

STSW COVID-19 Survey Results: Open Comment Responses

Other staffing challenges:
a PRN position with our team was on hold for several months, so met heavier patient load
adapting to providing patient care remotely: F2F encounters, remote psychosocials, remote support groups
Being pulled to other areas of the hospital that are short staffed due to COVID admissions
covering colleagues quarantining because someone in their lives tested positive for COVID
Covering for colleague who had suspected exposure of COVID and required to quarantine
Covering for colleagues who were exposed to COVID
Covering for coworkers with mental health changes as a result of covid
COVERING FOR STAFF FURLOUGHED
elimination of two positions, one kidney transplant colleague and our Txp SW float
furlough with pay for 6 weeks
Furloughed as in forced PTO hours taken
hiring freeze; unable to fill open positions
hiring freezes for positions that were furloughed or vacated permanently
I am so grateful that we were not redeployed or furloughed! Grateful for Mgmt recognizing value of remote work
I was required to use ATO.
lack of direct in-person contact with VAD & heart transplant colleagues, 2 transplant center social workers permanently laid off with no plan to fill those positions, multiple colleagues in other areas of the transplant center being laid off.
lost the other social worker
mandated 2 PTO a pay period for one month
Mandatory days off
MDs and NPs working remotely but social work mandated to be onsite (with exception of SWers with documented medical conditions).
more hours working, everything seems to take longer
Multiple SW team members have put in their resignation, morale is low
Reduced hours and redeployment were temporary. I was redeployed and continued working in Transplant. We were working way over our FTE and being paid under our FTE.
REduction in force amongst our transplant social work colleagues
Temp coverage suspended, no plans to hire for approved position.
voluntary time off was encouraged
Other personal challenges:
Communication with staff around seriousness of situation not transparent
disconnection from patients and colleagues
Fatigue from increased anxiety, pain
Financial - lost about 5 weeks of pay after running out of PTO. It took 3 months to get unemployment benefits.
Friends and family not respecting that my patients are very high risk and I need to be extra cautious
Frustration about not being permitted to telework
Juggling on site work with spouse at home work
Learning new methods for telework from the office (connecting with patients remotely, from my hospital office). Not permitted to work from home.
loss of work/life balance, grief response for patients whom passed away whom I had assessed over the phone, but never met in person
Not being given the option to work from home
Not feeling supported to be able to work remotely while the rest of our transplant team is able to (for some reason the health system is saying social work needs to be on site)
Perceived lack of value placed on staff safety including limited safety measures put into place (less than what state and fed health authorities mandated)
Requested accommodations due to being in a high risk category-but later found out our jobs would not be protected and so I chose to return to work and take a chance.
Sick leave due to pending COVID test due to symptoms
sick leave due to quarantine after illness, pending test results
Trying to figure out kids' virtual learning while I still have to go in for onsite work.
Working from home due to personal medical issues
Working with my own children yo understand need to quarantine. Loss of activities for children.
Other virtual care challenges:
Administering screening tools is different and more time consuming, but I wouldn't classify it as "harder"
Definitely the license issues!!!
Difficult to hear!
Harder to develop a therapeutic relationship/alliance, though it can be done.
I am now responsible for scheduling my own appointments. The benefit of this is I can decide how busy I am with evaluations on a given day. The downside is that I spend a LOT of time leaving messages, scheduling appointments, dealing with no shows for scheduled appts. My team has NOT been willing to be flexible or find ways to support me in this.
I find it actually is more helpful to patients. They are more relaxed in their own home, can 'go to' medications for name/ dosage. Typically the patient can have privacy if desired and can seek support if needed. The feed back is that pts appreciate tele health. Limitations, some do not have access to computers however, if they have a smart phone they can access our My Chart system for tele health visits.
It's more difficult to hear some patients over the phone and understand them, especially if they have a soft voice or an accent.
More work on the front end to get scheduled. Before, the coordinators would schedule our visit in conjunction with the education class. Now I am responsible for scheduling my own appointments.
Patients in inappropriate/unsafe settings, such as a car; some patients who have difficulty using the technology/virtual platform
really feel it is a challenge to do both the initial interview and follow up
Unable to truly assess the ability of the pt & caregiver to physically get to the transplant center
Very much a change and adjustment that presents for stressful times for me.
Video quality or lack of high speed internet
We have dropped screening tools. Now trying to figure out ways to reimplement. Would like to know how others are doing it.
Working with older patients who only have a smart phone and no computer so they see a very small screen. Also ones with poor quality broadband strength for pixilation and other tech drag issues.
Other virtual care opportunities:
Able to include more of the patients support team
Able to meet with patients without interruption from other providers
Assessing pt's facial cues as not covered by masks
Availability to have caregiver(s) join from other locations/states who might not have joined without vitutual assessments.
Easier to establish rapport/ read body language due to lack of mask.
I only do follow up phone calls, no real virtual care.
Increased participation in support groups
just a new way to do the work including a successful transition to virtual support group which we will maintain as an option even after can return to on-site groups again as this expands the opportunity for patients/family whom live far away to participate as well.
Opportunity to include more caregivers in assessments
patients seem more relaxed to know we are minimizing risks
We have had out of state family members join in on the Video psychosocial assessment.
with visitor regulations easier to include caregivers in evaluation
zoom family meetings are very efficient and convenient for clinician and families
Other in-person care challenges:
Difficult with pts who are hard of hearing people or deaf
Exposing donors to unnecessary risk- many of them clearly feel uncomfortable being in a hospital setting during this time. They wear cloth masks, many of them ineffectively and we spend an hour in a closed room together. This does make me concerned for my own risk and for my patient's as I see multiple people a day.
Fear of contracting COVID-19 from the patient or family
Harder to find clinic space
Harder to help patients make connections with other patients.
I am only seeing patients who are hospitalized. Due to visitor restrictions there is only 1 caregiver at bedside.
Initially we were not fitted for n-95 masks and thus could not enter the rooms of pts on trach collar or high flow O2 (who are not COVID+), but n-95's are no longer required for these pts
It is a challenge to talk a lot with a mask on and glasses. It gets very hot and foggy despite using defoggers. Social distancing in exam rooms can be challenging- especially if they want a family member to be in with them for a portion of the evaluation. It is also unnerving to me that we accept donors from all over the US and many, many are from states who don't mask or social distance for political reasons. I believe that every day I am putting myself at risk.
Many of the patients, especially males, consistently let their surgical masks slide down to where if they have Covid-19, they can put me at greater risk. I do wear an N95 and eye protection, and I sanitize the meeting area after each encounter.
Much harder to hear.
my own discomfort about being in the clinic room too long
no challenges
None
none
none
our young children seem to be scared by our face shields and/or goggles plus masks. Impact of development with isolation. Now that virtual is an option, families are more resistant to have in-person visits d/t convenience. I accommodate by doing every other if able.
Scheduling issues/rescheduling/delays due to remote schedule
unable to see facial expressions, patients and families unable to maintain social distancing or wearing PPE
Visitor policies are a barrier to pt care. The importance of caregiver/support systems is clearer every single day. It is taking pts longer to recover from surgery/complications. Educating families about the natural course of illness/surgery is much harder. Difficult for our team to keep up with pt/family information needs. Family anxiety is more of an issue. Would be interesting to do a study on the impact of limited/no family/caregiver contact on non-covid hospitalized pts. Impact on LOS and outcomes. Pts are delaying or not coming to the hospital due to their fears of covid. Use of interpreters is far more difficult. non
What are some of the other questions you'd like to ask your transplant social work colleagues about their experiences with COVID?
Are my colleagues at other transplant centers being informed when their teammates/staff test positive for COVID? Are centers/hospitals doing contact tracing/notifications with staff? (Ours does not appear to.)
Are staff owned by transplant vs auxiliary staff treated different and have different expectations in remote working and other instances?
Are SW's working remotely? How is it working out?
Are your patients allowed any visitors? Do you see major psychosocial challenges due to the no visitation? How about with ICU patients?
Are your programs planning that this opportunity with virtual care to continue virtual care long-term, as insurance payment allows?
Can't think of any.
Challenges and opportunities for caregiver availability given economic impacts of COVID (loss of jobs, financial stability, etc)
Disability and who does it?
Do their institutions required them to always be on site too? If so, have they talked with the management about working remotely?
Do they foresee that their role will be handled differently, post Covid
Has your dress code changed? (ie did you switch to scrubs, buy extra shoes that are left in the garage, etc) How much time were you furloughed?
Have you experienced any bias due to your age or medical conditions? How have limitations on visitors affected patient recovery from cardiac surgeries?
How ar centers handling out of state living donors during the pandemic?
How are they doing. I hope they are safe and their families are safe.
How are you assessing caregivers now that there is are visitor restrictions? What financial resources do you have for patients who have lost wages, income or insurance due to covid?
How are you doing support group?
How are you finding team dynamics? Have Zoom meetings altered your sense of connection? How anxious do you feel about contracting Covid 19?
How are you managing to support, or connect to services, patients whom have struggles with substance use/abuse? How are you managing to support, or connect to services, patients with mental health issues? How has it been for you to cope with the loss of work/life balance, to imcede your work space from bleeding into your home space? In follow up, what boundaries, if any, have you found helpful in setting up? How has your center/institution, and social work department, leadership risen to the occasion? Correspondingly how have they not, or perhaps have disappointed you? Please identify the number one positive outcome you have experienced over the course of navigating the multiple changes occurring r/t the COVID-19 pandemic, and the primary negative effect for you personally, and professionally.
How are you safely (HIPPA/privacy, risk, etc) doing virtual support groups? Do you limit the number of attendees, and how?
How do we find ways to care for our own fears of contracting COVID or family and caring for the patients needs? What strategies are working? How much do leverage do we have to advocate for ourselves in the institutions we are employed in?
How do you handle your anxiety, if there is any, regarding the possibility to contract COVID by coming into the hospital to work?
How do you manage expectations at the time of transplant when you could not effectively communicate them during eval? For example, our patients have to stay locally for 3-4 weeks post-transplant and the expense falls on the patient. We have some, but very little, resources for free or reduce cost housing. Pre-COVID we were able to discuss this in person and reiterate the importance of prepping for this, since our center does not require fundraising. Now, we still discuss this over phone in our eval visits, but our patients are more and more claiming they did not know or did not prepare, even though they received the same information and discussion as pre-COVID patients did, just over the phone.
How do you think outcomes are effected by virtual visits? (i.e. transplant understanding/expectations, caregiver plan reliability, mental health assessment)
How have they managed assessing emotional health during COVID?
How many patients are you transplanting due to covid destroying their organs?
How much are people having to pivot and provide really basic needs like food and shelter resources, when before you might be doing more help with specific transplant needs?
How well did you feel supported by your social work dept as well as the transplant program during the first few months of quarantine (March 2020-May 2020)? Was your social work dept able to provide you with guidance on how to work during a global pandemic? Was anyone else afraid they would contract this disease while working on-site and that it will result in a fatal outcome for self or loved ones?
how/has the ability of patients to use telemedicine (video calls) been impacted by patient's familiarity with technology or ability to access smartphone/tablet/computer?
I am interested in hearing about the virtual systems each hospital is using at this time.
I have an observation. As a trauma recovery specialist, I think it's going to be a long time before we even realize how much the pandemic has affected each of us, mentally and emotionally. And yet, we still have more adjusting to do. Even makes self-assessment all the more difficult to do at this time. The pandemic is chronically challenging for our profession in ways we do not even realize, yet.
I have been in contact with several colleagues around the country and discussed various aspects of change in Assessment.
If you aren't back in the office doing in person assessments, when do you anticipate returning? What is the trigger to return?
if you have set clinic/evaluation days, are you able to work remotely the other day(s) when you know you will not be needing to complete any in-person visits?
Is anyone getting hazard pay due to COVID?
Is your facility going to allow ongoing virtual/telephonic visits or will you eventually return to pre-covid management of patients.
Of note, you asked about video evals but not phone. I am doing 90% phone evals.
our psychiatric/psych is all telemedicine are you having difficulty getting good assessments from them due to not being in person evaluations in regards to psychiatric issues.
Positive patients Positive colleagues Screening process prior to going into work daily
Techniques to build rapport with telehealth.
Very curious to know if there is a difference in ability to telework between SWkrs managed by management departments vs SWkrs managed by Social Work/ Care Management departments
Visitor policies: are they different for Tx pts? What impact have you seen? How has communication with the outpt rn coordinators changed? Do you have "outpt rounds/"
we have had a decline in referrals from our dialysis units. Has anyone seen a decline?
What challenges are they still facing with having access to caregivers feeling depressed during hospitalization.
What have you found helpful to encourage patients who are beginning to present as hopeless when living in a "COVID bubble?" What strategies have you found or suggestions have you have made to management to make eventual in-person visits safest and most comfortable (I have some anxiety about returning to a small clinic room with barely 6 feet available distance).
what other techniques or work arounds have you found to be effective in allowing for tele or video evaluations and mostly virtual work flows?
What percentage of your post-transplant patients have tested positive for COVID-19? What percentage of your post-transplant patients have died due to COVID-19?
What types of precautions are transplant social workers taking outside of work? (i.e, limiting face to face contact outside of immediate family, not going to restaurants, limiting travel)
Will remote work be offered at your institution post pandemic?
Would you like to continue doing telehealth after covid is gone?