Nursing Home Social Workers Perceptions of Preparedness and Coping for COVID-19

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Abstract

Objectives: Social work has a long history of responding to the needs of vulnerable populations during times of crisis and disaster. Social workers are working at the front lines responding to the current COVID-19 pandemic in a variety of health care practice settings, including nursing homes, however it is unclear how social workers perceive their preparedness during this time.

Methods: This study employed a cross-sectional survey to nursing home social workers via social media on feelings of preparedness for COVID-19, what has been most professionally helpful for social workers during these times in their role in COVID-19, as well as demographic questions. Demographic data were analyzed using SPSS and qualitative data were analyzed using the rigorous and accelerated data reduction (RADaR) technique.

Results: Data are based on a sample of 63 (*N*=63) nursing home social workers. Findings revealed that while some social workers felt prepared for the coronavirus, many respondents stated that they were unprepared to meet the demands and challenges they were facing. Moreover, participants shared that professional support was critically important to get through COVID-19.

Discussion: These findings are important, as social workers are tasked with ensuring each resident attains their highest level of psychosocial well-being, which can be achieved only when nursing home staff are supported. Findings from the present study suggest that additional support for nursing home staff ought to include peer mentoring and mutual support. Additionally, improved leadership across health care settings is worth assessing.

Keywords: *long-term care, COVID-19, social workers, health care*

Nursing Home Social Workers Perceptions of Preparedness and Coping for COVID-19

The profession of social work has a long history of responding to the needs of vulnerable populations during times of crisis and disaster (Rosoff, 2008). Social workers (SW) are working on the frontlines responding to the current COVID-19 pandemic in a variety of health care practice settings, including nursing homes. Nursing home (NH) SW are responsible for addressing the psychosocial needs for residents and assessing the mental health of residents through training, staffing, and interdisciplinary care team involvement (Frahm et al., 2010; Simons et al., 2012). Approximately 83 percent of all nursing homes (Roberts & Bowblis, 2017) employ a SW that engages in direct service with resident family members, serve as advocates for residents, and ensure culturally sensitive and culturally-appropriate care and service delivery (Miller & Hamler, 2018). NH residents are particularly susceptible to severe complications and mortality from COVID-19 as these individuals are typically older, with high levels of chronic illness and/or impairment (Barnett & Grabowski, 2020).

As a result of COVID-19, there is a "new psychosocial playbook" for SWs in nursing homes (Bern-Klug & Beaulieu, 2020, p. 1). However, the question remains how SWs perceive their preparedness for this new "playbook" and what has helped them most professionally during COVID-19. Given the extraordinary circumstances of the pandemic and the key role of NH SWs as frontline staff, this area of research warrants further attention.

Methodology

A cross-sectional survey of NH SWs was conducted from April 28 to May 12, 2020 to explore their frontline experiences during COVID-19. University-IRB approval (IRB #: 1585325) was obtained in mid-April 2020; subsequently, a survey link via Qualtrics was embedded in a recruitment script and posted to social media (e.g., LinkedIn, Facebook, Reddit). The survey link was also distributed to potential participants via email through the researchers' professional networks. The survey was brief in order to reduce participant burden during a time of crisis, to increase participation, and to focus on the information that was essential to the study. For this report, the research team examined the

following broad open-ended items, in addition to demographic questions, 1) please describe your feelings of preparedness for COVID-19; and 2) please share what has been most professionally helpful for you during these times in your role as a social worker during COVID-19.

Data Analysis

Demographic data were analyzed using SPSS (IBM Corp, 2017). The qualitative data were organized and analyzed using the five phases of the rigorous and accelerated data reduction (RADaR) technique (Watkins, 2017). First, one researcher organized all data in an "all-inclusive data table technique" (Polenick et al., 2020, p. 593) using Microsoft Excel spreadsheets. Each spreadsheet contained column headings: transcript number, research question, response from the participant, notes, and coding themes, as part of the RADaR technique (Watkins, 2017). Next, as part of Phase Two, two members ensured rows of data answered the research questions. All data that did not fit the research question were removed. Any data that the research was confused on was marked in the "notes" column. For Phase Three, the researchers met again to discuss progress on the data and the development of open codes. In Phase Four, the researchers moved from open codes to narrow "focused codes" (Grinnell & Unrau, 2011; Watkins, 2017, p. 3). In Phase Five, the researchers discussed interpretation, resolution, and the further elimination of any data, identifying and organizing all responses for the final product.

Results

Demographic Overview

Data are based on a sample of 63 (*N*=63) NH SWs. The majority of the SWs were female (*n*=62, 98.4%), white (*n*=54, 85.7%), and had their master's degree (*n*=32, 50.8%). Of the degree disciplines, 84.1% had their degree in Social Work (*n*=53) and reported that their job title was Social Service Director or Director of Social Services (*n*=30, 47.6%). Compared to a nationally representative sample obtained by Bern-Klug et al. (2009), the sample was similar in gender (94 vs. 98% female) and

race (90 vs. 86% white). Our sample was more educated, with 51% versus 21% holding a master's degree (Bern-Klug et al., 2009). When describing their hours worked during a typical work week before COVID-19, Social Workers' hours ranged from four to 60 hours per week (M=39.85, SD=10.46). During COVID-19, Social Workers worked from 0 to 70 hours per week (M=41.05, SD=14.68). Three SWs reported 0 hours, one who stated they were an intern who could no longer work. The majority of SWs were employed at a corporate facility (*n*=37, 58.7%), followed by non-profit facilities (*n*=20, 31.7%); sixty-five percent (*n*=41) worked at a facility with 120 beds or less, and most reported having just one Social Service staff at their facility (*n*=30, 47.6%). Compared to the national make up of ownership, we had slightly fewer social workers from corporate facilities (59 vs. 68%). Our sample adequately represented facilities with less than 120 beds (65 vs. 69%) (Bern-Klug et al., 2009). (see Table 1)

[Table 1 here]

Qualitative Results

Preparedness for the COVID-19 Pandemic

Participants first shared their perceptions of preparedness for COVID-19 as NH SWs. While a small group of respondents indicated that they felt prepared to a certain degree, many respondents stated that they were unprepared to meet the demands and challenges posed by the pandemic.

Unprepared

Overall, most participants (N=20; 31.7%) reported feeling unprepared for the pandemic. For example, one participant stated, "There was very little preparation at all for COVID-19." Another explained "we are rolling with it as we go as we didn't have a chance to prepare." Other responses included: "we really did not see this coming," "not ready," "poorly prepared," and "lacking." Some participants pointed toward problems with facility preparedness:

> The facility is not able to adequately handle the current crisis at hand and management has ceased stand up meetings so no one is kept abreast. Staff is anxious, scared, mean, and unprofessional, people keep quitting and it is difficult to work under such extreme stress of virus let alone staff. ED (*executive director*) is micromanaging and writing people up instead of offering support and comfort.

Other participants shared feelings related to professional preparedness:

> Nothing could have prepared me for this. There is no 'preparing' for helping residents and families work thru (*sic*) the losses they are experiencing. I never in my life would have thought I would be 'keeping families apart' and working on creative ways to help everyone stay connected.

In addition to these feelings, participants shared that their lack of preparedness contributed to feelings of stress. For instance, one social worker disclosed:

> We have had emergency preparedness drills but nothing r/t (*related to*) pandemic like this. I felt unprepared. Our community had planned a COVID "drill" 2 weeks ago and we never carried it out. Our administrator does not communicate well. With no practice COVID drill, we had our first positive resident case last evening. It was stressful and chaotic.

Another stating, "I was not prepared either with PPE or mentally. I am paid hourly so I cannot have over time and have to clock out, but I am overloaded with work now and severely anxious residents, families, and staff."

Some SWs expressed concern about personal health, safety, and facility protocols. For example, one SW shared:

> I am at extreme risk should I catch COVID-19; therefore, I have been working from home and having staff in the facility assist with me completing assessments via phone/video. My

facility had no protocol for how to handle several staff needing to work from home/not be in contact. It has been a learn as we go type of experience. I am the only SW and I have an assistant, who also has lung disease and was put off work due to her level of risk. So, I have had to balance personal safety and wellbeing with being available for my staff and residents.

Finally, some participants commented about lack of preparedness for and access to personal protective equipment (PPE). For example, one participant reported, "We lack appropriate PPE should we get a case in the facility." Other participants noted problems with PPE, sharing "in the beginning we were not allowed to wear PPE, now its mandated" and "my facility was pretty prepared, but we used masks too late." Similarly, a participant shared, "We were not as prepared with PPE and staffing considerations. Several staff are high risk/compromised and there was no protocol for handling the need for some to be away from facility."

Prepared to somewhat prepared

Participants responses included feeling "well-prepared, "very prepared," and "prepared and ready" (N=15; 23.8%) for COVID-19. One participant expanded further sharing, "I feel I am as prepared as I can be in this time. Mainly needed is the ability to be open minded, flexible, and positive for coworkers and residents and their families." Several reported on the preparedness of their facilities in responding to the pandemic. For example, "corporate has been good at directing and putting interventions in place for liability reasons no matter how futile they really are." Another SW shared, "We had been through severe flu outbreaks several times before. I believed that we were as prepared as anyone could be, followed the news, tried to think of what eventualities we might face."

Others reported mixed concerns about regulations, preparedness and COVID-19. One participant shared:

> We were prepared for potential exposure due to the large amount of staff that work in the facility. The difficulty has come with the regulations in place of having enough staff to meet the psychosocial needs of the many residents we have. Without having visitors or volunteers or group activities this has been very trying on the social service and activity staff.

Another participant described, “our building is somewhat prepared. We were hit hard and I felt like management could have done better in preparing the whole building.” In a similar way, one SW shared, “Instructions changed hourly and [we] never know what is the most current.”

Helpful Factors during the COVID-19 Pandemic

SWs shared professionally during COVID-19 they received support from co-workers, peers, supervisors, and outside social workers. One primary theme emerged across the responses – the importance of professional supports.

Professional supports

Support was frequently stated (N=23; 36.5%) as important in helping nursing home social workers get through COVID-19. One participant explained, “Talking with coworkers and family is helpful! Being able to share struggles is thereputic (*sic*).” Another participant said, “Peer support and talking with others that are in similar roles as me.” Specifically, sharing in a common experience and discussing the reality of their situation with peers was very helpful:

> We had to see ourselves as first responders and care for ourselves in these ways. Talking with colleagues about the situation. We feel alone on our island in LTC which is a really different experience in healthcare. Hospitals are waiting for acute patients to arrive. We know our residents and share many of the same stories and fears. Even if the conversation feels like idle chitchat, or might be seen in other times as "wasting time" it is all invaluable. And we joke, that the only place we really have

> to go is the gas station in order to be able to get to work. If we are going to risk our lives to stop for gas- there must be a large chocolate purchase involved.

Support from peers, and especially fellow social workers and social service directors, were identified as integral to coping with COVID-19. A SW described their appreciation for the support of their social service director, explaining that "I appreciate that my the (*sic*) social services director, my higher up, is making sure I don't work overtime and insane hours." Another agreed their supervisor's support was key, "Mental health support from supervisors and frequent breaks when at home." Similarly, "Debriefing with other social workers" and "Support from social work friends that aren't necessarily 'front line', like marketers" was identified as helpful. Some participants identified that having a shared, collective experience with other social workers was a source of support:

> The buddy system. Sharing the journey with the social worker at a sister home has been invaluable. Would not be able to go through this without that person who understood and shared. Our knowledge and experience together was greater than we could have ever been individually.

Support from other SWs included virtual resources and online support groups. For example, one SW described "there is a weekly Zoom support group meeting from the University of Buffalo (I think) that's very helpful and supportive." Another shared, "Facebook group," and similarly, "I love having a fb community (sic) of social workers to talk with, compare ideas." Lastly, web-based listservs with other social workers were identified as valuable sources of support such as the University of Iowa Long-Term Care Social Work forum.

Discussion

Social workers play a critical role during a pandemic, providing essential psychosocial support focused on resident well-being (Bern-Klug et al., 2018). Our research, exploring NH SWs perceptions of preparedness during COVID19, suggests that most felt unprepared for the demands and challenges posed by the pandemic. These responses echo the perceived lack of preparedness in the NH industry more broadly (Quigley et al., 2020). Our results suggest there is a need for better organizational and individual supports for NH SWs.

Preparedness is the capacity to react to situations and it can be measured on the individual, organizational, and systematic levels. On the individual level, SWs reported signs of overwhelming stress and being "severely anxious". Others reported that they felt unprepared "mentally" for stressors caused by the pandemic, including exposure to the virus, long work hours, isolating residents from families, and the deaths of residents. At the organizational level, participants reported that facilities lacked leadership and direction, and few had policies that could guide the organizations through the pandemic. Finally, participants reported that their facilities could not or did not obtain the necessary PPE. This reflects a systematic failure felt throughout healthcare settings.

Much is being learned throughout the COVID-19 pandemic and recommendations are emerging that address the challenges reported herein. The American Geriatrics Society has called for more support and training for NH staff, including paid sick leave, online training in infectious disease control, and supervisory mentoring (2020). Findings from this study suggest that peer-mentoring and mutual support should be added to this list. Sharing and processing pandemic stressors with other NH social workers and colleagues offered a positive outlet for giving and receiving support, empathy, and coping. Organizations may help promote peer support by encouraging a formal or informal "buddy system" and providing the time and space for staff to safely share their experiences with one another (Wu et al., 2020). Online peer and mutual support groups may also provide an

effective avenue for sharing and support. Indeed, renewed support and investment in peer mentoring and peer support programs for healthcare professionals may be one of the few positive outcomes of this pandemic (Behrman, Baruch, & Stegen, 2020).

Researchers have also called for improved leadership across healthcare settings and have urged facilities to systematically evaluate their ability to provide services effectively in the face of a pandemic surge (Kumar et al., 2020). On the systematic level, the pandemic has raised calls for sweeping changes to the healthcare system, such as expanding the Affordable Care Act and Medicaid coverage, which could reduce health disparities and the impact of future pandemics (King, 2020). What these recommendations hold for the NH industry and their staff and residents remains to be seen. Nursing homes are just one segment of the healthcare system and the voices captured in this study are just a fraction of the healthcare workforce; however, we need to listen to these individual voices to better understand the message of the entire chorus.

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Table 1. *Demographic Information of Survey Participants*

Variables	% (n)/Mean (SD)
Gender	
Female	98.4 (62)
Male	1.6 (1)
Race/Ethnicity	
White	85.7 (54)
Latinx/Hispanic	3.2 (2)
Asian or Pacific Islander	6.3 (4)
Other	1.6 (1)
Not specified	3.2 (2)
Highest Level of Education	
High school or equivalent	4.8 (4)
Associates degree	3.2 (2)
4-year degree (BS/BA)	41.3 (26)
Masters degree (MS/MA)	50.8 (32)
Degree Discipline	
Social Work	84.1 (53)
Gerontology	1.6 (1)
Liberal Arts	4.8 (3)
Science	6.3 (4)
Not specified	3.2 (2)
Job Title	
Social Service Director/Director of Social Services	47.6 (30)
Social Worker/Social Services	22.2 (14)
Social Service Coordinator, Manager, or Assistant	6.3 (4)
Counselor/Psychotherapist	4.8 (3)
Other (e.g., Intern, LCSW, Qualified Social Work)	19 (12)
Weekly Hours	
Typical work week before COVID-19	39.85 (10.46)
Typical work week during COVID-19	41.04 (14.68)
Ownership Structure	
Non-profit	31.7 (20)
Corporate	58.7 (37)
Government	1.6 (1)
Other (e.g., private)	6.3 (4)
Unknown	1.6 (1)
Maximum Capacity of the Facility*	
120 beds or less	65.1 (41)

121 beds or more	33.3 (21)
Not specified	1.6 (1)
Number of Social Service Staff	
One	47.6 (30)
Two	25.4 (16)
Three	11.1 (7)
More than three	11.1 (7)

**facilities with greater than 120 beds are required to hire a full-time qualified social worker*