impact it's going to have on [patients and families], so like, the rest of their lives because of decisions we're making now". These experiences of moral distress were common throughout discussions with participants; most practitioners spoke about their professional duty to uphold their values and visions, and experienced distress when they were prevented from doing so.

Sue, Ava, and Penny described experiencing the anger and frustrations of patients and family members regarding restricted visits:

> …our [social workers] took a lot of the force of very upset, angry people, distressed because of the impact of that 'only one parent can be in NICU at a time right now', and still to this day like now that's been very hard to manage with people so we take the burden of that… (Ava)

> …I mean, we also took a bit of abuse from some of our family members about the rules… (Sue)

> The amount of times that we were called cruel, unfeeling, other terrible names and words, those types of things don't just roll off of you, they really stick with you because it's very much not what I want to be. I'm not here to be cruel, I'm not here to be unfeeling… (Penny)

In Sue's quote, she described instances of 'abuse' from family members who were "resisting" and "really angry" during conversations regarding visitor policies. Similarly, Ava stated that family members often directed their anger and frustrations towards social workers, as they were frequently the practitioners who were tasked with enforcing visitor restrictions. Penny further described how her identity (*that is not what I want to be*) and purpose (*I am not here to be that*) as a social worker were challenged by being called names, such as cruel, by patients and families. Both Penny and Ava refer to the enduring effects on them of these difficult interactions with patients and families – 'really stick with you' ; 'still to this day…that's been very hard to manage'. Healthcare social workers were conflicted between following organizational policies and promoting their core values and principles as professionals. These experiences led to moral distress that are well demonstrated throughout the quotes of participants.

Theme 3: Respect and care – organizational and among colleagues

While participants described many serious challenges to their wellness and wellbeing during the pandemic, and indeed described an overall high level of distress, they also highlighted protective factors of their wellbeing. Most commonly, participants noted that the response of respect and care from both the organization and among colleagues preserved some aspects of wellness. For example, the development of the resilience team within HHS was found to be resourceful and valuable among all participants who were able to access this service. The resilience team was readily accessible for six out of nine participants, or those who worked on inpatient units. Social workers valued and leaned on support from colleagues. However, peer support was not always straightforward, and was sometimes thwarted.

Responding to heightened stress among colleagues

Social workers are frequently referred to as the experts of coping and wellness and the go-to practitioners for when crises emerge. During the pandemic, they found themselves called on and relied upon much more significantly, including by their colleagues. Penny described instances of increased emotional labour during the pandemic:

> The team really leaned on us the best of times and they leaned on us even more so throughout the pandemic…we were supporting staff who were distressed throughout the pandemic – and I mean staff support like we have never seen, like full on impromptu group therapy sessions at nursing stations that we were running impromptu that we weren't planning for.

Penny described the spontaneous group therapy sessions at nursing stations as "very challenging" yet also crucial moments in acknowledging the shared experiences of healthcare work during the pandemic. She states that these moments were a time for everyone to find "validity" in their collective distress.

River reflected on the challenges of navigating heightened distress among both patients and colleagues:

> …it's an odd position to be in for social work because, at the same time, you're also responsible for everybody else. We're the folks that get pulled aside by management positions asking about anything for particular staff or 'do you think we're doing this okay? What are your thoughts on this?' so it's a lot of layers to try and either see through or unravel at the same time and balance out because you want to take care of yourself … but how do you really do that while working with folks who are dying and working with staff with complex matters as well as their own grief throughout this pandemic…

In this quote, River demonstrated how social workers were called upon more significantly during the pandemic as distress, grief, and loss became heightened among patients and peers. As described by River, managers were consulting with social workers in hopes of receiving guidance on how to adequately support workers. Practitioners were often overstretched as worsening conditions heightened the need of their skills and knowledge among patient populations and among colleagues.

Resilience team

      In an effort to protect the wellness and wellbeing of frontline workers, HHS developed a framework of PAUSE, RESET, NOURISH, or PRN (Hamilton Health Sciences, 2021). This framework is based on neuroscience (neuroplasticity) and the theory that our brains constantly change based on how we think (Hamilton Health Sciences, 2021). The abbreviation PRN is familiar to healthcare workers, meaning "as needed". The purpose of this framework is to encourage staff to engage in small, frequent practices throughout the day that focus on calming the nervous system (Hamilton Health Sciences, 2021). As mentioned by several participants, a major component of the PRN approach is the Resilience Team. This team includes onsite psychosocial specialists whose sole purpose is to support staff throughout the organization. The Resilience Team periodically meets staff on the units and provides (optional) support, including team debriefing, individual support, group activities, moments of mindfulness, humour, and resources.

      River described that since the implementation of the PRN framework, her multidisciplinary team began daily practices of mindfulness (breathing exercises) – which have continued to this day:

> I guess you could say the best way that we've been practicing self-care is just taking moments daily for ourselves and practice resilience in the morning as well at one of our huddles, there is a deep breathing exercise called the Lotus flower… it is a nice little break in between, and the reason why I mention that is it's really good to have moments like that continuously rather than just saying 'I'm going to take today off and have a bath' – which is great too don't get me wrong but it's very nice to just continuously have something and to recognize it as well.

In this scenario, River reflects on her teams' commitment to cultivating mindfulness through daily deep breathing exercises, an approach that was introduced by the resilience team and continued by the unit. Deep breathing can help calm anxious thoughts and foster the

development of distress tolerance while calming the nervous system. It may appear minimal,

however breathing exercises provide practitioners a moment to ground themselves, cultivate

calmness, and thus preserve their capacity for responding to patient and family needs. River

further described how these moments supported her wellness and wellbeing:

> We hoped to kind of seize a moment during the day where we're all together, we all can breathe for a few seconds here, drop what we're doing – unless something is happening, of course, but just take a moment to center yourself, feet planted, know where you are, listen to your body, get back to it. This started during the pandemic and it's been, I find, really beneficial but it's also really nice the way it's presented, too, because it's not something everybody has to do which I think is a really important aspect of resiliency because everybody is their own person and their own individual matters of how you handle your own grief or your own stress is important to acknowledge too because there's no blanket that's going to figure it all out for everybody.

Importantly, River highlights the individuality of wellness and wellbeing. From her experiences,

the Resilience Team respected this facet by giving practitioners the option of participation.

Interestingly, River described how these exercises were implemented at the beginning of the

pandemic however have become integrated in her daily practice. This highlights a positive

outcome of the organization's response to COVID-19, normalizing and integrating activities of

wellness into daily practice.

Nicole shared her experience of the resilience team where she described a time that she

felt supported by the Resilience Team facilitator:

> After huddle, she said, 'how are you today?' and I was like "oh I'm okay' and she just saw right through it and asked if I have a second to talk about that 'okay', and the thought flashed in my head like, do I really have time to sit down and talk about this? That was my initial thought and I'm pretty sure she could see me thinking about it … and I don't remember what she said but I was like, 'actually yeah let's have a chat' and it was nice to talk to them because you feel like they're genuinely interested in making sure that you are okay and then because they work in the hospital with you they can sit and work through what some options are that you can do work wise to resolve a problem, but then also what you can do for self-care and personal as well … and I felt heard, which was nice.

Nicole echoes the reflections of River, where the resilience team prioritized giving practitioners the choice of engaging, a similar value of social work (meeting people where they are at). It is possible that this alignment with social worker values established a safer space for this participant – encouraging her to engage in the support offered. Additionally, those who chose to engage in support directed the conversation – whether it be personal or professional related, or both. In Nicole's quote, she highlighted how she sought support over a work incident and strategies for personal wellness. Interestingly, Nicole stated that she felt heard – something that has otherwise been reported as missing (and needed) by other participants during their reflections of leadership.

In the section above, participants in this study discussed how they were often the people turned to by colleagues in distress. This was one of the reasons participants valued the Resilience Team – it meant that this role of 'caring for the caregivers' was shared, and institutionally supported. Ava described how sharing this role with the Resilience Team preserved her wellness:

> think that was very thoughtful in their process, that hopefully we could use the resources to tell colleagues, 'hey why don't you look at this' and familiarize myself – also for myself, but also so I know what I can tell people if they need something because they're likely to come to a social worker and ask.
>
> I think that is a positive thing that they're trying to really get as many resources out there for people … I think that sometimes it's a hard position because we have taken on the ownership of caring for patients but also during this, I think a lot of caring for staff and their coping which has been a big thing in some ways…

The consensus among participants was that the resilience team was an essential part of their journey during the pandemic and has been integral in preserving their wellness and wellbeing. Their offerings of individual support, team debriefings, group activities, humour, encouraging moments of mindfulness, and resources for staff were invaluable. Participants reported feeling empowered in moments of despair, supported while otherwise feeling

'abandoned', and heard when they needed it most. It is apparent from the stories told by

participants that the resilience team was a great strength during the pandemic and potentially an

initiative that continues within the organization and inspires others to support the wellness and

wellbeing of staff.

Peer support

For the most part, social workers valued support from colleagues and frequently reported

leaning on one another throughout the pandemic. Camille described her experiences of support

from colleagues in moments of adversity:

> …when I was at work and I was feeling overwhelmed or particularly kind of
> saddened about a specific case I would very much lean on my colleagues for
> support and I would try to celebrate the small accomplishments and then debrief
> the more difficult ones.

Camille's quote demonstrates the value of respect and care among peers as she described feeling

confident in her ability to rely on her colleagues for support during reflections of challenging

cases. This experience of team debriefing was reflected in all interviews; participants often

reflected on their appreciation of all team members and reported many instances of feeling cared

for by peers:

> …my colleagues were always checking in with me in terms of, 'how are you
> doing? Are you managing? Are you coping? We're worried about you' … who
> you work with makes a lot of difference in terms of your workday or how it goes,
> or your work-life satisfaction, I think. (Kim)

> I felt very comfortable reaching out to colleagues or to my manager when I felt
> that I needed them or just needed an ear or needed to run something by them or
> support … I also felt very comfortable knowing that if and when I needed that
> support that time was taken and I was listened to and attended to. (Harper)

> …we started about a month ago doing a weekly check-in…seeing how
> everybody's doing, what we can do to support one another, what we know that's
> new to support one another, what are we thinking about from the future as well…
> (River)

Reciprocal peer support was reported as particularly valuable during moments of crisis. In one

quote, River reflected on how she and her colleagues felt supported at work based on finding

validity in their shared experiences:

> … people almost would rather be here at times because it helps process things a
> little bit better with things that don't need to be mentioned, we don't need to have
> a discussion about something that we know, without saying words we know how
> one another are affected by this – to a certain degree, and it's a bit easier to be
> here with those folks while we're laughing – because we're still laughing about
> things, and then how we respond and how we still provide care at that same time
> so it's almost in a sense that it's a bit more difficult to be at home and take a day
> off than to be here and work through all these challenges as well and that's been
> said from numerous staff as well outside of social work.

This quote demonstrates the power of peer support– a powerful method of preserving wellness

and wellbeing as the risk of isolation decreases through the strengthening of meaningful

connections via shared experiences. As reflected in River's quote, healthcare workers alike have

shared similar experiences throughout the pandemic and may find a sense of validity and

connection through this deeper sense of understanding among one another – potential healing in

of itself.

Participants reported that peer support was sometimes undermined by COVID-related

stress within their workplace. Most notably, the visitor policy created significant tension among

colleagues as everyone felt particularly distressed by the organization's decision to separate

patients and families during critical moments. As a result, displacement of frustration was

sometimes experienced among colleagues. Penny reflected on the lack of care and respect she

experienced within her team when COVID cases increased, bed availability was stretched, and

visitations were further restricted, "team members started pinning against team members and

people start pinning against you because they feel that you're making uncompassionate

decisions". She stated that she was "in between a rock and a hard place" as she was frequently

looked at by team members to enforce and regulate visitor policies – that she too felt were unjust, yet unsupported by peers in the process of making really hard decisions guided by policy.

Penny also reflected on a time that she felt she lacked care and respect for her colleagues during the redeployment process. As previously discussed, Penny received several redeployed social workers without notice, and thus was not prepared for their arrival:

> …that was the worst – not knowing what to do and then also again, knowing that you're supposed to be welcoming them and training them and I just didn't have the time or the wherewithal, I wasn't coping already as it was and then they were here on top of that, and I just felt like such a terrible social worker and teacher and colleague and I just felt terrible all around.

This quote demonstrates the consequences of COVID-related stress on peer support, where sometimes practitioners felt unable to provide adequate care and support for their colleagues as they did not always have the capacity to do so. Elaine reported an instance of feeling uncared for by peers when she returned to her unit after unanticipated time away:

> …just subtle things that are sort of like you're back but we're not going to let you fit in right away … it was hard enough as it was to just then have all this sort of bumpy stuff, people just either not saying much or, 'oh hi' and then walking…

From her view, she felt unsupported by her peers upon her return during a time that she reported needing support the most. Interestingly, she informed me that she has also put herself in the shoes of her peers and can empathize with them in the sense that perhaps they felt "they were doing all of the heavy lifting" while she was away. Her narrative points both to the choices her colleagues made about how to treat her, and also the very difficult organizational context of their actions.

CHAPTER 5: DISCUSSION

This study set out to explore the experiences of healthcare social workers in Hamilton, Ontario during the COVID-19 pandemic. My particular focus was on wellness and wellbeing, or

lack of wellness and wellbeing. Understanding how social workers experience wellness and wellbeing may offer insight for sustaining the practice of social work, while recognizing factors that hinder the experiences of wellness may offer direction for advocacy efforts related to persistent problems in social work labour conditions. The participants' discussions demonstrated key issues of tension and conflict, and effectively illustrated how organizational processes and decisions affected social workers' experiences of care. This included perceived lack of professional agency and power, particularly regarding the redeployment process and in advocacy efforts, and experiences of moral injury as practitioners felt distressed by the incongruence between organizational decision making and core social work values and ethics. Participants did note, however, that experiences of respect and care – both those initiated by the organization and among colleagues, preserved some aspects of wellness. Most notably, the development of the Resilience Team and experiences of peer support were reported as protective factors. These results are discussed in further detail below.

Professional powerlessness

Lack of professional agency and power were well illustrated in this study. All participants reflected on instances where they felt unheard and devalued in their advocacy efforts for flexibility and change in stringent organizational policies. The theme of professional powerlessness is not uncommon to the profession of social work – particularly in healthcare settings. For instance, O'Donnell et al. (2008) noted that social workers may experience power differentials as their role has been historically subordinate to other disciplines within the medical hierarchy. Although my study does not suggest the social work role as subordinate within

healthcare, participants' significant experiences of lack of professional agency and power may demonstrate a lack of respect or understanding for the role of social work within healthcare.

Powerlessness and misconceptions about the social work role is well demonstrated in the redeployment process. Several participants stated that social work teams had proactively developed redeployment drafts among themselves based on their relevant experience, skills, and knowledge. Despite these efforts, participants noted that they were never consulted and rather the redeployment process was dictated by senior administrators. Consultation with the social work practice council was also neglected from redeployment planning. Further, participants stated that decision makers gave no consideration to skill set as practitioners were placed in settings without relevant skills and knowledge. Participants stated they were treated as 'interchangeable' in a system that failed to recognize specialized social work knowledge and skill. This study extends and confirms the reviewed literature of Ashcroft et al. (2021), where social workers reported feelings of loss and powerlessness in their professional practice as the redeployment process lacked flexibility, adequate training, and consideration of relevant skills and knowledge.

Participants also described feeling powerless in their advocacy efforts for patients and families affected by COVID-related policies. While the purposes of infection control measures are understood, social workers also acknowledged the substantial implications of these on the wellbeing of patients and families. Several participants noted that they were rejected by leaders when advocating for what they felt was reasonable and warranted flexibility or discretion, and consequently felt 'abandoned' and 'disposable' when their professional voices were rejected. While the research conducted by Banks et al. (2020) suggested that some social workers contemplated breaching policy or went ahead and used their discretion, none of the participants

in this study reported using their professional discretion against organizational decisions. Nonetheless, participants were critical of organizational policies that created unjust practices and continued their efforts of advocacy for change.

The collective action of healthcare social workers is significantly affected by the hospital's infrastructure. For example, prior to hospital restructuring in the late 1990s, HHS had a dedicated social work department. In 1999, Globerman (1999) wrote, "hospital restructuring is not negotiable" and "many discipline-specific departments are being dismantled and the resulting losses and anger are enormous" (p.17). Currently social workers no longer have a paid professional leader or department and efforts to coordinate and collaborate as a discipline are facilitated by social workers volunteering their time. The consequences of a dismantled social work department are reflected in the experiences of participants in this study– specifically a lack of professional power and autonomy. For example, practitioners expressed feeling disempowered in their advocacy efforts, in part, because a formal avenue for their collective professional voice is missing in their infrastructure. Reintroducing social departments, therefore, may more adequately support the autonomy of social workers as professional standards would be shared and their discipline would hold more power in making change in relation to these standards.

Moral Injury

A significant theme regarding the experiences of moral injury among healthcare social workers was identified in this study. Organizational decision making during the pandemic created substantial distress for practitioners as decisions were often incongruent with core social work values. As noted by O'Donnell et al. (2008), the values of social work may be in alignment with some of the organizational mission statement, however there is often an incongruence in the

hierarchy of values. For instance, the organization's decision to implement stringent visitor

restrictions disregarded patient and family wishes and caused suffering in favour of

organizational and public health. As demonstrated in this study, overly rigid interpretation of the

policy, lack of careful assessment of actual risks in particular situations, and lack of discretion to

make exceptions created significant distress for most participants. Visitor restriction policies

significantly conflict with the social work values of self-determination and autonomy, thus

creating challenges for practitioners in adhering to their professional standards of practice. These

findings confirm previous studies, where conflicting values created moral distress in practitioners

and impeded on their experiences of wellness and wellbeing (O'Donnell et al., 2008; Stanford,

2011; Banks et al., 2020).

Participants also experienced moral distress in their complicit role in enforcing visitor

restrictions. Banks et al. (2020) described instances where therapeutic alliance was affected by

PPE and physical distancing. My study adds to this by showing how therapeutic alliance was

affected because the social work role of enforcing visitor restrictions undermined patient and

family trust in social workers. Participants identified that visitation policies created a duality in

their role as 'policing' visits is contradictory to their helping role. Many participants described

feelings of distress during this process as they were sometimes viewed as uncompassionate and

uncaring. One participant had mentioned on several occasions that the visitor policy had created

immediate trauma for her and described difficulties with sleeping and nightmares.

Moral injury had also developed among participants due to the significant increase of

inadequate and inequitable distribution of resources for those in need. With worsening conditions

of patient populations, participants reported an increase in demands – both in volume and

complexity, while at the same time resources were becoming unavailable and / or significantly reduced due to the temporary cancellation of services. For example, social workers were expected to discharge folks facing homeless while shelters were at capacity and / or locked down due to COVID outbreaks. Similar experiences were reported for older patient populations who could not return home, however local retirement homes were at capacity or experiencing outbreaks. Still, social workers were expected to prioritize patient needs without availability of resources to meet the complexity and volume of demand. All participants reflected on the influx of referrals – ranging from financial support to grief and coping, and described experiencing distress as they felt unable to meet patient needs adequately. These findings extend the study of Banks et al. (2020), as their research reported the ethical challenges experienced by social workers in prioritizing the needs and demands of service users as community services were drastically reduced during a time where the suffering of communities increased (i.e., heightened financial crisis, grief, loss, isolation).

Challenges to professional integrity was also found to create moral distress among participants. As practitioners reported that some COVID-related organizational policies were unjust and overly rigid, several participants advocated for flexibility and change to accommodate the needs of patients and families. As previous mentioned, these efforts were often rejected. There was one incident reported by Sue where she described success in her perseverance, however several other instances reported by practitioners led to less desirable outcomes. As a result, practitioners were often complicit in practices they perceived to be harmful and often unjust, adding significant stress to already challenging working conditions. Several participants described experiences of distress as they acknowledged the implications these practices would have on the lives of patients and families.

The experiences of moral injury described in this study highlights the difference in prioritization of values between healthcare organizations and social work practice (O'Donnell et al., 2008). This incongruence interferes with practitioners' ability to practice in accordance to their professional standards, creating ethical dilemmas and distress for workers (O'Donnell et al., 2008). Previous research has suggested that with the support of adequate resources, practitioners can remedy some this distress (O'Donnell et al., 2008). In this study however, participants reported stretched and frequently unavailable resources, thus heightening experiences of distress.

Respect and Care

While several challenges to maintaining wellness and wellbeing were reported by participants, they also frequently reflected on the value of respect and care, both organizational and relational. Most notably, participants reported the Resilience Team to be a very valued resource as they felt supported, heard, and cared for through their support strategies. The Resilience Team offered team debriefing, individual support, group activities, moments of mindfulness, humour, and resources – all of which were reported as helpful in preserving their wellness. Several participants made note that participation was always optional and described this as an integral aspect of resiliency as each person manifests wellness in different ways.

As reported by several participants, the Resilience Team manifested a climate of mindfulness and care on the inpatient units. This was reflected in River's description of the changes to her team's morning huddle routine, where their physician or case manager now facilitate deep breathing exercises on a daily basis based on their experiences with the Resilience Team. Normalization of wellness practices was reflected throughout participant's discussions and can be seen as a positive outcome of the organization's response to COVID-19. Further,

participants reported the personal and professional value of the Resilience Team as practitioners were offered a place of support to debrief challenging cases *and* personal challenges. This is important as practitioners are often faced with critical incidents however are not always offered safe spaces for debriefing, reflection, or processing due to patient privacy and confidentiality.

While Banks et al. (2020) discussed circumstances of practitioners balancing their own emotions while working moments of crisis, my study drew attention to how a key experience for these hospital social workers was responding to the heightened emotions of their healthcare colleagues. Several participants noted the benefit of the Resilience Team in that they were no longer the sole practitioners available to support colleagues. As described by Penny, social workers frequently led 'impromptu group therapy sessions at nursing stations' to support staff in distress. These instances were common among several participants who reported feeling overwhelmed by supporting patients and families, their own loved ones, and colleagues, while also navigating their own heightened emotions during the pandemic. The organizational response of care and support through the Resilience Team thus was found to lessen the strain and preserve the wellness and wellbeing of social workers during the pandemic. From this finding, an area of advocacy could be for more organizational supportive practices to ensure that caregivers are receiving adequate care and support – not only from colleagues, but importantly from the institution.

Support from colleagues was also found to be significantly important in the preservation of wellness and wellbeing among practitioners. Indeed, Kinman et al. (2020) found that peer support helped to normalize responses during the challenges faced by healthcare workers during the pandemic. This idea of normalization and validity through similar shared experiences are

well demonstrated in conversations with River as she felt that processing challenging workplace moments was better achieved at work than at home, in part because her peers in some way shared an understanding. Similarly, Penny, Camille, and Sue reported finding comfort among colleagues during challenging moments as they felt connected through a sense of understanding without always having to describe their thoughts and feelings.

In addition to reports of relational care and respect, this study also found that peer support was sometimes thwarted due to high stress working conditions during the pandemic. From discussions with participants, it was found that organizational policies, most notably the visitor restriction policy, created significant tension and conflict among colleagues. While navigating visitor restrictions, Penny shared that she felt unsupported by colleagues when having to make really hard decisions that she too felt were unjust and had unsuccessfully advocated for change. Elaine also described instances of feeling uncared for by colleagues when she returned to her unit after unexpected time away. She reflected on feeling 'unwelcomed' but interestingly placed herself in the shoes of her colleagues and reflected on their 'heavy lifting' while she was away. Incidences of conflict and tension between colleagues may have been the displacement of intense emotions. It is likely that the practitioners' feelings of being overwhelmed, strained, and overburdened by increased workloads, stretched resources, and inadequate support from their organization led to displaced frustrations among one another. This creates direction for advocacy as group cohesion and workplace culture are threatened when organizations are insufficient in their supportive practices of workers.

Conclusion

As with all studies, this research has limitations and the topics it addresses would benefit from further examination. The sample for this study included healthcare social workers in Hamilton, Ontario, who work with a variety of patient populations across Hamilton Health Sciences. As seen in the results section, practitioners' experiences of distress (or lack of wellness) were significantly shaped from an organizational level. For future research, it may be beneficial to include and compare additional healthcare organizations. Extending research to multiple organizations may draw together similarities and differences in the ways social workers experienced (or did not experience) care and wellness organizationally. From this knowledge, advocacy efforts may arise to promote workplace wellness with effective strategies.

What this research (in the specific context of hospital social work during COVID-19) teaches us about hospital social work is that organizations play a significant role in shaping practitioners' experiences of wellness and wellbeing, or lack of wellness and wellbeing. Specifically, hospital social workers feel uncared for, unsupported, and devalued by leadership when their professional voices are refused and muted by leadership. Neglecting to consult and liaise with the social work committee, and social workers themselves, regarding processed that directly affect their practice creates feelings of mistrust and betrayal. Lack of professional agency and power heightens distress among practitioners as their rejected advocacy efforts often lead to unwanted complicity in unjust practices and compromised patient care. Additionally, incongruence between organizational actions or inactions and the practitioners' professional values creates substantial moral distress in workers as they are pushed further away from practicing in alignment with their standards – again developing feelings of organizational abandonment. Sometimes, stringent organizational decision making can also hinder peer support among colleagues (an important strategy of preserving workplace wellness) due the displacement

of frustrations. In closing, this literature offers future direction for advocacy efforts in re-establishing social work departments within healthcare to preserve professional agency, develop peer support programs to provide care for caregivers, and develop more transparent, regular, and reciprocal communication and consultation between leadership and practitioners.

APENDIX 1

LETTER OF INFORMATION / CONSENT

Self-care and Coping Strategies of Hospital Social Workers During the COVID-19 Pandemic

Investigators:

Local Principal Investigator: **Student Investigator:**
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Purpose of the Study

The purpose of this study is to explore how healthcare social workers experienced self-care and coping strategies during the COVID-19 pandemic. This research intends on exploring the impact of COVID-19 on hospital social workers through the narratives and reflections of Hamilton Health Sciences (HHS) and St. Joseph's Hospital (SJH) social workers themselves. This research is being conducted for the purpose of my thesis.

You are invited to take part in this study that seeks to explore the self-care and coping strategies of healthcare social workers during the COVID-19 pandemic. I am hoping to learn about how you experienced self-care during this time and in part as a way to understand how HHS/SJH shaped your experiences.

Procedures involved in the Research

For this research, I hope to interview ten social workers employed with Hamilton Health Sciences and/or St. Joseph's Hospital. If you are interested in this study, I ask that you contact me (Lacey Ricard) directly via email or by phone (contact information above) and we will arrange a date and time to review the study and answer any questions you may have.

From there, if you are interested in participating in the study, I will ask that you sign the consent form and send it to me via e-mail. I will then sign the same copy and return it to you via email. Once consent has been obtained, I would like to interview you individually (one-on-one) via Zoom, with your choice of having the camera on or off. You would be interviewed once, by myself, for approximately 40 minutes. You and I will coordinate a date and time that works for us to complete the interview.

With your permission, I would like to record our Zoom interview. By recording the interview, I will be able to use the transcriptions derived from Zoom software to further analyze the interview. From these transcripts, I will use quotations in my research where appropriate. Prior to doing so, I will e-mail you a copy of the transcripts from the interview and you will have the opportunity to edit them as you see fit. You also have the opportunity to choose the name you would like to be associated with your quotes; you can use your name or choose a pseudonym (i.e., an imaginary name).

At the beginning of the interview, I will ask you for demographic information such as your age bracket (18-29, 30-40, 41-50, 51-60, 61+), current employment status (full-time, part-time, casual, temporary, permanent), and the gender and race you identify with, if any. For the interview, I will be asking you questions about your self-care and coping strategies prior to and during the pandemic in the context of your workplace. Questions may include:

- What does self-care mean to you?
- What does coping mean to you?
- Prior to COVID-19, what were the self-care and coping strategies you used to mitigate burnout and manage stress related to your workplace?
- How did you experience self-care and coping strategies during the pandemic?
- If at all, how did your self-care and coping strategies change during the pandemic?
- How did Hamilton Health Sciences shape your experiences of COVID-19?
- What wellness programs were put in place? How did you experience these?
- From your perspective, what was missing from the organization's response in regard to supporting the wellbeing of healthcare workers during the pandemic?

Potential Harms, Risks or Discomforts:

The risks involved in participating in this study are minimal. It is possible, however, that questions and discussions relating to your experiences at HHS during the pandemic may trigger distressing memories and/or feelings of discomfort. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. You may also take a break and/or withdraw (stop taking part) at any time. Economic and social risks are also possible as you will be asked questions regarding the support you received from your organization during the pandemic. If you choose and consent to identifying your name, there is a risk that your employer or colleagues will see your reflections and analysis. These risks can be mitigated (reduced) by either choosing a pseudonym name (imaginary name) rather than your own name or to decline answering such questions. Please keep in mind, however,

that stories can be identifying themselves. You may wish to alter the stories you share to mitigate the risk of being identified. I describe below the steps that I am taking to protect your privacy.

Potential Benefits
Potential benefits of this research may include contribution to the existing body of knowledge on self-care, coping, and wellness of frontline healthcare workers (social workers), however it should be noted that you will not be benefited directly. I hope that by learning more about how hospital social workers coped with work-related stress prior to and during the pandemic, and how your organization either promoted, reduced, or maintained your ability to cope, structures within society (such as healthcare institutions) will better understand the strengths and gaps in supporting your wellness.

Confidentiality
You have the choice to participate in this study confidentially. If you would like to participate confidentially, I will not use any information that would allow you to be identified. Only you and I will know whether you participated in this study unless you choose to tell other people. To ensure confidentiality, you can choose a pseudonym (a fictional name) that will be associated with your quotes in the research. Please be aware though that we are often identifiable through the stories we tell. Since the communities at HHS/SJH are relatively small and interconnected, others may be able to identify you on the basis of reference you make. Please keep this in mind in deciding what to tell me and the stories you share. If you would like your own name to be used in my research and associated with quotes, please be aware of the risks this may pose. The risks are outlined in detail above. Again, you will be given the opportunity to review and edit your transcripts if you wish to do so.
The information and data you provide will be kept on my password protected personal computer in a password protected file. This computer is only accessible to me. Once the study has been completed and my thesis has been defended, the data will be deleted from my computer and therefore no longer accessible.

Participation and Withdrawal
Your participation in this study is voluntary, meaning that it is your choice to be a part of the study or not. Should you decide to be a part of this study, you can decide to stop (withdraw), at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. You also have the option of removing data that has previously been collected. If you would not like to answer some of the questions during our interview, you do not have to. If you would like to withdraw from the study, please call or email Lacey Ricard at 519-319-1811 or ricardl@mcmaster.ca

Information about the Study Results
I anticipate that I will have completed this research project by approximately mid-August 2021. If you would like a brief summary of the results, please let me know over the course of the study and I will send information about the study results via e-mail.

Questions about the Study
If you would like to participate in this study, please contact me via email or by phone. You may also contact me should you have questions or need more information about the study itself.
Please contact me at:
Email: ricardl@mcmaster.ca
Phone: 519-319-1811

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Lacey Ricard, of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I will be given a signed copy of this form. I agree to participate in the study.

_____   _____   _____
Name of Participant (Printed)   Signature   Date

Consent form explained by:

_____   _____   _____
Name and Role (Printed)   Signature   Date

APPENDIX 2

Guiding interview questions
1. Can you tell me about a time at work during the pandemic when you felt that others had your wellbeing at heart? When someone was caring for you in some way? (colleague, supervisor, patient/family)
2. Can you tell me about a time when you did not feel cared for at work?
3. What did you find to be the most challenging aspect of wellness and wellbeing over the course of the pandemic?

          o   Did anything ease that experience for you?

          o   How did you try to take care of yourself in that hardest thing?

4. Can you share a story around this experience?
5. How did your experiences of wellness and wellbeing affect your role as a healthcare social worker?
6. Did anything in your workplace or work experience, or your co-workers, supervisors, or patients support you in taking care of yourself over the last year? How?
7. Did any of the formal programs at HHS relate to these experiences of caring for yourself or being cared for?
8. How did you experience these programs?
9. From your perspective, was missing from the organization's response in regard to supporting the wellbeing of healthcare workers during the pandemic?

REFERENES

Alexander, M. (2021, April 12). NHS staff are suffering from 'moral injury', a distress usually

      associated with war zones. *The Guardian.*

      https://www.theguardian.com/commentisfree/2021/apr/12/nhs-staff-moral-injury-

      distress-associated-with-war-zones-pandemic

Ashcroft, R., Sur, D., Greenblatt, A., & Donahue, P. (2021). The Impact of the COVID-19

    Pandemic on Social Workers at the Frontline: A Survey of Canadian Social Workers. *The*

    British Journal of Social Work, 1-23. https://doi.org/10.1093/bjsw.bcab158

Banks, S., Cai, T., De Jonge, E., Shears, J., Shum, M., Sobočan, A. M., Strom, K., Truell, R.,

    Uriz, M. J. & Weinberg, M. (2020). Practising ethically during COVID-19: Social work

    challenges and responses. *International Social Work*, *63*(5), 569-583.

    https://doi.org/10.1177/0020872820949614

Brown, C. (2021). Critical Clinical Social Work and the Neoliberal Constraints on Social Justice

    in Mental Health. *Research on Social Work Practice*, https://doi.org/1049731520984531.

Canadian Association of Social Workers. 2005. *CASW Code of Ethics*. https://casw-

    acts.ca/en/Code-of-Ethics>

Clarke, C. (2009). Paths between positivism and interpretivism: An appraisal of Hay's *Via*

    Media. *Politics*, *29*(1), 28-36. https://doi.org/10.1111/j.1467-9256.2008.01335.x

Currin-McCulloch, J., Chapman, B., Carson, C., Fundalinski, K., Hays, M., Budai, P., &

    Kaushik, S. (2021). Hearts above water: Palliative care during a pandemic. *Social Work*

    in Health Care, *60*(1), 93–105. https://doi.org/10.1080/00981389.2021.1885562

Di Camillo, J. A. (2020). Triage protocol guidelines. *Philadelphia: National Catholic Bioethics*

    Center.

Duschinsky, R., Lampitt, S., & Bell, S. (2016). Sustaining social work: between power and

    powerlessness. *Journal of Social Work, 17*(6), 750-752.

    https://doi.org/10.1177/1468017317715575

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley &

    Sons. https://doi.org/10.1002/9781119975144

Frechette, J., Bitzas, V., Aubry, M., Kilpatrick, K., & Lavoie-Tremblay, M. (2020). Capturing

　　　lived experience: Methodological considerations for interpretive phenomenological

　　　inquiry. *International Journal of Qualitative Methods*, *19*, 1-12.

　　　https://doi.org/10.1177/1609406920907254.

Globerman, J. (1999). Hospital restructuring: Positioning social work to manage change. *Social

　　　Work in Health Care, 28*(4), 13-30. https://doi.org/10.1300/J010v28n04_02

Greenberg, N. (2020). Mental health of health-care workers in the COVID-19 era. *Nature

　　　Reviews Nephrology*, *16*, 425–426. https://doi.org/10.1038/s41581-020-0314-5

Guest, G., MacQueen, K. M., & Namey, E. E. (2011). *Applied thematic analysis*. sage

　　　publications. https://dx.doi.org/10.4135/9781483384436

Hamilton Health Sciences. (2021). *COVID-19: Resilience Support Toolkit.*

　　　https://www.hamiltonhealthsciences.ca/covid19/staff-physician/hhs-resources/resilience-

　　　support-toolkit/

Kinman, G., Teoh, K., & Harriss, A. (2020). Supporting the well-being of healthcare workers

　　　during and after COVID-19. *Occupational Medicine. 70*(5). 294-296.

　　　https://doi.org/10.1093/occmed/kqaa096

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., Wu, J., Du, H., Chen, T., Li, R., Tan, H.,

　　　Kang, L., Yao, L., Huang, M., Wang, H., Wang, G., Liu, Z., & Hu, S. (2020). Factors

　　　associated with mental health outcomes among health care workers exposed to

　　　coronavirus disease 2019. *JAMA Network Open. 3*(3). 1-12.

　　　https://doi.org/10.1001/jamanetworkopen.2020.3976.

Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research; rationale,

  issues, and methods. *Research in Aging. 17*(1), 89-113.

  https://doi.org/10.1177/0164027595171005.

Mason, J. (2002). *Qualitative Researching*: *3rd Edition.* Sage Publications.

Miller, J. J., & Reddin Cassar, J. (2021). Self-care among healthcare social workers: The impact

  of COVID-19. *Social Work in Health Care*, *60*(1), 30–48.

  https://doi.org/10.1080/00981389.2021.1885560

Murphy, K. (2020). Death and grieving in a changing landscape: facing the death of a loved one

  and experiencing grief during COVID-19. *Health and Social Care Chaplaincy*, *8*(2), 240-

  250. https://doi.org.10.1558.hscc.41578

Nair, S. S., & Prem, S. S. (2020). A Framework for Mixed-method Research. *Management*, *8*(2),

  45-53. https://doi.org/10.34293/management.v8i2.3220

National Association of Social Workers (2020). *Self-care during the coronavirus pandemic*.

  NASW. https://www.socialworkers.org/Practice/Infectious-Diseases/Coronavirus/Self-

  Care -During-the-Coronavirus-Pandemic.

O'Donnell, P., Farrar, A., Brintzenhofeszoc, K., Conrad, A. P., Danis, M., Grady, C., Conrad, A.

  P & Ulrich, C. M. (2008). Predictors of ethical stress, moral action and job satisfaction in

  health care social workers. *Social Work in Health Care*, *46*(3), 29-51.

  https://doi.org/10.1300/J010v46n03_02.

Ontario Health. (2020). Clinical Triage Protocol for Major Surge in COVID Pandemic.

  https://med.uottawa.ca/pathology/sites/med.uottawa.ca.pathology/files/clinical_triage_pr

  otocol_for_major_surge_in_covid_pandemic_-_march_28_20205.pdf

Pulla, V., & Carter, E. (2018). Employing interpretivism in social work research. *International

  Journal of Social Work and Human Services Practice*, *6*(1), 9-14.

  https://doi.org/10.13189/ijrh.2018.060102

Ross, A. M., Schneider, S., Muneton-Castano, Y. F., Caldas, A. A., & Boskey, E. R. (2021).

  "You never stop being a social worker:" Experiences of pediatric hospital social workers

  during the acute phase of the COVID-19 pandemic. *Social Work in Health Care*, *60*(1),

  8–29. https://doi.org/10.1080/00981389.2021.1885565

San Juan, N. V., Camilleri, M., Jeans, J. P., Monkhouse, A., Chisnall, G., & Vindrola-Padros, C.

  (2021). Redeployment and training of healthcare professionals to Intensive Care during

  COVID-19: a systematic review. *MedRxiv*. 1-24.

  https://doi.org/10.1101/2021.01.21.21250230

Sherman, E. (1991). Interpretive methods for social work practice and research. *Journal of

  Soiology & Socia Welfare*, *18*(4). 69-81.

Stanford, S. (2011). Constructing moral responses to risk: A framework for hopeful social work

  practice. *British Journal of Social Work. 40*(1), 1514-1531,

  https://doi.org/10.1093/bksw/bcr030

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19

  pandemic: considerations for palliative care providers. *Journal of pain and symptom

  management*, *60*(1), e70-e76. https://doi.org/10/1016/j.jpainsymman.2020.04.012

World Health Organization. (2021). *Weekly operational update on COVID-19 - 12 July 2021*.

World Health Organization. https://www.who.int/publications/m/item/weekly-operational-

update-on-covid-19---12-july-2021.

World Health Organization. (2020a, June). *Self care during COVID-19*. World Health

Organization. https://www.who.int/news-room/photo-story/photo-story-detail/self-care-

during-covid-

19#:~:text=Physical%20distancing%2C%20good%20respiratory%20hygiene,

disease%20pandemic%2C%20including%20for%20your.