



Mental Health
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du Canada



Exploring Two Psychosocial Factors for Health-Care Workers

**Support for Psychological Self-Care and
Protection from Moral Distress in the
Workplace: Facilitators and Barriers**

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Executive Summary

Psychological health and safety in the workplace is directly tied to our well-being. It is integral to our capacity to be effective, to feel significant, and to find meaning in our work. Those in health care face many challenges to being well at work, challenges that have increased exponentially during the COVID-19 pandemic. In this light, Canada's health-care leaders and policy makers have an ethical responsibility to support health-care workers in their psychological self-care and protect them from moral distress.

To better understand the facilitators and barriers related to these two psychosocial factors, we surveyed and spoke to hundreds of health-care workers* from several disciplines and workplaces across the country. Before doing so, we set out to build on what is known about psychological self-care and moral distress in Canadian scholarly and grey literature. We also sought to understand how individual health-care workers, teams, and organizations contribute to safer workplaces, including the barriers that make doing so more difficult.

We can now say, unequivocally, that addressing the well-being of the health-care workforce is of paramount importance, one that leaders and policy makers can no longer avoid.

Facilitators and barriers to support for psychological self-care

Health-care workers spoke about using proactive strategies such as prioritizing their own mental health needs and acknowledged that feeling appreciated by patients they cared for increased their capacity for self-care. They also felt that belonging to a team with supportive peer relationships and an authentic leader was an important facilitator to psychological self-care, as much so as working for an organization with an ethical climate.

On the other hand, some health-care workers saw overwhelming workloads as a barrier to wellness. They also considered management and team hierarchies impediments to accessing the resources needed for self-care. Organizations that were not prioritizing psychological self-care further hindered workers' efforts to care for themselves.

* We defined health-care worker as anyone working in health care, from front-line workers to leaders in primary to long-term care (and all organizations in between).

Facilitators and barriers to protection from moral distress

Health-care workers said that the feeling of making a difference through their work was a facilitator that protected them from moral distress. They also saw a healthy work culture with open communication within teams are critical to protecting against moral distress. In addition, having an organization with clear policies and guidelines to address adverse events and morally distressing situations was highly important.

Barriers related to protection from moral distress included unhealthy team environments, an “overwork” culture, and organizations that prioritized productivity over wellness.

Investing in Canada’s health-care workforce

Because of those who shared their personal experiences and wisdom, our exploration of psychological health and safety in health-care workplaces across Canada uncovered many opportunities for improvement. Participants not only spoke of challenges to supporting psychological self-care and protection from moral distress, they offered several excellent suggestions that organizational leaders and policy makers can implement over shorter and longer terms. While the case scenarios in Appendix II are just the beginning, they offer different models — seeded by the very health-care workers who know what’s important for their well-being — that could be expanded. The roadmap to building safer health-care workplaces has never been clearer.



Introduction

Ensuring physical and psychological health and safety for workers has long been an important and critical aspect of leadership and has also received support by decades of legislation.¹ In this context, the Mental Health Commission of Canada led the development of the National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard) in 2013 to support organizations that prioritize psychological well-being.² The Standard, which was the first of its kind in the world, initially included 13 psychosocial factors relevant to any workplace. This report focuses on two others that were more recently developed specifically for the health-care sector: (1) support for psychological self-care and (2) protection from moral distress.

While health-care workers spend their working hours caring for others, many are challenged to find the time and energy for self-care — and suffer because of it. We know that workplace psychological health and safety is directly tied to workers' well-being and the capacity to be effective, feel significant, and find meaning in their work. Yet we don't know what barriers and facilitators organizations meet when seeking to improve workers' psychological self-care and protect them from moral distress. If organizations fail to recognize and implement these factors, more and more health-care workers may leave their profession.

As Canada's health-care workers experience increasing demands on their time, the resources that support them are shrinking. The COVID-19 pandemic has worsened these poor working conditions, negatively impacting mental health and exacerbating feelings of moral distress

(i.e., feeling unable to take ethically appropriate action due to institutionalized obstacles).^{3,4} The pandemic's significant demands on health-care workers is resulting in growing departures from the profession,^{5,6} which in turn place further demands on those who remain. Health-care leaders, managers, and supervisors therefore have an ethical responsibility to protect health-care workers from moral distress by creating work environments in which staff feel supported and safe.

Such challenges for the health-care workforce are a global concern. A sustainable system must provide for current and future populations through calculated planning. Equally important is ensuring that they function well by supplying an adequate number of workers, making the most productive use of their skills, and creating healthy workplaces.

Two key questions therefore guided this project.

1. What barriers and facilitators do health-care workers, health-care teams, and health-care organizations meet when seeking to support psychological self-care and protect workers from moral distress, and what are the consequences of these psychological states?
2. In relation to the identified barriers and facilitators, how has the COVID-19 pandemic impacted workers, teams, and organizations?

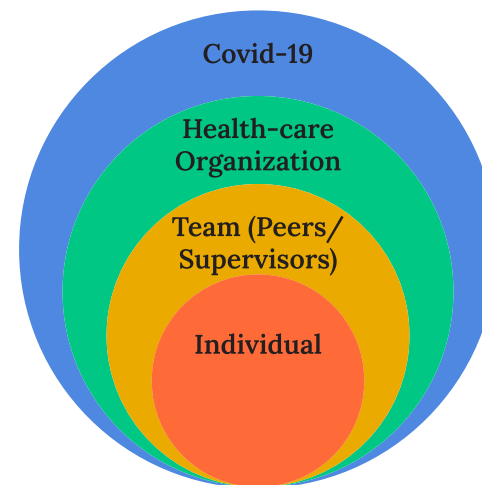
In setting out to answer them, we first looked at the academic and grey literature in Canada to find out what is already known. We then surveyed and spoke to hundreds of health-care workers from several disciplines and workplaces across the country.

This report describes the evidence we found in the literature and, after a brief description of our survey and interview methodology, presents the findings and several recommendations for health-care leaders and decision makers.

What we know

We know that health-care workers do not do their jobs in isolation; their psychological safety is affected by their role, the team they belong to, and the organization they work for. Capturing this interconnectedness or “organismic” nature⁷ was important to help understand the context in which support for psychological self-care and protection from moral distress occurs. Frameworks like Bronfenbrenner’s ecological model⁸ also enable us to understand the facilitators and barriers affecting health-care workers within different levels of influence. Our inquiry examined four such levels: (1) individual, (2) team (including peers and supervisors), (3) organization, and (4) COVID-19 (Figure 1).

FIGURE 1. Framework for Understanding the Different Levels of Barriers and Facilitators



The different levels of barriers and facilitators to support for psychological self-care and protection from moral distress.

The following literature review included studies with different types of health-care professionals (e.g., physicians, dentists, nurses, personal support workers) in multiple health-care settings (e.g., hospitals, clinics, emergency services, primary care). We also searched for reports, empirical studies, and policy documents specific to the Canadian health-care sector.

Support for psychological self-care

Health-care organizations that support psychological self-care create an environment that encourages staff to look after their own psychological health and safety. Facilitators and barriers can exist at various levels.



Individual facilitators and barriers supporting psychological self-care

The literature identified many facilitators to psychological self-care among health-care workers. Proactive personal strategies, including mindfulness and meditation exercises,^{9,10,11,12} alone time, eating comfort foods, spending time outdoors,^{13,14,15} and practising work-life balance (e.g., using vacation and sick days), were found to be helpful.¹⁶ In contrast, self-destructive behaviours, such as substance use and not using employee assistance program (EAP) benefits, were among the maladaptive coping strategies impacting such self-care.



Team facilitators and barriers supporting psychological self-care

Nurses highlighted the importance of supportive relationships with co-workers.^{17,18} The Canadian Medical Association also advises physicians to buddy up with one or more other doctors and connect with them regularly.¹⁹ While personal support workers stressed the important role of supervisors in workplace safety,²⁰ health-care workers emphasized the impact work schedules can have on psychological self-care. In intensive care units (ICUs), rotating shift assignments were associated with lower stress rates among staff,²¹ whereas pharmacists reported a desire to have short shifts with breaks and regular shifts that include the same team members.²²

Just as positive and supportive relationships with co-workers can support psychological self-care, negative relationships at work can increase stress. Midwives reported stress due to conflict and bullying with other health-care providers on their team (e.g., nurses and obstetricians).²³ Likewise, physicians reported that fewer supports and resources from colleagues negatively impact their well-being.²⁴ Additionally, health-care workers emphasized how poorly defined job descriptions (role ambiguity) increase stress.²⁵



Organizational facilitators and barriers supporting psychological self-care

At the organization level, health-care workers connected time away (e.g., holidays) with lower levels of stress at work.^{26,27,28} Similarly, health-care workers emphasized the importance of having work schedules (and control over them) that leave sufficient time for personal life.^{29,30} Having clear guidelines and directives from one's organization was also shown to support psychological self-care.³¹

While time away from work supported psychological self-care, excessive workload^{32,33} and workplace culture³⁴ were identified as two barriers to doing so. ICU nurses felt that, in the unit's culture, staff should hide their stress to avoid appearing weak.³⁵

Protection from moral distress

Health-care organizations that protect from moral distress create an environment that enables staff to perform their work with a sense of integrity that is supported by their profession, their colleagues, and their employer.



Individual facilitators and barriers to protection from moral distress

As reported in the literature, health-care workers used several coping mechanisms to protect themselves from moral distress. Among them were avoiding emotional attachments to patients and their families;^{36,37} practising self-awareness, reflection, reframing, and self-care; and learning to accept the limitations of medicine.^{38,39} Those in the ICU found that rationalizing and philosophizing about the nature of their work was helpful.⁴⁰ Health-care workers also emphasized the importance of taking time off to gain distance from the intensity of moral distress.^{41,42} In addition, they felt increased protection when motivated by a sense of purpose and armed with a learned coping capacity.

In terms of maladaptive coping strategies, studies mentioned compartmentalizing and substance use as contributors to increased moral distress.⁴³



Team facilitators and barriers to protection from moral distress

Included in the protections at the team level for health-care workers were open team communication, relationships with co-workers, and support from management. Those working in ICU and palliative care emphasized the importance of being able to discuss distressing situations with compassionate colleagues.^{44,45,46} Health-care workers

also described the protection they experienced from having positive relationships with colleagues (e.g., sharing laughter and humour).⁴⁷ In the same way that social workers felt reduced moral distress when having their managers' support,⁴⁸ nurses reported such a reduction when their managers were physically present and available during shifts.^{49,50}

In contrast, unsupportive comments from co-workers exacerbated feelings of moral distress.⁵¹ The literature also described how the attitudes, actions, and/or approaches of one team member can be enough to make a difficult situation traumatic.^{52,53} In addition, health-care workers emphasized how feeling dismissed or not being given respect by team members increases their moral distress,⁵⁴ as do power struggles between team members.⁵⁵



Organizational facilitators and barriers to protection from moral distress

Our literature review found a few organizational supports to protect health-care workers. These included being given physical time and space to process morally distressing events,⁵⁶ sufficient staffing levels to provide good care,^{57,58,59,60} and increased autonomy and flexibility in their schedule.⁶¹ Health-care workers also described how formal supports such as ethics debrief sessions, access to consultations with bioethics experts, and bioethics training helped protect them from moral distress.^{62,63}

One organizational barrier was a lack of human resources.^{64,65,66,67} Without sufficient staffing levels, none of the facilitators to protect health-care workers can be implemented.

Methodology

A mixed methods approach

We used two simultaneous strategies to find out what health-care workers in Canada had to share about themselves, their teams, and their workplaces in relation to psychological self-care and moral distress:

- A national survey (English and French) distributed to as many organizations and associations representing health-care workers as possible. The survey, which ran from December 1, 2021, through January 31, 2022,⁶⁸ was completed by 982 respondents (from every province and territory).
- A series of 60-minute, semi-structured interviews (English or French) with key informants from multiple disciplines and health-care sectors. Conducted between November 15, 2021, and February 10, 2022, all interviews were audio recorded, transcribed verbatim, and analyzed using a thematic approach. A total of 29 interviews with 30 participants were completed. Tables 1 and 2 provide more detail about the participants (both survey and interview) and where they worked.

Ethics approval was received from the Queen's University Health Sciences Research Ethics Board and the HEC Montréal Research Ethics Board.

The largest health-care worker groups to complete the survey were nurses (31%) and social workers (11%) (Table 1). Most survey participants worked in hospitals (37%), home and community care (13%), and long-term care (13%) (Table 2).



TABLE 1. Distribution of Health-Care workers by Discipline

Profession	Number of Survey Respondents and Interview Participants	Percentage of Total Survey Respondents and Interview Participants
Nurse (RN, RPN, PN)	309	31%
Social Worker	114	11%
Personal Support Worker	56	6%
Physician	50	5%
Physiotherapist	44	4%
Paramedic	47	5%
Dental Assistant	36	4%
Medical Technologist	34	3%
Occupational Therapist	32	3%
Manager	25	2%
Administrator	33	3%
First Responder	20	2%
Other	213	21%
Total	1,013	100%

TABLE 2. Distribution of Health-Care Workplaces

Profession	Number of Survey Respondents and Interview Participants	Percentage of Total Survey Respondents and Interview Participants
Hospital	372	37%
Home and Community Care	135	13%
Long-Term Care	124	13%
Emergency Services	73	7%
Primary Care Clinic	66	7%
Dental Office	57	6%
Mental Health Clinic	36	4%
Public Health	19	2%
Other	130	13%
Total	1,012	100%

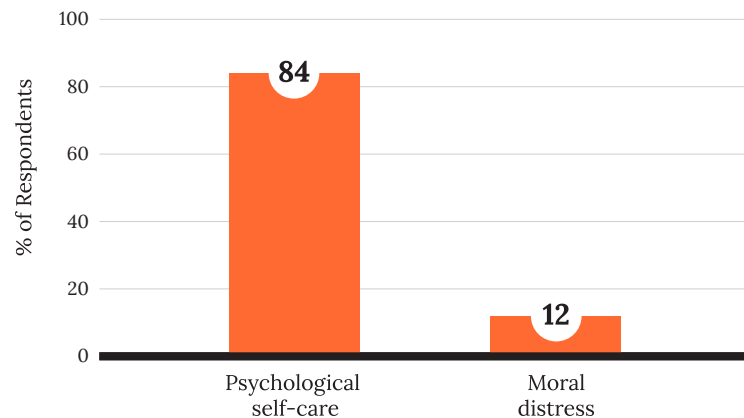
Findings

Survey: Psychological self-care and moral distress in relation to outcomes

All 982 health-care professionals responded to survey questions about their perception of psychological self-care and moral distress. Eighty-four per cent reported a somewhat positive perception of their ability to perform self-care, while 49 per cent experienced mild to acute levels of moral distress, and 12 per cent moderate to acute levels (Figure 2). These last levels of moral distress may seem lower than expected given that the Omicron wave was sweeping through Canada while the survey was being conducted. It is possible, however, that fewer health-care workers with moderate to acute levels of moral distress completed the survey than did those with lower levels.

FIGURE 2. Self-Care Versus Moral Distress

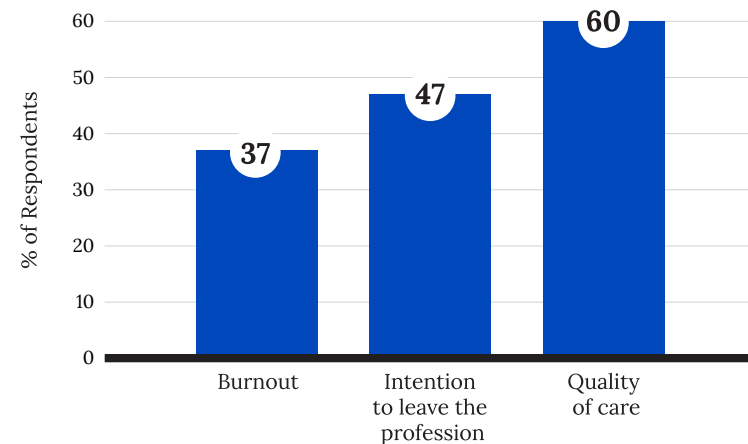
Percentage of sample who somewhat to strongly agree they perform PSC or experience MD



Note: This figure shows the distribution of survey participants who responded “somewhat” to “strongly agree” that they can perform self-care or experience moral distress.

FIGURE 3. Burnout, Intention to Leave, Satisfactory Quality of Care

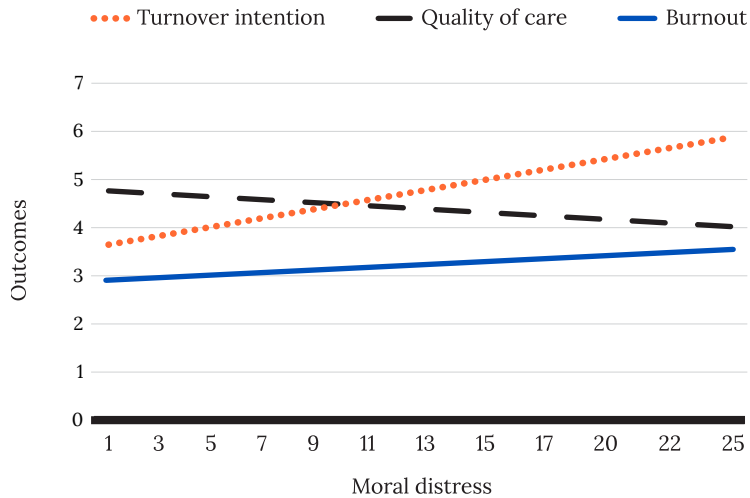
Percentage of sample who somewhat to strongly agree they experience these outcomes



Note: This figure shows the distribution of survey participants who responded “somewhat” to “strongly agree” to experiencing burnout, the intention to leave their profession, and satisfaction with the quality of care they are able to provide.

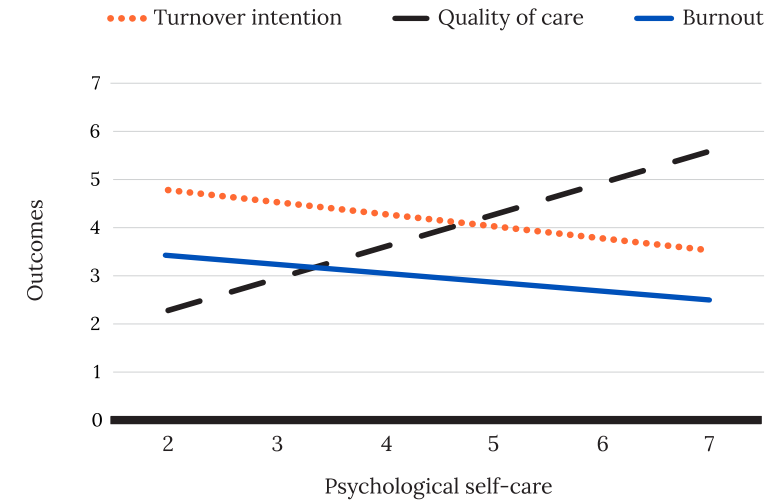
In these same respondents' perceptions regarding their (1) level of exhaustion, (2) intention to leave their profession, and (3) the quality of care they are able to deliver, nearly 40 per cent reported feeling burned out, 50 per cent said they intended to leave, and only 60 per cent indicated that they were satisfied with the quality of care (Figure 3). When we relate these factors to psychological self-care and moral distress, we can see that higher moral distress corresponds to higher levels of burnout (Figure 4), whereas performing self-care corresponds to lower levels of burnout (Figure 5). This suggests that when health-care workers can take care of their health and avoid moral distress, they are less exhausted and less likely to leave their profession.

FIGURE 4. Impacts of Moral Distress



Note: This figure shows the relationship between moral distress (higher moral distress is represented by higher values on the x-axis) and burnout, intention to quit, and perceived quality of care. The y-axis represents the Likert scales for each of the three factors. Higher Likert scores represent more acute responses.

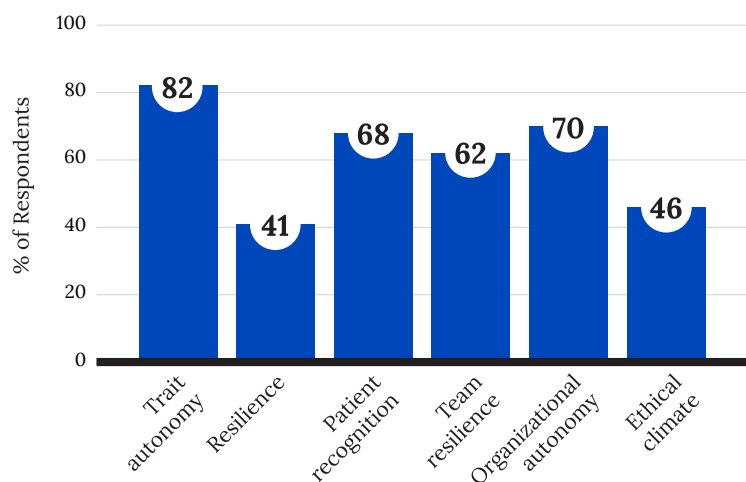
FIGURE 5. Impacts of Psychological Self-Care



Note: This figure shows the relationship between psychological self-care (increasing values on x-axis represent increased capacity to perform self-care) and burnout, intention to quit, and perceived quality of care. The y-axis represents the Likert scales for each of the three factors. Higher Likert scores represent more acute responses.

FIGURE 6. Experience of Facilitators

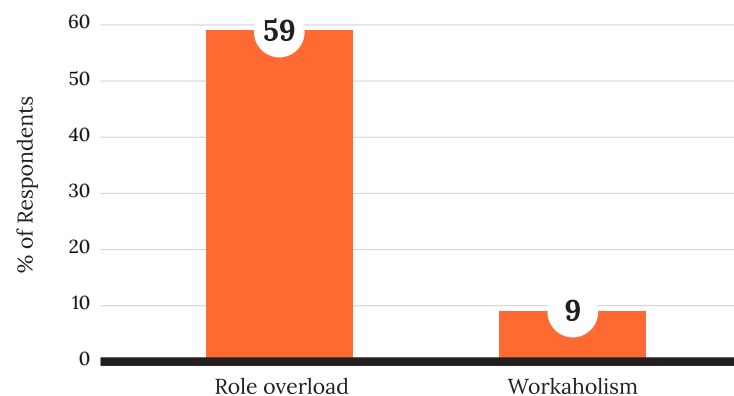
Percentage of sample who somewhat to strongly agree they experience facilitators



Note: This figure shows the percentage of respondents who felt that they experienced trait and organizational autonomy, personal and team resilience, patient recognition for the care they delivered, and an ethical workplace climate.

FIGURE 7. Experience of Barriers

Percentage of sample who somewhat to strongly agree they experience barriers



Note: This figure shows the percentage of respondents who felt that they experienced an overload of work within their role and perceived themselves to be workaholics.

Given these findings, we sought to analyze some potential facilitators and barriers that could impact a health-care workers' ability to support their psychological self-care and protect themselves from moral distress. Among the support mechanisms evaluated, we found that less than 50 per cent of respondents moderately to strongly agreed that they had a high level of individual resilience and worked in an ethical climate (Figure 6). We also learned that 60 per cent of respondents were experiencing work overload (e.g., too much work) within their role (Figure 7). Unfortunately, role overload is the reality facing the health and social services system in Canada, particularly in the context of the pandemic, and has ended up making certain previously unacceptable situations justifiable. This persistent feeling of overload can partly explain the results related to moral distress.

Facilitators and barriers to support for psychological self-care

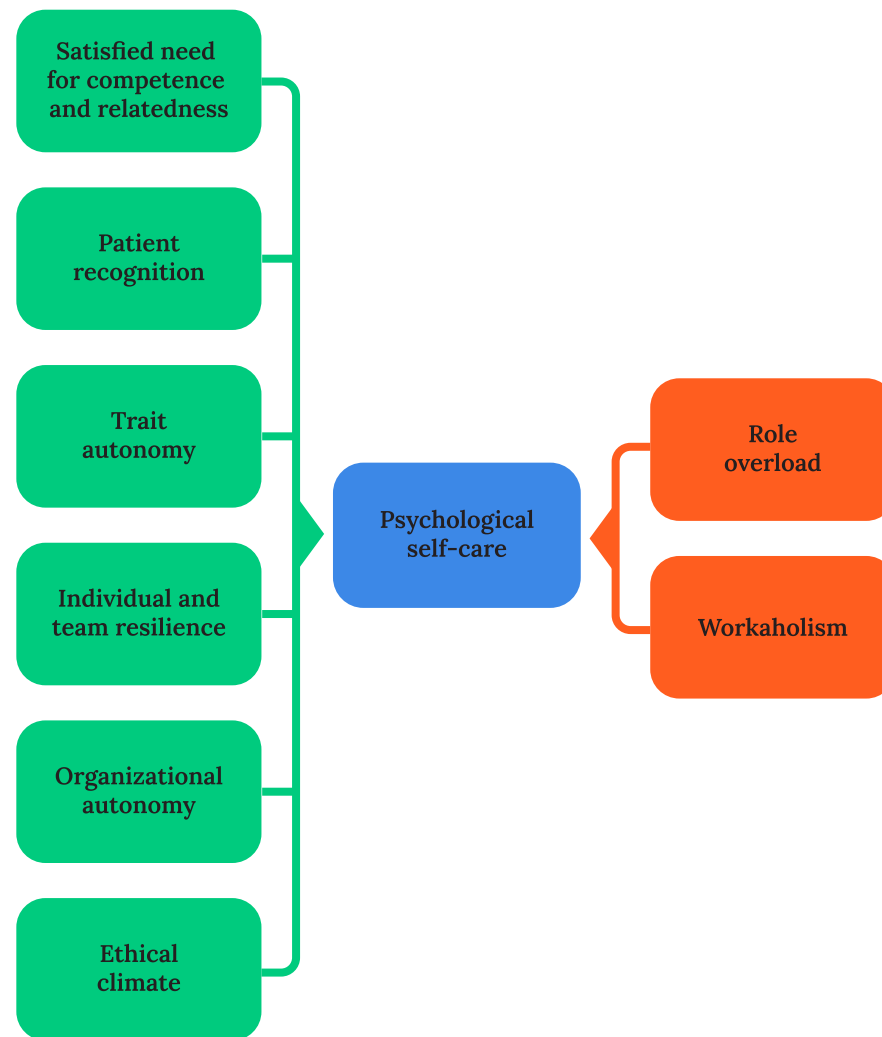
Survey findings

We asked survey participants whether they had access to certain support mechanisms or faced barriers in relation to their psychological self-care. Figure 8 shows the results after analyzing all 982 responses. That analysis suggests that, to increase the performance of psychological self-care, health-care workers must

- be more satisfied with the impact of their skills and their relationships with others
- receive more recognition for their work
- be given the autonomy to act according to their values
- demonstrate greater individual and team resilience
- know that organizational decisions are made, above all, with ethical considerations in mind.

At the same time, role overload should be reduced to avoid workaholic behaviours or obsessive thinking about work.

FIGURE 8. Facilitators (left) and Barriers (right) to Support for Psychological Self-Care



Interviews findings

We also spoke directly with 30 health-care workers and administrators across Canada to gain a better understanding of support for psychological self-care and protection from moral distress.

Individual facilitators to support for psychological self-care

The health-care workers we spoke with emphasized the importance of prioritizing their own needs. Two specific actions facilitated support for their psychological self-care: (1) using the resources available to them and (2) being vocal about their wellness needs. Many spoke of the available counselling services or psychological safety representatives in their organizations, indicating that taking the time to use these valuable resources was helpful. Sometimes, health-care workers needed to speak up when working conditions made psychological self-care more challenging. It was also evident that many sensed a shift in organizational culture as younger generations joined the ranks. Some older participants spoke of how younger health-care workers place more priority on wellness than others.

“The newer generation seems to be a little more aware that it’s not their role to burn themselves out, but to take some self-care. And that means putting some limitations on it. And so, it’s a little bit of an old guard/new guard. And I am hoping there is a big switch in terms of self-care itself.”

Individual barriers to support for psychological self-care

Participants described a significant barrier related to psychological self-care: the inability to acknowledge how important it is to prioritize mental health. Specifically, health-care workers told us that the obligation to care for others before caring for themselves was common in health care, and that a mindset of self-sacrifice was prevalent. Also, many were hesitant to identify when they were feeling burned out or experiencing personal mental health struggles, lest it be seen as negatively impacting their job performance. The stigma around pursuing help for mental health issues was a significant contributing factor to this reluctance.

“I think historically there is belief that health-care workers are to be stoic and tough, and you know, this is what I signed up for. Yes, people are going to die. I need to just move on to the next patient. That is the expectation.”



Team facilitators to support for psychological self-care

The two most identified facilitators to supporting psychological self-care in health-care teams were related to peer relationships and the existence of supportive leadership. Within teams, health-care workers valued being able to normalize psychological self-care through frank and honest conversations and speak freely about personal challenges. The act of giving (and getting) advice from other members of the team enabled them to build critical peer relationships, which they relied upon.

The most supportive leaders acted with personal integrity and “walked the talk” when upholding policies and practices designed to support staff (e.g., debriefs, check-ins). The supervisors who facilitated psychological self-care that benefited the entire team recognized workers’ need for personal autonomy, managed workloads appropriately, and prioritized a positive work-life balance.

“I think the other thing we do is encourage our managers to have individual conversations with team members to say, how can we reduce some of the load on your plate right now?”

In the survey, health-care workers indicated that team resilience was the top facilitator to support for psychological self-care. It was defined as the ability of a given work team to cope and deal with difficult situations. To increase the team’s resilience, each member must perceive their contribution as being useful to the group and feel free to express their opinion without value judgment or contempt from others.



Team barriers to support for psychological self-care

Health-care workers told us that the existing health-care culture was the primary barrier challenging team support for psychological self-care. They reported that this culture was impacted by two factors: (1) the inability of middle management to relate to front-line workers because of a lack of related experience and (2) the existence of hierarchies perpetuated by those at the top.

“The ones that I work closely with get it, and the ones at the very top get it. But [those in] middle management don’t get it. So, we are not doing very good with that.”



Organizational facilitators to support for psychological self-care

A key organizational facilitator was having decision makers at the top make a visible commitment to embed psychological self-care into the organizational structure. Leaders demonstrated this in two ways: (1) building support into policies and procedures that prioritize workers and (2) acknowledging the importance of having a preventive focus to minimize potential harm. Policies that support formal team debriefs ensured that these would happen regularly. Preventive strategies that included training in self-care during onboarding and creating staff positions specifically related to wellness demonstrated an organization’s commitment to its health-care workers.

“There are organizational factors that we can address to reduce the stresses in the workplace, that the organization has to be responsible for.”



Organizational barriers to support for psychological self-care

Interview participants saw an organization's inability to prioritize support for psychological self-care as a significant barrier. This lack of prioritization occurred in plans or policies to address psychological self-care and in the creation of dedicated resources to support wellness.

Psychological self-care is negatively impacted when organizations do not purposefully develop and include strategies to address it or cannot identify resources such as dedicated wellness staff or physical spaces for breaks. Participants saw such an impact to be a direct result of excluding health-care workers from decision making at the organizational level or else not inviting their input for decision makers at the top.

“I also think there needs to be funding lines that really recognize [wellness]. Things like maybe a wellness committee where you do have adequate funding to support wellness activities for staff.”

Facilitators and barriers for protection from moral distress

Survey findings

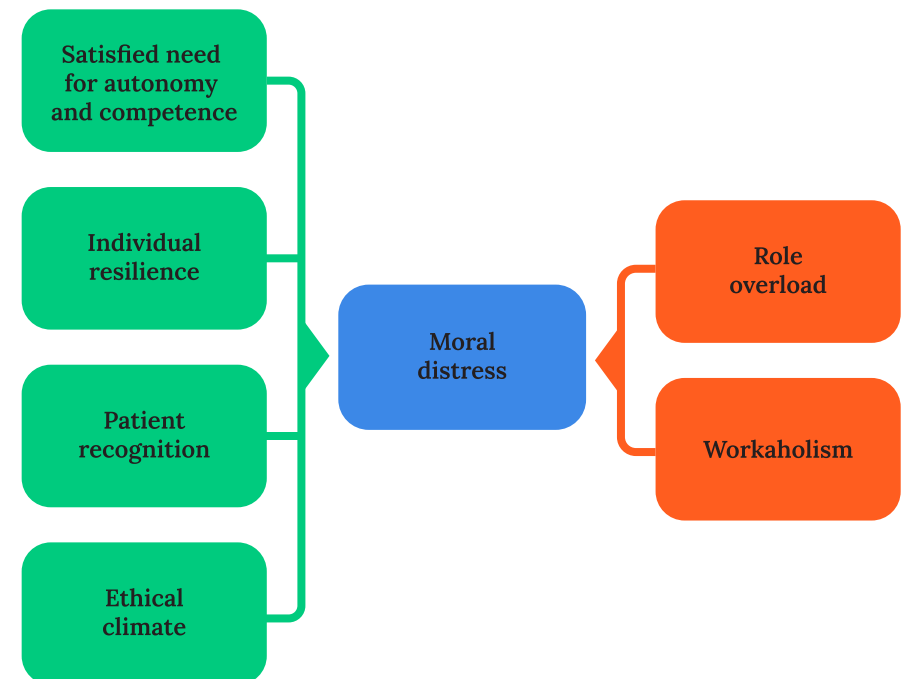
By analyzing the responses of all health-care workers, we identified a few facilitators and barriers to moral distress (Figure 9).

Our findings suggest that, to reduce moral distress, health-care workers must

- have autonomy in their work and feel competent in their skills
- have personal resilience
- receive recognition from their patients for the care they provide
- work in an ethical environment.

Similar to the findings with psychological self-care, feelings of moral distress can get worse when health-care workers experience role overload and workaholism.

FIGURE 9. Facilitators (left) and Barriers (right) to Protection from Moral Distress



Interview findings

The interviews allowed us to deepen these results and target other areas of intervention.

Individual facilitators to protection from moral distress

Health-care workers told us that, while they accepted moral distress as part of their job, two key factors helped mitigate its impact: (1) feeling like they are making a difference through their work and (2) having the ability to advocate for change.

“Whether it is system change within their own system and challenging authority to move in certain directions and challenging within the system itself, or larger than the system they are within, it’s pushing for change. You will find some nurses, pushing very hard for harm reduction. Pushing very hard for de-criminalization of sex work and public health problems. That is one way of doing self-care in a healthy way.”

Individual barriers to protection from moral distress

Several participants felt that the concept of moral distress is not well understood, although it is intrinsic to working in health care. Some mentioned how the difficulty of recognizing situations that cause moral distress in oneself makes it hard to ask for help and limits one’s capacity to address it in their peers.

“If you work in health care, you can’t avoid an occupational stress injury, it is a by-product of the work that you do. It is the cost of caring and working in health care.”

Team facilitators to protection from moral distress

A healthy work culture was viewed as a critical facilitator to protection from moral distress at the team level. In such environments, peers and leaders support each other through communication and a sense of autonomy. A team that makes it possible to communicate about difficult cases and acknowledge personal struggles can be protective in relation to difficult situations. Fostering a sense of autonomy and control among team members can mean, for example, that there is trust in the expertise and experience of a nurse to carry out patient care decisions or else support for a colleague when they take a break or vacation despite increasing the workload of others.



Team barriers to protection from moral distress

The most frequently discussed barriers to protection from moral distress at the team level relate to an unhealthy work culture, including those that normalize “overwork” or cannot recognize “re-traumatization” when it occurs. Team leaders may contribute to an overwork culture by neglecting to consider workers’ realities in scheduling decisions (vacation recall, mandatory overtime) or workload. Peers also contribute to this barrier by shaming colleagues who take breaks in their day or time off for vacation.

Another barrier mentioned was “emotional dumping” in relation to moral distress, either when it occurs without adequate space to safely share feelings or when sharing between peers amplifies the trauma while a limited capacity to provide support exists.

“We still have a culture in health care that says, if you are struggling with a mental issue let alone a mental illness, that you are weak and you have failed... [Peers] don’t treat people who go off work with depression and anxiety, for example, the same way they would treat someone who was in a car accident.”



Organizational facilitators to protection from moral distress

Participants felt that organizations can best protect health-care workers from moral distress by putting supportive resources in place (for when it does occur) and developing policies that guide necessary action. Examples of resources included educational sessions for staff when they need protected time and having dedicated wellness team members in the organization.

Wellness staff may include mental health professionals as well as ethics specialists who can provide support through morally distressing decisions.

Having clear policies (e.g., formal guidelines) that are enforced can provide a roadmap to help guide action when morally distressing situations occur and shift accountability away from the individual worker.



Organizational barriers to protection from moral distress

Barriers to protection from moral distress at the organizational level are factors that prevent employees from accessing support and guidance when they need it. These included insufficient resources dedicated to workers’ mental health and a lack of protected time for wellness. When there are insufficient resources dedicated to staff mental health, such as limited funding for counselling services in the benefits package, it not only prevents staff from accessing support, it also signals that the organization does not believe their well-being is important.

Others noted that a lack of protected time for wellness due to the prioritization of productivity was a barrier to accessing counselling services or taking a training course outside of paid work hours.

Psychological safety in the context of COVID-19 pandemic

Despite the obvious hardships the pandemic has brought to the health-care sector, some facilitators for psychological self-care were mentioned. The health-care workers we interviewed described feeling that the stigma related to mental health has decreased and that the ability to discuss personal struggles with peers has become more widespread and accepted. At the team and organizational levels, the shift to virtual and remote work has helped support worker autonomy through flexibility with scheduling and enhanced work-life balance (especially around family responsibilities), but only for those able to work from home.

“There is a lot of encouragement now to say, *we want you sometimes in the office and sometimes virtually*. Trying to give people control over when and how and what that looks like. The idea is that if you can control your calendar and your schedule, then it will make you feel less anxious and stressed out.”

Nearly every barrier related to the pandemic arose from staff shortages, which participants noted was a pre-existing issue worsened by COVID-19. For some, the increased workload due to staff absences and attrition became unmanageable during the pandemic and contributed to their own deteriorating mental health, which in turn led to even higher rates of attrition.

Within teams, the increasing workload meant the loss of time or space for nurturing supportive peer relationships that were previously found to be beneficial to team functioning and a source of support for psychological self-care.

At the organizational level, staff shortages forced the introduction of toxic policies such as mandatory overtime and the cancellation of vacations, alongside the creation of unhelpful resources that did not come with the necessary protected time to use them.

“There might be these nice emails that come around saying, take time for yourself. Make sure you have a cup of tea and all that kind of stuff. But on a scale of 1 to 10, with this being an environment that is truly concerned about your mental and physical health, I would say it probably rates a 4 out of 10. There are many people who are being forced to work double shifts to cover off for people who are off sick or who are isolating.”

“When it comes to actually working in the hospital units, it is a bit tougher because there is so much demand that you are continually being asked to work more and more and more and more. So that has been a real challenge throughout this whole pandemic. I have seen some comments around mandating that we take an online course in personal resiliency. But while you are doubling up our assignments, adding another course on top of that is not really helpful.”

Health-care workers mentioned two facilitators that protected them from moral distress, both of which reduced their personal responsibility: (1) Having ethicists as part of a support team enabled dialogue on morally challenging decisions related to patient care, and (2) providing organizational policies to guide workers helped to alleviate some of their decision-making burden associated with working during a pandemic.

Yet these organizational policies to support decision making were somewhat of a double-edged sword, since workers sometimes felt that they had to withhold care from a patient (when they thought it was needed) due to the obligation to follow policy.

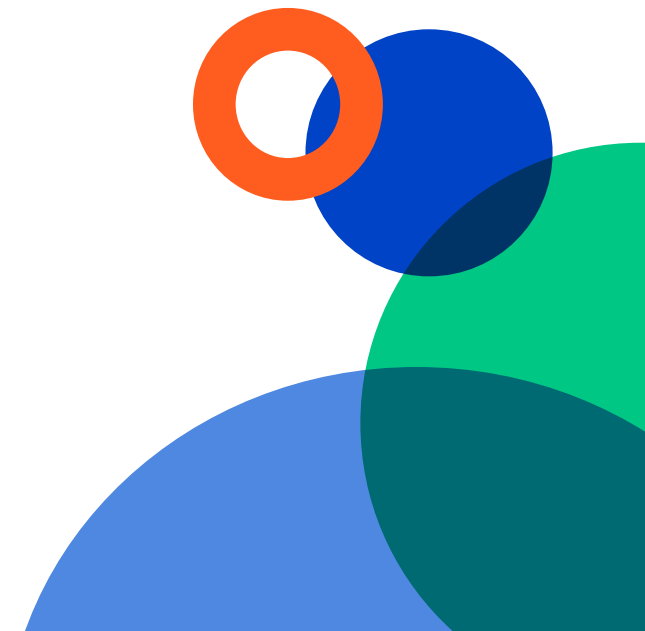
“So just to sum it up I guess, what would help with the moral injury would be policy and procedures. So just take it right out of their hands altogether.”

The pandemic brought new situations with the potential for moral distress, such as staffing challenges, constant change, and limitations on how care could be provided. Staffing issues and a lack of resources resulted in overtime, support fatigue, and burnout; and despite a

willingness to support their peers, health-care workers have been suffering. Navigating ever-evolving COVID-19 policy changes, including those related to day-to-day operations and the general uncertainty of not knowing what the next day would look like, has taken a considerable toll.

The provision of care, including its allocation and withdrawal based on care-related restrictions or policies (e.g., preserving patient goals, dignity, visitors, and vaccinations) has caused significant and increased moral distress for health-care workers.

“I have personal experience where you stand there and watch people die in front of you. Knowing that all they need is a simple procedure that you could do, that isn't available to you now because a policy or decision maker in the clinical governance model has decided that it is too high of a risk.”



Considerations for Health-Care Leaders and Decision Makers

Our exploration of the two psychosocial factors — psychological self-care and protection from moral distress — was grounded in engaging health-care workers, teams, and organizations throughout Canada. This process uncovered several poignant realities that we believe leaders and decision makers must attend to and act swiftly upon. To that end, we have identified a number of opportunities that enable health-care organizations to embed supports for these factors, which ultimately influence the way teams function and how individuals are affected.

The following recommendations (along with the case scenarios in Appendix II that provide models for action) are presented as ways to bolster the battle-weary health-care system and benefit us all.

1. An ethos that may have been partially dismantled by the pandemic relates to health-care workers' reluctance to acknowledge their limits and address their mental health needs. While we know the stigma in health care prevents these workers from admitting their limitations, the stress placed on the entire health-care system during the pandemic made it “OK” for them to talk about issues of personal struggles, feelings of exhaustion, and becoming burned out. Since breaking down cultural barriers in health care remains crucial, organizations must prioritize psychological health and safety beyond the pandemic through advocacy, strategy, and action.
2. Health-care workers need time and space to support their own psychological self-care. A lack of time away from work (e.g., vacation days, sick days) makes it more difficult to engage in psychological self-care and impacts crucial relationships between co-workers. Organizations must make every effort to protect sufficient time off for health-care workers.
3. Organizations must advocate for sustained resources (human and financial) to support and protect their health-care workers. Doing so would include embedding long-term supports such as wellness champions, ethicists, adequate benefits, and protected budget lines for psychological health and safety.
4. To support health-care workers, appropriate and adequate operational policies and procedures must be put in place and followed throughout the organization. To ensure that this support is adequate, every management team needs to implement policy consistently and reinforce the importance of reliable application by including it in all manager onboarding. Clearly developed protocols for supports (e.g., debriefing sessions after significant events) can assist teams and team leaders and provide some protection from moral distress.

5. Because leading in health care is never without challenges, organizations must prioritize leaders' development to assist them in their role. They should seek out and support leaders who can continue to learn and grow while being compassionate and authentic. Leadership development and coaching – in conjunction with knowing how to optimize performance among skilled health-care workers who are challenged in their stressful environments – are critical and must be cultivated and rewarded.
6. To improve transparency, communicate effectively, and increase trust in leadership, health-care organizations should cultivate an ethical work climate. While this is an important facilitator, less than 50 per cent of those in our sample felt that they worked in such a climate. Proactive initiatives, like giving voice to employees and including them in decision-making processes, can support the emergence of an ethical focus.
7. Staffing shortages and (at times) high numbers of patients have dramatically increased workloads for health-care workers. Almost 60 per cent of respondents said they were experiencing moderate to severe role overload. In response, health-care organizations have been forced to introduce measures like mandatory overtime and cancelled vacation days, which in turn have limited these workers' time away from work and their ability to build positive relationships with co-workers. While COVID-19 has exacerbated these challenges, organizations must continue to focus on the critical importance of health human resources (HHR) after the pandemic ends. Canada desperately needs an updated HHR strategy that addresses the current crisis, and organizations must do everything they can to make sure it remains front and centre for policy makers.



Conclusion

Every health-care worker in Canada deserves to be employed in an organization that prioritizes psychological health and safety. In terms of achieving this prioritization, the COVID-19 pandemic has brought to light many challenges on multiple levels. If anything, conducting this inquiry during a pandemic has amplified these workers' urgent call for decision makers to enact change.

We heard that health-care workers are highly resilient and continue to work hard to care for others. That said, many are at their breaking point while trying to cope with increasing uncertainty related to staffing shortages, insufficient resources to support their mental health needs, and an infectious disease that continues to infect tens if not hundreds of thousands across Canada. We also heard about the value of supportive teams (both peers and supervisors) and the importance of communication during the myriad of changes being made to protocols and procedures. At the organizational level, commitment and transparency from leadership were identified as essential to providing support for psychological self-care and protection from moral distress among health-care workers and were key factors in their capacity to feel safe.

When we eventually emerge from the pandemic, organizational leaders and policy makers need to continue taking action to increase the psychological health and safety for all health-care workers. Doing so requires a commitment to a safer workplace, to making sustainable changes, and to acknowledging that health-care culture must shift so that it cares for those who care for us. Identifying solutions that are grounded in prevention and the promotion of well-being will help strengthen the system we all depend on and demonstrate value to our entire health-care workforce. There is not a moment to waste.



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Appendix I

Definitions

Compartmentalizing. The separation of conflicting ideas or aspects of one's self to reduce tension and avoid conflict.

Ethical climate. Employee perceptions of organizational practices that reflect how decisions having ethical content are solved.

Individual resilience. The internal and stable disposition of individuals who can cope with and recover from hardships.

Organizational autonomy. The degree of autonomy that individuals perceive they have when working.

Support for psychological self-care (specific to health care).

A health-care workplace where staff are encouraged to care for their own psychological health and safety.

Patient recognition. A patient's explicit expression of appreciation to their caregiver for the care and treatment received.

Protected time. Time allocated for educational activities. Protected time spent by a health professional engaged in a professional activity – learning, teaching, administration, etc. – cannot, by contract, be used for clinical duties.

Protection from moral distress (specific to health care). A health-care work environment where staff are able to work with a sense of integrity that is supported by their profession, employer, and peers.

Role overload. The perception that role demands are overwhelming relative to the available resources.

Satisfied need for competence. Competence refers to the degree of experienced mastery and the ability to bring about desired outcomes.

Satisfied need for relatedness. Relatedness is the experienced warmth, bonding, and care from significant others.

Team resilience. The ability of a given work team to cope and deal with difficult situations.

Trait autonomy. The internal and stable disposition of individuals who act in accordance with their values and feelings.

Workaholism. The tendency to work excessively hard and be obsessed with work, which manifests in working compulsively.

Appendix II

Case scenarios: Capacity-building strategies

1. A large hospital demonstrates support for self-care among its health-care workers by providing regular educational events (including accredited CME credits) and hosting related webinars and speakers. While presentation days and times vary, recordings are available for those unable to fit them into their schedule. Staff and management are urged to attend, paid for their time, and (where feasible) provided with lunch. Each session is evaluated for its content and value, and the opportunity to hold a team dialogue is encouraged as a follow-up activity.



**Organization
level**

2. A decentralized team of social workers has banded together to advocate for improved treatment of youth with few supports who present to community services with suicidal attempts. Advocacy efforts can give health-care workers an opportunity to demonstrate self-care through contributing to larger change efforts and increasing the visibility and importance of one's work. When these efforts are well coordinated and hopeful, they empower people and promote camaraderie with peers, despite the substantial challenges that accompany efforts to change a system.



**Team
level**

3. Events that have a significant impact on health-care teams can either be used blame and shame or offer opportunities to learn and grow. To protect nurses from events that cause moral distress, one specially trained nursing manager regularly brings teams together to discuss them. Soon after a distressing event, the nurses directly impacted are contacted personally and invited to join. The protocols used to facilitate the sessions are developed by the organization, which also provides time for nurses to attend. The discussions are used to review, discuss, offer insights, and develop constructive ways to mitigate the risk of similar events in the future (finger-pointing is not allowed). Among the outcomes are changes to policies and procedures.



**Team
level**

4. A large, decentralized primary care organization encourages self-care for health-care workers (including physicians) by providing access to psychological services (employee assistance program, private therapist) with confidential access. The organization also actively promotes these services during staff orientation, team meetings, in communications from front-line supervisors, and in agency-wide correspondence (newsletters during COVID-19). Managers are trained to recognize the signs and symptoms of mental illness and to refer workers to EAP early on.



**Health-care
worker level**

5. Psychological safety in the workplace is critically important for one provincial health-care organization, which has taken tangible and visible steps to complete an inventory of practices, elicit input from health-care workers, and develop new policies to enact change. Once funding for the project was in place, the organization put together a dedicated team to collect, synthesize, and report on its yearly activities. This demonstrated commitment has led to an increased focus on self-care practices among workers (shown in the last four annual staff surveys). To increase the response rate, the organization compensated employees who completed the anonymous surveys (e.g., draws, gift cards). It also provides training to all management in the use and application of easily accessible national standards and implementation guides.



**Organization/
association
level**

6. One large hospital considers debriefing after a significant event very important, but it also encourages health-care workers to determine when it is needed. Soon after such an event, team members are identified and invited to meet over coffee in an assured safe space for sharing. Supervisors are adequately trained to facilitate these meetings using protocols developed by the organization, which gives team members sufficient time away from their duties to attend. Annual staff surveys have highlighted the critical importance of this practice (and the leadership from team supervisors) for managing events that cause moral distress.



**Team
level**

7. Continuous communication by leadership at one rural hospital has led to a workplace culture that health-care workers highly value. The integrity leaders demonstrate has allowed workers to perform their own roles with integrity, which is critical in times of moral distress. Health-care workers feel that they can trust the information leaders share and take honest and open actions without fear of reprisal. Leadership regularly seeks out worker feedback and incorporates them into their proposed solutions. When workers approach management, their concerns are taken seriously, and their confidentiality is protected.



**Leadership
level/
organizational
level**

8. A community services organization has shown a visible commitment to its workers by creating a permanent wellness champion position. Its responsibilities include identifying areas for organizational improvement, encouraging opportunities for self-care (in the workplace and at home), and proposing evidence-based policies to leaders.



Organization level

9. Addressing psychological safety in health-care workplaces is more likely to succeed when medical education curriculums include it. Those that do emphasize the value of self-care and the challenges of moral distress well before health-care workers enter practice.



System level

10. One hospital offers its clinical staff protection from moral distress by providing ethicists to consult with when a difficult decision is required (e.g., a transplant). Health-care workers can bring ethical dilemmas to these specialized staff members, who offer support through an ethical review that includes meeting with patients to enable a full dialogue and informed decision making. Support from an ethicist trained in difficult conversations and choices can be extremely valuable for those burdened by having to make difficult and distressing clinical decisions.



Organizational level

11. Health-care organizations that prioritize spiritual health must take extra steps to promote the acceptance of all religious beliefs, including Indigenous practices. In this context, cultural safety training and emphasizing respectful practice can help protect individual health-care workers from moral distress. Such training and practice can also ensure that patients whose spiritual well-being impacts their physical and emotional health receive the best care, particularly at the end of life. In addition, cultural inclusion enables staff to have time away from work for religious holidays and to cover for workers whose religious holidays differ from their own. Having spiritual advisers available for consultation is also beneficial for professional staff, patients, and their families.



Organizational level

12. One community service agency demonstrated its commitment to support for psychological self-care by making it a strategic priority in each of its last three strategic plans, whose goals and strategies provide tangible steps for meeting their vision. Its reaffirmation by the CEO and leadership team every three years does not mean the organization has failed to achieve this priority. On the contrary, by continuing to add to this initiative each time, they intend to protect and build on what has been accomplished (resources for staff) rather than let it be forgotten.



**Leadership/
organizational level**

13. To limit the “noise” caused by the rapid fire of announcements throughout the pandemic, one provincial professional association committed to posting the most up-to-date COVID-19 information for its members in an easy-to-access location (also included as updates in regular member newsletters). This initiative became a dependable resource for evidence-informed strategies amid changing advice and regulations. In turn, giving professionals access to a trusted source of information helped decrease incidents of moral distress.



**Association/
Systems level**

14. When one long-term care home experienced a high number of deaths or a substantial loss, leaders brought in a professional counsellor to lead group debriefing sessions. The facility provided private therapy services to full-time staff as part of their benefits package, but the group sessions seemed to remind staff about the availability and helpfulness of these services. Leaders also felt that these sessions allowed some staff to take part who might not otherwise have sought a counselling session following a time of high stress in the organization.



**Organizational
level**

15. Due to the high death rate in long-term care during COVID-19, allowing time for staff and families to grieve became more challenging. One organization provided protection from the moral distress this created by making a bereavement counsellor available for both groups. The ability to honour residents who died at a memorial service each month also enabled staff to talk to one another, take time to grieve, and prevent the hectic nature of the pandemic from dismissing death so easily.



**Organizational
level**

16. One private long-term care organization prioritized the use of continuing education for all staff, something uncommon in this sector. Leadership recognized that providing paid time for training (specifically for management and front-line personal support workers) pays dividends for the organizational culture while supporting professionals that work in isolation at separate locations who rarely get the chance to connect with their peers to share knowledge. An annual two-day learning event has also benefited leaders and other workers, leading to an energized workplace and potentially increased staff loyalty in the organization.



**Organizational
level**



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