Nursing Home Social Work During the COVID-19 Pandemic: Reflections Behind the Mask

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Abstract: The majority of COVID-19 deaths between 2020 and 2021 were older adults with compromised health. Nursing homes in the United States were the highest risk places for death caused by COVID-19 due to the physical vulnerability of residents, close quarters, and staffing shortages. Skilled nursing facilities are required to have trained social work professionals to meet the psychosocial needs of residents—made more severe as a result of the pandemic with visit restrictions, limited staff, and few incentives—yet the placement on trained social workers of incredibly high caseloads and expectations was only increased during the pandemic. Our article provides literature relating to social work wellbeing, recommendations from us the authors, and includes a first-person account of our daily work life to illuminate the complex and rigorous, psychologically demanding, and still too-little recognized role of the nursing home social worker as a key agent for change, problem-solving, and essential care.

***Keywords*:** COVID-19, nursing home social work, psychosocial care, social work in skilled nursing facilities, nursing home death

COVID-19 was not just a disruption for nursing home staff and residents; it stands as a catastrophe that devastated occupants of long-term care facilities like nothing in recent history ever has. As of December 2020, out of approximately 270,000 COVID deaths, nursing home residents and staff comprised 106,000 such casualties—and as of mid-2021, 40 percent of all US COVID deaths have been linked to long-term care facilities (AARP Public Policy Institute, 2021; Bondi, 2020; HealthDay News, 2021; Konetzka, 2021). In fact, terms such as “hot spots” or “death traps” were regularly used where the spread of the virus was rampant among the vulnerable nursing home residents in places like New York, Louisiana, Minnesota, Connecticut, and Rhode Island (HealthDay News, 2021). The catastrophe had deep and lasting painful realities for the front-line workers, stretching beyond nurses, including the under-sung, essential certified nursing aids (CNAs) and the social workers or social service designees.

Social work is a stressful role in non-catastrophic times. The added pressure of the pandemic created an impossible work-life situation for many professionals, adding to fatigue, high-risk behaviors, loss of trust in administration, and burnout. Advocates for improved psychosocial services hope that COVID unearthed the reality of the nursing home industry employing undertrained social work staff (Bern-Klug & Beaulieu, 2020), but the cause-and-effect relationship of higher trained social workers and improved care quality data remain hard to substantiate, in part leaving facilities defaulting to bare bones staffing. Comorbidity influenced increased death rates, but so did the reality of understaffing and risk to staff in a closed institution add to the residents’ vulnerability in a stretched-thin workplace (Miller et al., 2020, 2021). Still, efforts are alive and well to promote advocacy and policy changes to provide skilled gerontological social work services for vulnerable older adults, the need the pandemic critically highlighted (Berg-Weger & Schroepfer, 2020).

Social workers are people whose roles rely on familiarity and presence to problem-solve and intervene in complex mental and compounded physical health realities, planning and securing material needs while fighting for justice in many realms. In short, the role is impossible with the law still requiring only one certified social worker at a BSW or MSW level for 120 residents, and no standard for education or training for smaller homes (Elizaitis, 2021). The fault does not simply lie in the industry, nor the motivation of the professional, but in larger societal constructs that neither celebrate nor recognize social workers or nursing home residents and close the door to let them languish together. So, the true heroes are the ones who plug along, working against the tide of impossible demands and haunting memories.

Restricted Visitation Effects

Many of the people who would see residents and families daily were unable to have contact which presented both the residents and the staff with new challenges—from confirming end-of-life/DNR determinations to keeping up with routine care planning and upkeep of records. Presence of the outside community is a correlate of improved care via the Hawthorne Effect (outcomes influenced by the mere presence of someone monitoring), in some respects, but it works in favor of both residents and families (Allen, 2006). Lockdowns affected morale, health, and wellbeing in the facilities. Allen (2006) spoke about community presence influencing improved care quality and fewer complaints, and once the community was locked out and fewer were looking, care shifted to the necessity of triage and rationing of care due to the overwhelming needs of the residents juggled against the threats of the pandemic (McFadden et al., 2021). Alessandri et al. (2021) wrote about the “loss spiral” (p. 8595) that added to a decline of worker wellbeing and loosened the inspiration to care in the work setting (Seng et al., 2021). When the links were broken, so too was the care quality. The compounded realities only weakened care in nursing homes, fueling risk and eventual life loss. Furthermore, the loop of sending sick residents to the hospital often posed more risks than keeping residents in place. Staff were torn between their own safety, many working without the necessary personal protective equipment that was recommended by the Centers for Disease Control and other concerned experts who updated the country regularly. (The political climate itself was part of the risk slope as people were receiving mixed information from heads of state and leadership in the US Administration.)

Justice was not to be seen in nursing homes, which have historically been viewed as warehouses for older adults, despite long efforts to humanize and to professionalize and advocate for the 1.6 million persons residing in the US facilities. Members of the National Nursing Home Social Work Network (nh-sw-network@uiowa.edu), an invested group of researchers, scholars, and advocates of nursing home psychosocial care and quality, organized a national support session which took place each Monday from May to August 2020 with slots opened for other days/times where direct line workers could drop in and share sobering or hopeful stories. Sad realities included workers walking by lines of rented refrigerated 18-wheelers to house the dead due to the overload of the deceased in mortuaries in largely metropolitan areas. There was no time to mourn—social workers, if able, shared that they had to keep moving as the work was mounting and the residents needed them. More hopeful stories spoke about how to engage residents through creative enterprise, parades, card writing, recognition, Zoom meetings, and other virtual

(or when possible, socially and physically distant) interventions to lessen isolation, pain, and frustration of a world disrupted. The role of the family in nursing homes is often the area that can create the most help and the most labor-intensive effort, due to logical guilt and worry, and fear or realities of less-than-ideal circumstances and care. The biggest plus was that an already invested group mobilized quickly as if a social work national guard was on standby to hear, help, and hopefully heal by sheer presence or availability. While call-in numbers were at times low, due to the fact of no time with limited resources, many spoke about the sessions being uplifting and helpful even just to hear others were experiencing similar challenges. For those in facilities with fewer COVID-19 cases, participants were able to hear what to expect if numbers rose. One participant spoke candidly about how calling families to update on general health and happenings during the COVID crisis should continue even after cases decline, or a vaccine is available. Relationship building occurred with many of the staff who had to endure the worry of carrying on their own lives and go to work daily when the rest of the world was told to stay home. Not only could they not stay home, but they also had to enter the homes of others who were at the highest risk. The group carried on, though the role was lonely and daunting. The optimists among us hope that a silver lining is that the role of social work will be recognized as a key player in mitigating risk, finding new ways of doing things, and recognizing the resilience in the workers themselves who ultimately and directly enhance the lives of those they serve and support. The following timeline of one social worker's inside view shows a process of working solely against such mass opinions of under-valuing and ignoring realities of the hardship of all staff inside the facilities.

Essential and Overstretched Social Work

Staying and Leaving

Shortage and turnover of staff are prevalent in the nursing home in favorable economic times, never mind when there are factors intersecting with work continuity. For years, scholars, advocates, and practitioners like us have been concerned about work stability when tax refunds and other stimulus opportunities arise. This shows less that people are unmotivated, and more that people live week-to-week and that $1000 can make the difference for someone on minimum wage to not plan beyond the temporary windfall of money. People who are in highly paying or stable situations have a hard time relating and expressed sentiments profoundly such as: "People don't want to work anymore" due to "all those stimulus checks!" or "They can make more on unemployment." Responses such as "people DO want to work, for good wages and benefits and working conditions" elicit either blank looks, or mistrustful glares.

Small Incentives

Recognizing that nursing home staff were struggling, several symbolic efforts were made by local organizations and by the facility. We began 2022 with a budgeting and quality management meeting that acknowledged a need: When hazard pay was issued in facilities with high COVID rates in late 2020, their absenteeism rates were *half* what they were as of July 2021. Other incentives included the following, taken from second author Leff's notes:

Local hospitals offered monetary incentives (increased hourly pay, sign-on and referral bonuses) as well as in-kind benefits (several local, privately-run hospitals offered to pay for education for staff that stay at least 6 months/12 months, etc.).

The local Assistance League formerly offered small Christmas cash bonuses to facility staff but announced that no more bonuses would be given out after the 2020 Christmas season. This was announced in January of 2021, right after the holiday season. Vague talk of “budgetary issues” but no solid reason given. Staff became skeptical of the facility’s investment. Administration failed to make even a token attempt to fight the Assistance League’s decision.

Local Behavioral Health Unit (BHU) Outreach Coordinator mentioned that she had been trying to reach out to local nursing home social workers to assure them that the BHU was functioning as usual and accepting new patient referrals. However, she was reportedly unable to talk to any local social workers, stating “they are all gone.” When pressed to clarify she said, “all the nursing home social workers seem to have quit,” but she was unable to speculate as to where they went.

Social workers, housekeepers, and dietary department workers asked to stay late one to three times per week to serve and feed veterans, due to shortage of CNAs and Dietary Aides. All hours over 40 in a week eligible to be paid out as Overtime at “time-and-a-half.” Training on “how to feed” provided by Employee Education RN.

Admissions slowed due to lack of staff needed to care for prospective new admits. A member of the front office staff quietly mentions that “we are working our people to death.”

2020–2021 Timeline

Co-author Dan Leff's personal experiences as director of social services at a state-run nursing home inform the timeline-based narrative of the terrible events of the COVID-19 pandemic. The frank nature of this fact-based recounting of events constitutes a form of raw poetry.

MARCH 2020 – COVID hits America. The Veteran’s Commission in a Midwest state closes the doors of all 7 Veteran’s Homes (skilled nursing facilities open to qualifying veterans, referred to generally as MVH) to the public. During our daily Clinical [Interdisciplinary Team] meeting, my facility Administrator reads off the current tally of positive COVID cases in the other 6 facilities, for both residents and staff. Our facility is supremely vigilant, and we have no positive cases … yet. It’s apparent to me and most everyone else on my team that our Administrator, in a less-than-subtly competitive spirit, is pleased that we are COVID-free. It falls on my Social Services team to start the first of a near-infinite round of phone calls to families, to explain the protean and ham-handedly bureaucratic visitation rules. Needless to say, we bear the brunt of many irate and confused conversations with the family members of our residents.

APRIL 2020 – In a rare display of largesse, the Veteran's Commission provides my Social Services team with trac phones and iPads. We are then directed to call the families of our veterans and offer Facetime/Google Duo video chats, as well as phone calls, so families can talk with their veterans. Reaction to this program is mixed, ranging from outrage ("My father is scared and confused and I can't visit him??!!") to grateful ("Thank you for letting us talk to our veteran."). Social workers are required to keep track of how many phone calls and video calls we arrange each week to show that we are indeed "seeing to the psychosocial needs of MVH residents." We then forward our weekly tally of contacts to Administration and Medical Records (who add the information to the voluminous ocean of data for which they are responsible). For the first month or so, the weekly tally reports elicit praise from the Administrator ("Wow! That's a lot of contacts this week! Keep up the good work and thank you for all you do.") The praise then dies down, but my department is recognized at the January All-Staff Meeting for our diligence in keeping up with the contacts.

MAY 2020 – Restrictions continue. Our monthly Alzheimer's Support Group (which I run) is cancelled, which is honestly one less thing for me to do, in the midst of all going on. I am given an official letter, signed by my Administrator, stating that I am in fact an "Essential Worker" and am to be allowed to go about my business. I am to keep the letter in my car's glove box at all times in case I am stopped by some sheriff or policeman during a shutdown (thankfully, I am never stopped by Law Enforcement and the letter stays in the glove box, where it remains to this day). The phrase "thank you for everything you do" is more frequently used as a way to end phone calls or emails. I predict that this will soon become the equivalent of "have a nice day," and say so to a few other people, none of whom do more than smile knowingly and nod when I mention it. I realize quickly that my George Carlin-esque devotion to poking holes in sacred cows will be unwelcome in this rural Midwestern milieu, most especially during a time of outbreaks and quarantines.

JUNE 2020 – Despite all our efforts, COVID-19 has entered the building. The Administrator and Director of Nursing grumble loudly about employees who proudly post non-socially-distanced escapades in bars and other venues on social media. Our Administrator, normally prone to mumbling and talking to his laptop screen during meetings, stands up and loudly announces the presence of COVID in the building, stating wearily "we did our damnedest to try to keep it out but it is here." We have had a number of employees get sick (in a rare display of forbearance, no one accuses the sick employees of unsafe behavior outside of work). The situation is now formally a crisis because the virus has hit the resident population. I wake up to a Saturday morning text from my Assistant Administrator, a fair-minded and hard-working woman; she requests that all Team Leaders (of which I am proudly one) contact their teams to try and get as many people as possible to come in and move belongings and do other chores to facilitate access by Maintenance to key areas so that magnetically-sealed doors and air-recycling units can be installed. These installations are critical in turning Unit A into an Isolation Unit. Part of Unit C is also similarly sealed off to serve as a Quarantine Unit, for those who may have been exposed but are under observation, and haven't yet tested positive.

Our other two units (B and D) retain their original function and populations. Unit D is a locked unit, reserved for residents at risk for elopement due to dementia or behavioral issues. We hope against hope that COVID does not get into Unit D, for we know how rapidly it will spread. Our worst fears are realized later in the game.

JULY 2020 – Video chats and phone calls continue on the Isolation Ward. Social workers are encouraged to go onto the Ward for 2–3 hours at the end of the day to help veterans chat via phone/video with their families. Entrance onto the Ward requires full Tyvek jumpsuit, N95 mask, face shield, gloves, and shoe coverings. Tyvek jumpsuits are initially available in sizes ranging only up to 1X; I put on the jumpsuit and burst the front zipper in a manner that would do The Incredible Hulk proud. I cover the front of my garb with a protective gown and later snag a bunch of 3X jumpsuits when our Requisitions department finally gets some in. Working 2 hours in such garb is a herculean test of endurance; in less than one hour in full garb, I am dripping in sweat and fighting fatigue. My first day on the Ward I find out that the CNAs there lack phones, laptops, bottled water, and radios, and chargers for all of these items. I become their advocate and the Assistant Administrator helps me get the Ward staff what they need; she and I agreed in advance that she would be my point of contact for all Isolation Unit needs. I also notice quickly that the least experienced and least motivated staff are assigned to the Ward. Beds and material are stashed in the hallways in this chaotic and leaderless situation. Information is also at a premium; more and more residents are sent over the Isolation Unit but the staff there lack a current census and roster. I make copies of the most up to date census sheets available and bring them over for my end of day rounds, to grateful sighs of relief from the confused staff.

At the end of each shift on the Isolation Ward, I leave by an outside door and go to my car, dripping with sweat from 2–3 hours work in full hazard garb as described above. When I get home I strip all clothing and throw it right into our laundry machine. I then take a shower immediately. My wife avoids all contact with me until I complete this ritual. Words are inadequate to describe my feelings of being filthy, hazardous, and unclean; these feelings being in addition to those of weariness and fear after seeing Isolation Ward suffering first-hand.

AUGUST 2020 – Demand by families for video/phone chats increases. The Assistant Administrator requests (falls just short of ordering) Social Services staff to work on the Isolation Ward each weekend to facilitate video/phone chats. I agree and take the first weekend. My team is cooperative and we get the month covered. Fortunately, the weekend work "requests" trickle away after a couple of months, and some subtle negotiation between myself and our thoughtful Assistant Administrator.

During one Saturday shift, the CNAs on the Isolation Unit complain that one resident's wife has obtained the number for one of the nurses' station phones and has called incessantly to speak to her husband. The tracphones, placed on the unit for use in helping residents call their families, have been left unplugged overnight and are useless. At a loss for other ideas, I get the wife's number and call her from my personal iPhone. I reach her

and give the phone to her husband, who has a brief but loving conversation with her. (I later wipe the phone down with a bleach wipe and leave it in my car overnight for extra preventive measure, before bringing it back into my house.) The wife asks me "You let my husband use your own phone? Don't you know he has tested positive for that COVID?" I respond by telling her "Yes, I knew. Do you want to know a secret? I'd do it all over again." Choking back tears, she thanks me. The resident is dead within a week.

SEPTEMBER 2020 – Wing D is the aforementioned locked unit. Bringing our worst nightmares to life, COVID has swept through Ward D like wildfire and there is no one left on the unit except me (because that's where my office is). All residents are in the hospital, on the Isolation Ward, or dead. I walk through the corridors and hear only my footsteps where once the noises of televisions, crying out of confused Alzheimer's patients, and Bingo games were heard. I am still coming to terms with the impact of this empty silence on my soul. The following year, a social worker at a facility in Florida asks me to describe that empty feeling more specifically. I refer her to the haunting scene in "Citizen Kane" in which the protagonist, alienated from all around him by his wealth and anger, is at last alone in his mansion, with only his possessions for a cold sort of comfort. (Needless to say, a social worker like myself lacks luxury and other lavish resources for "comfort," cold or otherwise.)

Not long after Labor Day, all Leadership members at all 7 facilities are asked to speak to a law firm. The facilities are under investigation by order of the Governor for allegedly allowing the pandemic to get out of hand, resulting in many deaths and hospitalizations. My own deposition was scheduled for a Saturday morning. I come in and take the call, which lasts for 2 hours. I am assured before the deposition begins that, while names of witnesses will be included in the concluding report, no quotes will be directly attributed. I try to bear in mind the advice often given to me by my attorney father (may he rest in peace) … "Never volunteer information."

OCTOBER 2020 – At the insistence of the Governor, the results of the investigation are published and made available to the public. Quotes are very much directly attributed, and my name is mentioned several times. I am a little dismayed with how much information I seemingly "volunteered" (somewhere in the afterlife, my father must surely be shaking his head). I email my Assistant Administrator to ask what in blazes I'm supposed to do if I get sued over this report. She doesn't reply immediately so I call her. She tells me "Don't worry about it."

NOVEMBER 2020 – Active positive COVID cases in the building start to wind down as residents either die or recover. Wing A is to remain an Isolation Ward indefinitely. The MVC determines that we are eligible for hazard pay so my paychecks are a little bigger. This helps a lot but sadly the hazard pay will wind up going away in March of 2021, just when I start getting used to it.

DECEMBER 2020 – The Administrator (at the not-so-subtle prompting by the Director of Nursing) declares "I want to get all that stuff out of the Chapel by Christmas." Social

workers (with help from other departments) begin the herculean task of moving items into various rooms. Confusion abounds and I introduce the Midwestern folk to the term “schlep” which I find needs no translation. The Isolation Ward is nearly empty. When the last veteran moves off, the Ward is deep cleaned and then kept empty, due to staffing shortages. Grumbling about how “nobody wants to work because of all these unemployment benefits” is occasionally heard, but the grumbling gets louder and more frequent after the 46th president is sworn in. I point out that the benefits won’t last forever, and the immediate rebuttal from a coworker is “Well, they don’t seem to think so!”

Casual conversation among my coworkers reveals that I am not the only one who is drinking more alcohol lately. I get some counseling through our Employee Assistance Plan and this helps, somewhat. A social work colleague in my city admonishes me on Facebook: “Dude, you’re grieving over all that’s happened to you this year! You are only human!”

JANUARY 2021 – Now down to nearly half our original census of nearly 200, we try to settle down into some sort of new normal. Rules governing visits with residents by family, friends, and clergy are revisited and modified various times. I find that regular visitors are more apt to take the changing rules in stride, with shrugged shoulders and a chuckle over “government regulations.” After extensive and confusing wrangling with our HQ, we are given directives regarding admitting new residents. Our nurses are sent to do a PCR test on prospective admissions. Once cleared as “negative” for COVID, they are admitted and then placed in Unit C’s Quarantine area for two weeks prior to transfer to their assigned room. Families are usually less than pleased that they are not able to visit during the two-week quarantine period; however, I notice that the families of residents suffering from Alzheimer’s are grateful for the two-week hiatus and are quick to nod agreement.

SPRING/SUMMER 2021 – HR has become more desperate to find workers. Our Recruitment Officer asks me my advice on how to find and retain new people. When I tell her “Get HQ to pay us more,” she smiles ruefully. Grumbling over how “they” don’t want to work persists. I point out to one coworker that “they” are tired of overworking for paltry wages and poor treatment. I am immediately told “Oh no! That’s not the reason! The real reason is that this new generation doesn’t want to work!” Well at least I now know who “they” are. In this ethnically and demographically homogenous rural area, there’s not much reference to other races but inter-generational ageism is alive and well.

AFTERMATH: WINTER 2021/22 to SPRING 2022 – Around the end of 2021, a variety of incentives were introduced by the state legislature, with the goal of raising pay for state employees in general and Veterans Homes workers in particular. The standard Cost of Living Allowance is bumped up to 5 percent, a good step but still not quite in line with inflation. A better step involved pay raises for Nursing, Housekeeping, and Dietary staff. While no dedicated social worker would object to working people getting a much-

needed raise, Social Services (and Maintenance) workers did not get their base pay raised.

This led to an exodus from the agency being focused on for purposes of this analysis. Of a department of 5 workers, 2 left in the Spring of 2022 for a different state agency. They retained their benefits and PTO and got a nice pay raise, leaving behind the headaches of dealing with irate and confused families and residents. A sternly worded request to raise the pay rate for social workers ASAP is emailed to HQ. No response is ever received.

These two social workers truly cared for the resident population and left with tears in their eyes. Neither one said whether or not the experiences of 2020–21 were a factor in their decision to leave. Pay and commute times were mentioned as motivators. One of the social workers who did stay said they would leave once their pension was vested (in 5 years from the time of this writing) to “do something different,” with no mention of any deeper sentiments.

The lack of open communication about the events of 2020–21 forms a tapestry of silence that hangs over this particular Veterans Home like a gossamer web of sadness. The services of an Employee Assistance Plan are available to all workers but, apart from a brief mention during the New Employee Orientation, are not advertised. Counseling services are available through the [plan], for 6 sessions at a time—more sessions are easily obtained, as long as one gives a different “issue” as the reason. However, in a small, closely-knit, rural community, it is possible that local residents might not want to be seen visiting the offices of what few counselors might be available in the area.

A better intervention might be to have an out-of-town counselor provide sessions to employees at a designated location with a significant gap between each session, to allow clients to come and go hopefully without encountering anyone else. Perhaps better still would be to promote telehealth counseling sessions. This would require some active promotion by Human Resources but could be easily accomplished, especially considering the ubiquity of smart phones with video capability. Telehealth sessions would also eliminate the need to travel to the counselor’s location, a boon in this time of inflated gasoline prices.

Within the Home itself, ongoing research into the nature of trauma suggests a number of different potential interventions. Overall, two conclusions are most frequently arrived at by the various sources. First, self-care is universally touted. Most workers can identify at least the rudiments of good self-care (adequate sleep, better diet, etc.). Occasional chuckles about “wine and chocolate” as good “coping strategies” are still heard.

The second conclusion, deeper in its implications and perhaps more difficult to face head-on, is the simple fact that traumatic experiences must be processed effectively in order for the trauma survivor to have the opportunity to live in a manner that includes some promise of inner peace. No attempt was made by the nursing home in question to

facilitate any manner of process groups, journaling, or any other exercises to help traumatized workers process their experiences.

Pinning Down PTSD

To what extent has PTSD reared its head in the nursing home under discussion? No open discussion of the events of the pandemic was ever held, apart from continued admonitions to "follow infection control protocols, we don't want another outbreak." One of the staff in charge of training stated, "We just don't talk about what happened" (said with sad expression and tone of voice). In keeping with the taciturn communications culture, no more is said in this vein, at least within earshot of the reporter.

The need for ritual as a means of achieving solace is nearly universal among humans. The nursing home under discussion resorted to two rituals as a means of seeking closure:

- During Christmas of 2020, almost all of the staff stood in a circle in the main dining room. Going around the circle, the names of residents who had died during 2020 were read, as a means of honoring the dead.

- On Memorial Day of 2022, the names of all residents who had died during 2020 through the present time were read in a ceremony that was open to families and friends of the deceased. The gathering was the first Memorial Day service open to the public since 2019 and was well-attended. Two of the remaining social services staff read the names. One social worker made sure to include the nicknames by which the deceased had been known ("Big Cal," "Miss Nan," etc.). The voice of the other social worker, who had a lengthy and distinguished tenure at the home, almost broke with emotion several times during the reading.

While it is possible to consider these two rituals as "interventions" on behalf of weary and grieving staff, it must be noted that these were singular rituals with no follow-up or progress-oriented goals implicit. It continues to be difficult to gather data on the extent to which the trauma of the 2020–21 period left lasting marks on the staff. Certainly, one of the two social workers who quit in 2022 had, again, a very lengthy and distinguished period of service in the home, and it is possible that they quit in an effort to get away from the milieu with its attendant sad memories. Conversations had with nursing staff elicited a handful of statements amounting to "If we ever have another outbreak like that again, I'm out of here. I'm just going to leave. I am not going through that again." During the 2021–22 period, a number of CNAs and Certified Medication Techs resigned with no notice, with one CNA getting frustrated with a schedule change and leaving at the beginning of their shift. Direct correlations between individual traumas and reasons for leaving (and modes of departure) are, unfortunately, very difficult to track in this tight-lipped and somewhat reticent region. Since "what resists, persists," the lasting effect of the traumatic effects of the 2020–21 period may potentially be felt for some time to come.

Although it is well known that motivation to help is largely intrinsic, it is not to say pecuniary incentives don't reinforce good intentions (Francoise & Vlassopoulos, 2008). Good people often do good things based on their own moral compass of compassion, but the layer of accountability and recognition can reinforce positive actions and stronger ties to work, not to mention a host of psychological wellbeing realities and the balance between resources and outlook (Alessandri et al., 2021). Often there is a reductive tendency to blame poor care (service, etc.) on the workers not showing up, versus the loss spiral of job insecurity, worker risk, and fatigue that was resultant of poor governmental and industry oversight (Bondi, 2020). Concern seemed more about what the consumer wasn't getting versus the hardship that the worker was facing. In no way should this undergird exploitation of good people in impossible times and allowing valuable staff to be pulled out in the tide of devastation. Producing narratives such as this one, tuning into the challenge of remembering, documenting, and reflecting with intention to change is the only constant we can hold onto after so much horror in our ranks as social workers.

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