SIPTU

SIPTU Submission to the Special Oireachtas Committee on Covid-19 Response

Infection Risk and Disease among Healthcare Workers

July 2020

Executive Summary

This submission is presented on behalf of SIPTU Health Division to the Committee to review the experience of our members. The paper examines several contributing factors, including a study of the latest data on healthcare worker infection rates and the key findings identified, which SIPTU representatives contend have exacerbated the spread of the virus among the health workforce.

These factors include:

- The effects of the decision to decant the acute system to the community and the unpreparedness of those services to meet the challenges which were realised with the first phase of the virus.
- The lack of availability of PPE, the focus on delivery from China and the vulnerability of healthcare staff until stock levels were increased. Our examination will demonstrate real findings of the current level of satisfaction with training and availability of PPE stock but also contrast this with the initial stages of the disease when it was not attainable.
- Our paper will consider the outcomes of an ineffective testing and contact tracing capability in the early stages of the disease and highlight the importance of maintaining this capability in the times ahead.
- We will consider the challenges of redeployment within the health service, the revision of rosters and reduced staffing levels and identify the need to ensure services are reopened safely with appropriate safe practice guidelines confirmed for each location or speciality.
- We will consider the policies endorsed by government departments which failed to support healthcare workers find childcare so they could go to work or financial penalties which would arise if COVID—19 leave was required.
- SIPTU representatives have identified the real challenge of fatigue within the workforce and the need for an examination of appropriate supports which will assist healthcare workers maintain their health and wellbeing.
- We will also consider the challenges of accommodation during the pandemic when staff members were required to self-isolate and the consequent risks to their families or housemates.

SIPTU representatives would welcome the opportunity to discuss this written submission, and its recommendations, with the Committee and its members.

John King
SIPTU Deputy General Secretary

Kevin Figgis
SIPTU Sector Organiser

Monday, 6th July 2020

Chairman and Members of the Committee,

Please accept this submission on behalf of SIPTU, on the issue of **COVID-19 Infection Risk and Disease among Healthcare Workers** during the pandemic.

Introduction:

1. At the outset, we would like to briefly introduce the SIPTU Health Division. We are a multi-grade represented health division with over 42,000 members. Our membership covers a variety of settings including: Nursing/Midwifery, Health Care Assistants, Diagnostic & Therapy Health Professionals, Phlebotomists, National Ambulance Service and Support Grades. Our Division covers all areas of the health service including acute, mental health, care of the older person, community and intellectual disability.

1.1 This submission is presented and based on the data available to SIPTU at the time of drafting this document. We are acutely aware that the collection of data is an ever-developing process, but we believe the consensus determined within the submission will be reflective of the challenges to date and for the future in the management of infection risk and disease among health care workers.

1.2 It is important to state COVID-19 has impacted all sections of our society. Clearly some sections of our communities have been impacted to a greater degree and we will explore some of those examples within this submission. It should be noted by the Committee that the data demonstrates how this disease has affected workers across the health service and by multiple grades of staff.

Infection Rates among Health Care Workers:

2. In the first instance, we are going to highlight some of the recent data on infection rates for healthcare workers. This data has been presented to the trade unions through the Health Protection Surveillance Centre (HPSC) and is readily available to the Committee. The data highlights some interesting trends and provides an insight into the frontline of the fight against this deadly disease and those who have put themselves at risk in striving to help others in their time of need.

2.1 The recent report from the HPSC, published on 25th June 2020, highlighted the following data:

- **Total HCW infection Rate: 8,219**
- **Total % of overall infection rate: 31.8%**
- **New Cases from previous week: 28**
- **HCW hospitalised from COVID-19: 305**
- **HCW in ICU from COVID-19: 46**
- **Total HCW Deaths: 7**

In addition to the above-mentioned data, the recent report also demonstrates:

- **There was a spike in % rate of HCW v Total Infection rate of 40.6% in Week 20 (16th-20th May)**
- **The East Coast had 58.5% of all HCW Infection Rates followed by 13.7% in the North-East**
- **CHO9 had 26.1% of all HCW infection rates followed by CHO7 with 21.7%**
- **55.7% of staff had no underlying health issues**
- **16.8% was classified as a Community Transmission**
- **81.4% was classified as a Local Transmission**
- **Health Care setting was deemed to be the most likely source for 70.4% of cases**
- **Close Contact with a Confirmed Case was deemed to be the most likely source for 11% of cases**

The Categories of staff most affected by COVID-19 were:

- **Nurse 32.7%**
- **HealthCare Assistant 26%**
- **Allied Health Professionals (Others) 23%**

The locations most impacted by COVID-19 were:

- **Nursing Homes 22.6%**
- **Hospitals 8.9%**

Examination of Central Contributing Factors:

3 The data demonstrates the extensive impact this disease has had on healthcare workers. The impact has not only been on their health but also financially given they have not received payment as per their roster if they were required to isolate given the symptoms. The data also demonstrates the fact the disease has had a major impact across the health service workforce and in multiple settings. Most significantly, it is evident health services in the Community have been disproportionately affected as have services on the East coast of the country.

3.1 SIPTU believes several factors have contributed to the experience of the disease within our population. It is understood that, as a new disease, relatively little was known about the illness in the early weeks of infection. Equally, it must be noted the evidence presented suggests we were not prepared, in several key areas, to monitor and control the spread of the disease. While the list of factors would be considerably greater than the central points within this submission, SIPTU contends the following contributing factors significantly influenced the spread of the disease within our communities and healthcare workforce.

3.2 It should also be noted that not all workers working within the healthcare system are directly employed by the public health system. Some staff working in the health service are employees of contractors such as cleaning, catering or security. SIPTU understands the existing data includes all workers who have experienced the effects of the virus. However, there is a striking difference in the treatment of workers if they have come into contact with the disease. For example, the provisions of several of the supports available to healthcare workers, such as

COVID-19 leave, were not available to contract staff due to their employment not being funded by Government or the direct employer. SIPTU challenged the HSE at national level on this issue and were advised there was no jurisdiction on the public health service to enforce necessary protections for staff employed by a contractor but providing service on a HSE site. Due to the financial impact on contract staff if symptoms were identified, SIPTU believe this may have resulted in an increased risk in non-disclosure by individual staff.

3.3 Some SIPTU members employed by a contractor and assigned to work on a public health site advised their union that they were not being informed of risks or essential infection control measures. SIPTU raised this issue with the HSE at national level and a memo was issued through the system to remind all sites of their obligations to inform contract line management of the necessary dangers and precautions so that their staff could be advised and protected.

3.4 SIPTU also raised the issue of a failure of Government to provide a Death in Service gratuity if a contract staff member succumbed to the effects of the virus and infection occurred while on duty. This matter remains unresolved but is more harrowing given our understanding that among those healthcare workers who died because of COVID-19 are non-direct contract staff, such as contract cleaners, employed in public health facilities.

3.5 **Decanting the Acute System**: In the early weeks of the disease, significant emphasis was made by decision makers within the health service, and relevant Government Officials and/or Departments, for the need to decant patients from the acute system into the Community. SIPTU believes this was a significant factor in contributing to the rise of the disease within this sector as it was not prepared for the wave of the virus which would overwhelm its services. Public commentary was made for the need for '*Field Hospitals*' and possibly thousands of ICU beds. SIPTU is not doubting these judgements were made based on available data, expertise and the somewhat frightening pictures being broadcast from other European countries and further afield.

3.6 Decanting the acute system into community services resulted in many examples where the community facility was not able to cope with demand due to financial restrictions, lack of staff, unavailability of PPE, lack of training and no contract tracing or inappropriate testing model in place.

3.7 The HPSC data demonstrates the central fight against COVID-19 did not happen in the acute system and that community services bore the brunt of the illness.

3.8 **Personal Protection Equipment (PPE)**: SIPTU argues one of the most controversial aspects of the fight against COVID-19 has been the provision of Personal Protection Equipment or PPE as it is generally called. It is important to reflect on why the health service was not adequately prepared for the fight against this new disease. Frontline staff were put at risk due to unavailability of protective equipment which is central to the protections they require in their workplace.

3.9 Over the weeks from March, the HSE advised it had purchased 15 years of PPE and had these flown from China. A total of 259 flights were chartered, with 5 flights a day over 14 weeks. SIPTU raised several points with the HSE relating to the delivery of PPE and the location of stock from other sources both at home and abroad. Firstly, SIPTU expressed our concern at the reports that substantial amounts of the PPE sourced from China or at home was not fit for purpose within the health sector. Some reports quoted sources as describing the equipment as more suitable as painters' overalls rather than for a medical environment. We requested clarity on the amount of PPE which was not fit for purpose, its value and how it was used, if not appropriate to the health service. We did not receive substantial answers to these questions.

3.10 SIPTU has partaken in regular national meetings with the HSE and Department of Health since the middle of March. Of interest to this section, the National Occupational Health Advisor previously informed the trade unions that faulty or improper use of PPE accounted for approximately 4% of all infection rates with Healthcare Workers. While this figure may appear a low percentage of the overall tally, SIPTU argues it represents a significant risk factor which should not have arisen if proper equipment and training was in place at the outset of the pandemic.

3.11 It must be noted reports to our union suggest the delivery and distribution of PPE has greatly improved within the health service and most services are now recording steady access to the necessary safety equipment. A recent survey of our members confirms this is currently the case but also records the concerns of staff and the experience they had in the early weeks of the pandemic.

3.12 The SIPTU PPE survey was completed by a significant proportion of our membership across a wide variety of grades. Among the grades which engaged in our survey were:

- **Health Care Assistants**
- **Paramedics**
- **Nurses**
- **Midwives**
- **Health & Social Care Professionals**
- **Clerical/Admin**
- **Home Care Workers**
- **Others**

Others include: **Endoscopy Washroom Technicians, Medical Laboratory Aides, Theatre Porters, Physio Assistants, Household, Phlebotomists, and Chefs.**

3.13 The SIPTU PPE survey returned results which registered 40% worked in the Community, 38% in a public hospital, 2% in a private hospital and 20% in another category.

3.14 The SIPTU PPE survey returned a geographical breakdown which recorded 39% were based in a city, 19% classed themselves as rural and 42% were based in a town.

3.15 On a positive note, our survey suggests a demonstrable increase in the availability of PPE and an increase in confidence of healthcare workers as a result. 77.03% advised they felt they now had enough access to PPE currently, while 18.9% felt they did not. In addition, 85.6% of our members who undertook our survey confirmed they had received training on the appropriate use of PPE, while 13.5% advised they had not received any training to date.

3.16 On a negative note, our survey asked members to present an understanding of their experience in accessing PPE during the early weeks of the pandemic while it was not readily available. Some of the comments are quite illuminating of the environment within which our members found themselves in March and April.

3.17 Examples of some of these contributions from SIPTU members were:

- *"At times there was rationing of PPE and you were made feel guilty for asking for it."*
- *"PPE was scarce in March and April."*
- *"I had to sign a log on receipt of a pair of goggles. I was told that was my one pair for the duration and to mind them."*
- *"We had full PPE supplies from mid-April to Mid-June but only after a service user contracted the virus and died. At this stage many staff were self -isolating and some very sick before receiving full PPE. As soon as we were declared Covid free it went back to just aprons, gloves and masks."*
- *"We could usually access gloves and aprons with some difficulty. Now it's very difficult to access hand sanitiser and masks. Aprons can be in short supply too. The quality of the gloves and aprons is also poor."*
- *"In the early stages we frequently ran short."*
- *"I work with vulnerable , elderly intellectually disabled adults and we have to wear a mask if more than 15 mins with a resident. I have been told by my CNM2 , I cannot wear a Vizor as they are for ICU or ED depts. I think they would be appropriate as our residents are non-verbal & cannot lip read with normal face mask."*
- *"In the beginning we did not have sufficient PPE and on many occasions were told we didn't need to wear a mask."*
- *"Early on in this pandemic while I understand it was new and unknown to everyone, I felt completely exposed no PPE available other than gloves which were very difficult to source even to buy."*
- *"At the beginning of this Covid outbreak I had to go to my line manager and demand PPE and for her to organise a way so we could socially distance. She told me that I was very demanding!"*
- *"It was a few days when PPE was really short and we received dust masks. The managers CNM2 were accepting everything without questions. About PPE training, it was the worst ever. They told us don't be worried it is like an ordinary flu. When we were asking questions, they did not answer. I am only a care assistant, but I had the impression I know more about the virus then infection control do. We asked for scrubs and they said no. Good thing when first patient arrived nurse went to theatre and took scrubs and then CNM III came and told her to go and put the uniform on. Good thing nurse refused."*
- *"Suggested use of face masks as a pre-emptive to avoid CV19 transmission in early March and was severely reprimanded for doing so. Warned never to ask again. I'm still working there now, and masks are in use. However, I suffer extreme anxiety over what happened."*

- *"In the beginning the supply of PPE was restricted to just the covid area but eventually and after a lot of staff being exposed to positive patients unwittingly, they started to make us all wear full PPE."*
- *"At the beginning of the pandemic, various instructions were given to us by senior management and instructed us not to use PPE for suspected cases, unless confirmed cases."*
- *"PPE is locked away in managers office and rationed out. when management aren't in it runs out."*

4 **Testing/Contract Tracing**: This is another area which has improved with the increase in capacity which we are advised can now deliver over 100,000 tests per week. It is clear the increase in testing builds the bank of reliable data which demonstrates trends and behaviours of the virus within our communities. This was not always the case.

4.1 In the initial months, the lack of available testing capacity greatly increased tensions and vulnerabilities within the healthcare workforce. Staff were advised they would have to self-isolate pending a test and, in some cases, members advised SIPTU they had returned to the workplace weeks later, without the test being conducted. In other examples, members advised SIPTU they had been tested and remained awaiting results some five or six weeks after the test was completed.

4.2 SIPTU contends delays incurred in the development of appropriate policies, procedures and documentation to contact trace were contributing factors to the identified challenges in managing the spread of the virus. Delays in the development of such policies, coupled with the complexity of the healthcare workforce and multi-layered working environment resulted in increased exposure for healthcare workers.

5 **Return to Service**: SIPTU notes many services have been suspended since mid-March and are now facing a re-opening in the coming weeks. Our union has received many contacts from members who have highlighted their concern at the intended re-opening of their service and the potential for risk exposure if appropriate procedures are not put in place. One such example referred to a diagnostic service which introduced a screening of attending outpatients to ensure they did not have symptoms before meeting the radiographer who would undertake their scan. In this example, radiographers began scanning their patients on the understanding all outpatients had completed the screening and were cleared to continue. After several days, it came to light the cards were not being issued to the outpatients on arrival and radiographers felt they were put at risk as the agreed procedure for screening was not being implemented on arrival.

5.1 The restarting of normal service in the coming weeks will present significant challenges for the health service. In some cases, staff have been redeployed to other locations, such as the community, and there is a real prospect services may re-open with insufficient staff to provide care safely.

6 **Staffing Levels**: Staffing levels within the health service are a constant challenge. COVID-19 adds additional pressures on departments already subject to undue demand and strain. The '*Be on Call for Ireland*' project did not materialise meaningful outcomes. The trade unions understand

approximately 168 staff were employed through this process despite being advised over 75,000 expressed an interest. We are unclear if this was a result of ineffective recruitment processes or other factors. Effectively, the call for Irish health staff to return to Ireland, as made by the Taoiseach on St Patrick's Day, resulted in no major gain for the health service or its patients.

6.1 Staffing levels have also been strained over the past number of months due to the number of staff who were not able to attend work due to childcare issues. It is important to note the HSE repeatedly referred to its own survey of staff for Childcare which it accounted at 7,000. No SIPTU member has confirmed they were invited to participate in, or completed, the HSE survey. SIPTU membership is represented within the following family demographics for the purpose of identifying childcare during the pandemic: Co-Parenting where both are Essential Workers, Co-Parenting where both are Essential Health Care Workers, Lone Parent Health Care Worker.

6.2 While we have forwarded a separate paper to the Committee on the challenges of attaining childcare for healthcare workers over the past number of months, it must be re-emphasised the effects of the failure of the Government and employers to support workers striving to ensure their children were safe while they were at work and those workers who picked up the pieces when their colleagues could not come in, should not be underestimated.

7 **Rosters**: Rosters remained a challenge during the pandemic. This was caused by several factors. Firstly, many departments were severely depleted due to staff having to self-isolate and no additional resources were secured. This created major difficulties for rostering given that many services are 24/7 such as diagnostics where a significant part of the service is 'Call'. Line managers were required to cover excessive levels of vacant slots on the call roster due to the removal of staff requiring quarantining. This proved problematic as staff who remained on the roster already had their allocation of calls and there was an expectation they would also assume responsibility for the additional shifts arising. SIPTU members have said that this additional pressure, over a protracted period, has contributed to the effects of fatigue within the workforce.

7.1 During the pandemic, exceptional measures have also been introduced which resulted in many services being closed or suspended. Rosters were revised to meet the challenges of the disease with reduced staffing levels introduced. This had the effect of recognising the reduced availability of staff available and prioritised the essential tasks to be performed in the existing environment.

7.2 Some staff, such as doctors, nurses or health care assistants, were redeployed to meet the challenges of the spread of the virus within the community. Diagnostic staff were also subject to redeployment given the decision to cease scanning in some centres such as the National Screening Service.

7.3 It is essential appropriate risk assessment and reviews are undertaken prior to the re-opening of services to ensure safe staffing levels are present and secured. Many additional risks may arise if service output is increased without attaining the return of necessary and identified safe staffing levels within the department.

8 **COVID-19 Leave**: The decision of the Department of Public Expenditure and Reform not to permit employers pay their staff as per their roster, if they were put on COVID-19 leave, resulted in significant financial disadvantage being incurred. SIPTU believes this may have resulted in staff not declaring symptoms to their employer if they knew it would result in them being put off duty for a minimum of 14 days and thereby suffering the loss of overtime and premiums. It must be stated SIPTU represented grades within the health service rely on premiums earnings to meet their financial responsibilities. Our members cannot afford to live on basic salary therefore mechanisms which are introduced, which result in financial penalties, are subject to a real outcome of potential non-disclosure and a failure to have effective detection systems in place.

9 **Fatigue/Psychological Impact**: Given the challenges to date, SIPTU contends the real prospect of fatigue among the workforce should not be underestimated. The continuing draw on staff, their workload and morale are a major challenge which must be met with necessary planning and appropriate supports. SIPTU supports the need for a campaign which promotes wellness within the workplace and assists staff balance their work/life commitments while recognising COVID-19 will be part of the health service for the foreseeable future.

10 **Vulnerable Healthcare Workers**: Vulnerable healthcare workers have been cocooning since mid-March and a decision on their future return to the workforce is awaited. We understand significant challenges will lie ahead for some vulnerable healthcare workers who may be deemed to be unable to return to their substantive post held prior to COVID-19. SIPTU is calling on health employers and Government to ensure that every opportunity is used to maintain healthcare workers within the workforce and that retraining and/or reassignment is the preferred option of relocating workers by agreement where it is deemed it is unsafe to return them to their original post.

11 Accommodation/Arrangements for healthcare workers who needed to self-isolate/quarantine: SIPTU members contacted their union to express their dissatisfaction at the requirement for them to self-isolate/quarantine at home if directed to do so. Members believed this placed their families at risk of contracting the illness given the difficulty in maintaining self-isolation in a family home. SIPTU highlighted these concerns with the HSE during the early stages of the pandemic. Alternative options were not well developed across the system.

11.1 Another issue raised concerning accommodation was the common occurrence of multiple healthcare workers sharing a home. This is most prevalent for healthcare workers, such as students or former students, who are either from another country or are from a rural background and are based in a city. If one of the staff was required to self-isolate and remain at home, there was an ever-present challenge to manage the spread of the virus given the staff had restricted options to quarantine within the shared location, other healthcare workers were put at risk and the possibility of returning the virus to a healthcare facility was high.

In the next section, we will consider the important lessons to date and set out a number of recommendations we believe are central to the successful defence against a potential second wave.

11.2 **Summary and Recommendations:** On behalf of our members, SIPTU is grateful for the opportunity to present this submission to the Committee and look forward to your deliberations on the matters raised.

11.3 There is no doubt the experience of the pandemic has taught us many lessons. These experiences must form part of our planning for the future. In many cases, services were unprepared and did not have the essential equipment or training to support and protect healthcare workers in the fight against COVID-19. As an employer, the HSE has responsibilities to ensure the necessary measures are in place to protect staff and service users. COVID-19 demonstrates how unprepared our health service was given so many policies and procedures did not exist or required adjustment during the early phase of the disease. The State must ensure the HSE has the necessary resources to meet these demands.

11.4 During the initial phases of the pandemic, analogies were used by the HSE to liken healthcare workers to army personnel. We were informed the fight was on the frontline and healthcare workers were the soldiers who were being relied upon to buffer our society from the full effects of the disease. While intending no offence to the Defence Forces, SIPTU members believe the the linking of their role to this analogy was inappropriate as they feared it identified an acceptance of collateral damage and a willingness to assume loss as a by-product of fight against the disease.

11.5 SIPTU recommends a review must be undertaken of the overall experience from the pandemic. It is essential core learning is identified and actions are taken to ensure our services, and people, are not exposed to unnecessary risk in the future. The evidence suggests our health service was totally unprepared and to some degree we waited for the virus to arrive before measures were taken. It must be noted we appear to have made significant gains in key grounds such as PPE and Testing capability. The challenge for the future will be to ensure we adopt the learning and do not return to the pre-COVID phase which our members believe left healthcare workers exposed to unnecessary risk.

11.6 Lessons must also be taken from the experience of decanting our acute system and placing vulnerable patients into a care environment which was not prepared for the wave of infection soon to arrive at its door.

11.7 SIPTU argues the responsibility of the State and employers was to have undertaken significant risk assessment prior to the transfer of any patient, to ensure enough PPE stock was available, trained staff were on duty and the location was capable of monitoring and maintaining safe practice.

11.8 It is essential testing and contact tracing capacity is maintained in case a second wave of the disease arrives in our country. Testing must also be increased to be forward planning, such as testing before a worker is relocated and returned to or from a new location or regular testing in the community sector. We are witnessing the withdrawal from several of the initiatives

introduced over the past number of months such as the takeover of private hospitals or the closure of City West. It is imperative the HSE and Government departments identify the core functions which must be maintained in order to ensure a ramping up of resources can be achieved without delay.

11.9 SIPTU recommends a review on the experience of PPE during the crisis. It was not only the deficit of resources which proved challenging but also the concerns that some of the sourced equipment was not appropriate to the health service and/or staff were not trained appropriately for its use. Again, while this issue has improved in recent weeks, reflection is required on the experience of staff from the initial stages of the virus given that our survey demonstrates the fear and anxiety which was present within the health sector across multiple sites and specialities.

11.10 SIPTU recommends a review should be undertaken within each location to ensure that services are best prepared for the re-opening of capacity in the period ahead. Safe staffing levels is one issue which must be assured as is adherence to safe practice protocols such as when outpatients are presenting or attending at our Emergency Departments. Rosters must be appropriate to the staffing levels available and in line with best practice guidelines or professional body recommendations.

11.11 SIPTU recommends a review should be undertaken to examine the effects of fatigue on the healthcare workforce. The effects of COVID-19 has been consistent within the clinical workplace for many months and this can cause a damaging effect on staff well-being and mindfulness. COVID-19 living alongside a return to normal business will become the new norm. It is essential staff are prepared and supported to meet these challenges.

11.12 SIPTU recommends a review should be undertaken to examine the approach adopted by Government on a number of measures which resulted in staff being exposed to significant distress, both emotionally and financially, due to the failure to provide for the needs of childcare or loss of roster earnings such as premiums. The impact of the policies adopted were wider than on the staff members directly. The loss of the staff member had serious implications for service provision due to childcare needs and the impact of the position adopted on non-payment of roster earnings may have resulted in non-disclosure of symptoms by those who could not afford the financial loss.

11.13 SIPTU recommends the policy on accommodation for healthcare workers exposed to the symptoms of the virus should be reviewed in order to ensure their families, our communities and other healthcare workers or service users are not exposed unnecessarily. The experience of COVID-19 demonstrates this issue was sporadic and not uniformed in its approach. It was recommended the healthcare worker should stay at home if symptomatic or awaiting testing, but this presented major challenges to protect family members or other healthcare workers and patients if a communal living space was in place.

SIPTU Public Services
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