SIPTU

SIPTU SUBMISSION TO THE INDEPENDENT EVALUATION ON THE MANAGEMENT OF THE COVID-19 PANDEMIC IN IRELAND

Focus: Nursing Home Sector
On behalf of members in SIPTU Health Division

February 2026

Fairness at Work and Justice in Society

Index

EXECUTIVE SUMMARY

1.1 The Services Industrial Professional and Technical Union (SIPTU) welcome the opportunity to provide this submission to the Independent Evaluation of the Government Response to the COVID-19 Pandemic. This submission focuses on the nursing home sector, encompassing public, private and voluntary residential care settings for older persons and people with dependency needs. The submission draws on the experience of SIPTU represented frontline workers, particularly Health Care Assistants, multi-task attendants, domestic/household staff, catering staff and cleaners. Our members provided essential hands-on care during the pandemic under conditions of unprecedented pressure, traumaand risk.

1.2 Given the significant role our members played throughout the pandemic, we contend the independent evaluation is of critical importance. Nursing homes were one of the most heavily affected sectors during the COVID-19 crisis, with some of the highest mortality rates in Ireland. Our members were central to the provision of care during the crisis within the nursing home sector. Their experience provides a uniquely valuable perspective for assessing the State's preparedness, the adequacy of its measures, and the key lessons required to strengthen future resilience.

1.3 This submission focuses on the impact of COVID-19 exposure on healthcare workers and outlines key lessons and recommendations for future pandemic management. The submission references important research, data and articles which demonstrate a comprehensive overview of the impact of the pandemic on healthcare workers at the height of the emergency from 2020 to 2022.

1.4 Our submission presents the results of a comprehensive survey conducted by the SIPTU Health Division in December 2025 and January 2026. The survey was distributed amongst our membership within the health service to understand their roles, work environments, experiences and perceptions during the COVID-19 Pandemic. The survey aimed to capture a wide range of data, including workforce demographics, mental health impacts, workplace safety and the effectiveness of support systems.

1.5 The result of our survey provides valuable insight into the challenges faced by healthcare workers within the nursing home sector during the pandemic and the measures taken or needed to address these challenges. The findings of our survey are intended to inform key stakeholders about the critical areas our members contend need attention to improve the well-being of residents and the working conditions of healthcare workers. Our survey serves as a crucial resource for understanding the impact of the pandemic on the healthcare workforce and to support the development of effective strategies to support them in future public health emergencies.

1.6 This submission seeks to contribute to the independent evaluation of the COVID-19 Pandemic management in Ireland. It focuses specifically on the treatment, conditions and support offered to healthcare workers represented by SIPTU Health Division, including health care assistants (HCAs), Support Staff, Nurses, Activities Staff and other grades. These workers played a critical role on the frontline of the national response within the nursing home sector. The pandemic revealed both strengths and weaknesses in the preparedness, coordination and resourcing of the healthcare system. This submission also reflects on institutional responses of the Government, Department of Health, Department of Public Expenditure and Reform (DPER), the Health Service Executive (HSE), Private Sector Nursing Home employers and trade unions, as well as the disparity in treatment between public services and private sector healthcare staff.

Our Overall Findings

1.7 SIPTU members report that the initial Government response did not adequately recognise the vulnerability of nursing home settings. Our members argue that key systemic weaknesses, pre-existing long before COVID-19, were exposed because of the pandemic.

1.8 The nursing home sector was a high-risk healthcare environment, but many members felt the lack of key supports early on left both residents and workers unprotected in the critical opening phase of the pandemic. In addition, access to personal protective equipment (PPE) was severely delayed in many private facilities. Members also identified a lack of clarity with guidance, insufficient supply and unclear usage protocols placed staff and residents at avoidable risk. Our members reported infection Prevention and Control (IPC) structures were uneven with many private nursing homes organisationally isolated from public health decision-making processes. Significantly, staffing levels were severely compromised in many locations during outbreaks. This forced workers to deliver care in unsafe and distressing circumstances, often with minimal rest,

limited support and expanding duties. Critically, support grades such as cleaning, household and catering staff, who play a central role in infection control, often felt overlooked in guidance, priority-setting and recognition measures. When compared with the public sector, private nursing home staff faced structural inequalities, including lower pay, weaker or limited sick pay, insufficient occupational health access and significant delays in receiving the pandemic recognition payment from Government.

1.9 Many SIPTU members describe COVID-19 as the most traumatic period in their entire working lives. Our members reported the traumatic impact of being the only person present as residents died. Their distress at managing extraordinary levels of illness and death on a continual basis, particularly at the beginning of the pandemic. Staff reported persistent psychological distress, moral injury, burnout and long-term mental health effects. There was systemic fear of transmitting the virus to vulnerable residents or to their own families, with many staff employed in the nursing home sector were from overseas countries who worried about their families and how they were coping with the pandemic.

1.10 It is noted the State introduced important measures as the crisis escalated, such as:

- The Temporary Special Leave with Pay Scheme within the public sector
- Serial testing programmes
- HSE-led crisis support teams
- PPE distribution hubs
- Public health guidance consolidation
- Workforce mobility policy
- Targeted support to outbreak facilities

1.12 While these interventions were necessary and effective in stabilising many healthcare settings, they arrived after major outbreaks were already underway and significantly impacted the nursing home sector. Our members believed there was also an inconsistency in the application of supports available to the private sector and particularly excessive delays in recognising staff within the private sector with the Government approved recognition payment.

Key Structural Findings

1.12 Our members contend the pandemic exposed the problems in the sector; it did not create them. SIPTU believe the following systemic challenges were decisive factors in these conclusions:

- There was a fragmented and inconsistent response between private providers and the public health system.
- Long-term underinvestment by Government in public nursing home capacity and structure was exposed as a distinct weakness during the pandemic.
- Many workers complained of insecure work and poor pay standards for essential frontline staff employed in the private nursing home sector.
- Many workers complained of a fear of being a union member within private sector nursing homes due to the refusal of their employer to recognise the right of staff to organise.
- There is an overreliance on international recruitment and
- There was inadequate clinical governance in many private homes.
- There was an absence of integrated emergency response in many homes.
- There was inadequate clinical governance in many private homes.
- There was an absence of integrated emergency response in many settings staffing within the sector.

Our Recommendations

1.13 SIPTU contend there is a need to:

- Expand the presence of public run nursing homes within the sector. The state should rely less on the private sector to provide for the needs of our senior and often vulnerable, citizens.
- Establish a minimum legally enforceable safe staffing ratio across all grades within the public and private nursing home sectors.
- Implement a national standardised HCA role, including registration, training, certification and pay framework across all settings. This should be underpinned by an Employment Regulation Order and agreed by a Joint Labour Committee.
- Support the need for the professional regulation of all healthcare assistants employed within the Irish health system to ensure that all frontline healthcare workers are state regulated.

- Guarantee PPE stockpiles, clear distribution protocols and standardised essential training to all areas of the health service, including nursing homes.
- Integrate private nursing homes into HSE emergency operations, including outbreak management chains of command.
- Mandate clinical governance requirements in private homes.
- Ensure pay and other conditions of employment within the private sector are protected through a JLC to support recruitment and retention across public and private sector care workers.
- Recognise the rights of workers to be a union member and have their interests represented to their employer within the private sector.
- Expand public sector provision of long-term residential care in all areas.
- Establish permanent IPC outreach teams for the entire sector.
- Recommend timely access to trauma, counselling and bereavement support for staff working within all nursing home settings.
- Introduce clear contingency planning, simulation exercises and pandemic preparedness policy for all nursing homes.

Conclusion of the Executive Summary

1.14 COVID-19 exposed the vulnerability of the nursing home sector within Ireland's health system. The pandemic demonstrated that long-term residential care must be treated as an essential pillar of our community healthcare system and national emergency planning process.

1.14.1 The pandemic did not create the deep structural weaknesses experienced across the nursing home sector; however it did reveal and amplify the vulnerabilities that have been left for far too long. Fragmented governance within the healthcare system, understaffing, insufficient clinical oversight, weak integration with the wider health service and significant disparities between public and private sector working conditions all contributed to the scale of the crisis experienced by residents and frontline workers alike.

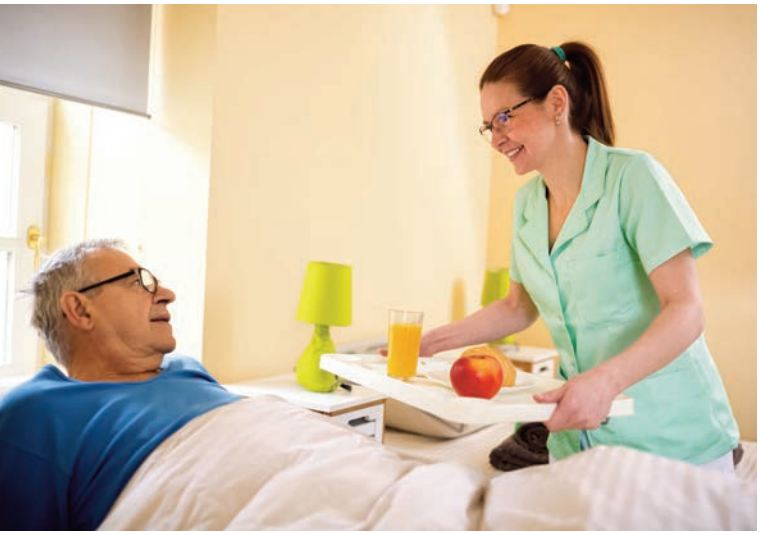
1.14.2 The workers represented by SIPTU, predominantly healthcare assistants, cleaners, catering staff, multi-task attendants and others, carried extraordinary responsibility under conditions of profound stress, trauma and loss. Their lived experience is not only a testament to their commitment and compassion but also an essential source of evidence for building a resilient, safe and equitable care system for the future. Many of these workers reported COVID-19 contributed significantly to negatively impact their mental health and wellbeing.

1.14.3 Reform of the nursing home sector is essential. The state relies too heavily on for profit organisations to provide for the needs of our senior citizens. Many workers working in the private sector earn significantly less and have conditions of employment which do not afford decent sick pay, holidays or pension entitlements when compared to their public sector counterparts. Workers within the private nursing home sector identify their fear in declaring union membership or their wish to organise for fear of reprisal from their employer.

1.14.4 It is an imperative to ensure that no resident, worker or family endures avoidable harm in a future health crisis. Action must be taken to strengthen the public sector role in long-term care, establishing minimum safe staffing levels, guaranteeing equitable pay and protections, standardising IPC and clinical governance and embedding nursing homes fully into national emergency and public health infrastructure. These reforms must be underpinned by respect for workers' voices and their right to union representation. Only then will we have a system which

supports early risk identification, workforce stability and effective crisis response.

1.14.5 We must learn from the experience of the pandemic. Residents will be better served by protecting frontline workers, addressing entrenched inequalities and building a unified, well-resourced, person-centred nursing home sector which can withstand future public health emergencies. The State now has the opportunity and responsibility, to implement meaningful change so that the failures exposed by COVID-19 are never repeated.



2. INTRODUCTION

2.1. SIPTU Health Division represents a broad range of essential care and support workers across Ireland's nursing home sector, both public and private. These workers are the backbone of residential care, performing hands-on care, infection control, dietary support, hygiene management, environmental safety and emotional care for residents.

2.1.1 SIPTU Health Division representatives welcome the opportunity to present this submission to the Independent Enquiry into the Government Response to COVID-19 as invited.

2.1.2 SIPTU Health Division represents over 42,000 health workers in a variety of roles within the health service including healthcare assistants, multi-task attendants, domestic staff and auxiliary personnel, all of which are critical to the delivery of care. SIPTU Health Division represents members working in both the public, private nursing home sector and funded agencies.

2.1.3 At the outset of the pandemic, SIPTU representatives outlined deep concerns over the high number of COVID-19 infections contracted by nursing home staff and the spiralling situation which was happening due to foreseen weaknesses within the system. It was also a cause of great distress to our members that such a high percentage of all COVID-19 fatalities were identified by the Department of Health as having occurred in nursing home settings.

2.1.4 This submission aims to assist the Independent Enquiry into the Government Response to COVID-19 by providing members of the Committee with a background on the sector and our members experience during the pandemic. We will also examine detail of the workplace and public health and safety issues presented to SIPTU representatives via our Union's dedicated COVID-19 helpline, dedicated email service and social media by a large sample of members and other key stakeholders.

2.1.5 During the COVID-19 Pandemic, our members stood on the frontline of one of the greatest crises in Irish healthcare history. Their experiences of risk, trauma, insufficient protection, exhaustion and extraordinary compassion form the core of this submission.

Purpose of this Submission

2.2. This document seeks to:

- Provide evidence-based analysis of the Government's response to COVID-19 in nursing homes from the perspective of our members working within the nursing home sector.
- Document our members lived experiences during the crisis.
- Identify strengths, weaknesses and gaps in the national response.
- Provide recommendations for policy reform, regulatory action and future pandemic preparedness.
- Ensure that the voices of support-grade staff are fully represented in the national evaluation.
- Draws from direct testimonies from SIPTU members and local Shop Stewards.

- Shows our engagement with the HSE, Department of Health and other public health experts.

Context of the Irish Nursing Home Sector prior to COVID-19

2.3 Understanding the Government's pandemic response requires acknowledging the structural weaknesses that defined the sector before COVID-19.

2.3.1 HIQA published their annual report on the regulation of designated centres for older persons in December 2024. Within the body of the annual report, HIQA confirmed there were 548 regulated nursing homes in the sector and more than 32,370 residential places at that time.[1]

2.3.2 Nursing Homes in Ireland are owned and regulated by a variety of organisations. These are primarily 1) the HSE 2) HSE Funded Section 38 or 39 Organisations as per Health Act 2004 and 3) Private Providers. HIQA advises within their report of the 548 regulated nursing homes referred to above 114 are HSE facilities, 19 are HSE funded section 38 or 39 organisations and 415 are private providers. The breakdown of beds associated with this demographic is 1) HSE - 5,279 2) HSE Funded – 1,075 and 3) 26,016 – Private Provider.

2.3.3 In SIPTU's opinion, the above-mentioned data demonstrates a failure on the part of the State to fully invest in a structured publicly owned model of long-term residential care for our elderly citizens. We suggest it is evident the focus to date has been to have long term residential care services provided to our elderly citizens through private service options rather than through state provided services.

2.3.4 As a result, the outcome for our elderly citizens and their families can be financial worry which we contend should not be their focus at a vulnerable time of their lives.

2.3.5 SIPTU has repeatedly called on the State to refocus its attention to Long Term Residential Care through directly provided, publicly owned organisations which are not for profit in their intent. We welcome the recommendations provided within SlainteCare and the Joint Action Programme on Capacity and Access in Redesign and Implementation of Integrated Care.

[1] *Available at HIQA Annual Report 2024 www.hiqa.ie/sites/default/files/2025-06/HIQA-Annual-Report-2024.pdf*

Nursing Home Care – A Fragmented Sector

2.4 Ireland's long-term residential care system is divided across different ownership and governance structures. Most beds are provided through private for-profit nursing homes, while others are provided through public nursing homes operated by the HSE or voluntary not for profit homes.

2.4.1 We contend this hybrid system creates a variation in staffing levels and skill-mix, different levels of pay and conditions which is often in the range of minimum wage within the private sector. There are also inconsistent levels of training and clinical support within the sector, varying levels of access to public health expertise, infection control systems and diverse financial incentives within the sector. Fragmentation undermined the State's ability to mount a uniform response during emergency conditions within the sector.

2.4.2 In a major research paper published in January 2024 by the Economic and Social Research Institute (ESRI), it was noted by December 2022, the voluntary/private sector supplied 83% of all LTRC home beds, with private for-profit operators contributing 74 %. (page 68)[2]

[2] *Available at LONG-TERM RESIDENTIAL CARE IN IRELAND: DEVELOPMENTS SINCE THE ONSET OF THE COVID-19 PANDEMIC*

Workforce Characteristics

2.5 The nursing home workforce is composed primarily of Health Care Assistants. Multi-task attendants, domestic/cleaning staff, catering staff, ancillary workers and registered nurses.

2.5.1 Before COVID-19, the workforce within the private nursing home sector already faced chronic issues with recruitment and retention due to:

- Low pay, especially in private homes
- Insecure hours and weak sick pay
- High turnover rates
- Reliance on migrant labour
- Limited training supports
- Minimal career progression opportunities

2.5.2 These conditions contributed to staffing shortages during the pandemic. They also contributed to many workers highlighting the psychological challenges and burnout they endured during the pandemic.

Clinical Governance Gaps

2.6 Many private nursing homes had no onsite clinical director, had limited access to infection-control specialists, lacked strong medical governance structures and where dependent on local GPs for medical oversight. Our members contend these gaps with the public health response contributed greatly to delayed decision-making and inconsistent outbreak management.

Infection Prevention and Control Weaknesses

2.7 Pre-COVID-19, IPC systems varied greatly across the sector. Some private homes delivered strong training programmes, but there appears to have been a great variance across the sector. Common issues identified within the nursing home sector included outdated policies, irregular audits, no dedicated infection control officer, a lack of access to timely specialist advice, poor ventilation systems, overcrowded or inappropriate room settings and shared sanitary facilities. These weaknesses became critical vectors for transmission once outbreaks began.

In a report published by the Health Information Quality Authority in July 2020 entitled *"HIQA report highlights the experiences of nursing home residents during COVID-19"* it stated *"COVID-19 has brought into sharp focus the need for reform of current models of care for older people in Ireland. The continued use of multi-occupancy rooms and outmoded premises in some nursing homes undoubtedly created challenges in containing the spread of infection. We must look to complementary models of care, such as homecare and assisted living and ensure that there is improved clinical oversight in all nursing homes. Furthermore, the regulations governing nursing homes are outdated and must be revised to make them fit for purpose, particularly as regards governance, staffing numbers, skill-mix and infection prevention and control. HIQA will continue to listen to the experiences of residents, relatives and staff to strive for safer, better care that focuses on the human-rights and individual needs of the person."*[3]

Reliance on Multi-Site Workers

2.8 Many private nursing homes relied on agency staff, part-time workers or migrant workers to staff their day-to-day services. Members stated it was common that staff would regularly send remittances home and share accommodation with other health workers to cover costs thereby increasing the risk of cross-contamination. We contend these economic pressures to work presented challenges in managing the spread of infection and maintaining safe staffing levels. The challenges identified heightened transmission risk between facilities, staff and residents.

2.8.1 SIPTU received many reports from members which claimed the HSE were having difficulty in engaging agency to take up shifts in nursing homes where there were outbreaks. This resulted in them having to redeploy their own cleaning staff from one nursing home to another when there was an outbreak. This depleted their own staff resources in one nursing home to fill a gap in another. It also caused potential vulnerabilities in infection control procedures.

[3] *Available at www.hiqa.ie /sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf The impact of COVID-19 on nursing homes in Ireland.*

Private Sector Funding Model

2.9 The Nursing Home Support Scheme in Ireland funds private providers per resident, not per staffing or safety standard. This model does not incentivise employers in the private nursing home system to improve staffing levels as they are cost prohibitively expensive. Other significant issues identified by the funding model within the private nursing home system include a limited capacity to invest in upgrades, a focus on occupancy over preparedness and minimal reserves for emergency expenditure. SIPTU argue this funding model is not fit for purpose to meet the needs of our citizens who require nursing home care and especially during a pandemic.

3. CONTEXT, EVIDENCE REVIEW AND FRONTLINE WORKER EXPERIENCE

CONTEXT: THE NURSING HOME SECTOR BEFORE COVID-19

Pre-Pandemic Structural Issues

3.1 The pandemic did not hit a neutral landscape. It landed on a nursing home system already affected by long-term and known weaknesses within the system. Issues such as funding model, staffing levels, over-reliance on agency and migrant workers and supports within the community healthcare model were exposed during the pandemic.

Fragmented system

3.2 Ireland's long-term care model is heavily split between public nursing homes operated by the HSE, private/for-profit nursing homes, which represent approximately 80% of all beds and voluntary/not-for-profit homes.

3.2.1 This fragmentation created differences in staffing models, governance structures, regulatory oversight and resourcing. SIPTU members consistently described the private sector as operating on very thin margins with varying challenges in staffing, training and infection control preparedness.

Chronic understaffing

3.3 Significant shortages of HCAs, multi-task attendants, cleaners and domestic staff were already evident long before the pandemic within the nursing home sector. Issues such as an overreliance on agency staff, high turnover rates, issues with training levels, unsustainable workloads and insufficient clinical governance supports in smaller private homes were regularly experienced by our members. Our members believe these issues directly impacted the ability of private nursing homes to respond to the emergency in a timely and necessary manner. In a paper published by Queen's University, Belfast in May 2022, they noted *"In Ireland, there were concerns about staffing retention and staffing levels in nursing homes. Emergency funding was sought by Nursing Homes Ireland (NHI) and the Department of Health to assist with staffing issues. Nursing homes were reported to be under severe strain, due to inadequate staffing levels."*[4]

3.3.1 Allegations of poaching experienced healthcare workers from the private nursing home sector continued throughout the early stages of the pandemic. On the 25th of September 2020, Nursing Homes Ireland issued a statement which stated it *"reiterated its call on Minister for Health Stephen Donnelly to stop the HSE targeting staff in nursing homes for recruitment in advance of the Winter period. The poaching is continuing despite a commitment by the HSE that it would cease."*[5]

[4] *The Management of COVID-19 in Nursing Homes in Ireland and England: Ethical and Legal Issues in a Time of Pandemic: PHELN WORKSHOP PAPER NO. 2, May 2022 available at PHELN_Workshop_Paper_No.2_May_2022.pdf*

[5] *Available at HSE Not Remaining True to Commitments on Non-Poaching of Nursing Home Staff - Nursing Homes Ireland via nhi.ie/hse-not-remaining-true-to-commitments-on-non-poaching-of-nursing-home-staff/*

Pay inequality and inconsistent standards

3.4 The public/private pay gap created an unstable labour market. Many experienced HCAs and cleaning staff had already migrated to the HSE for secure hours, pensions and higher wages. Private sector workers routinely lacked access to sick pay or paid training, PPE fit-testing, pay parity with HSE rates and occupational health supports. These inequalities within the sector played a significant role in the pandemic response, as staff faced infection risk without the security of guaranteed income or replacement staffing. The private sector has also continually faced challenges in retaining trained and experienced staff given the vast disparity of terms and conditions offered to staff between the public and private systems.

4. EVIDENCE REVIEW: HOW COVID-19 AFFECTED THE NURSING HOME SECTOR

4.1 The effects of COVID-19 within long term residential centres were devastating to the lives of residents, their families, staff and providers. Community and local transmission accounted for a high percentage of infections with widespread clusters in nursing homes and in long stay units. It is also important to note Health Care Workers accounted of most infections and there were several Health Care Worker deaths associated with COVID-19. SIPTU notes the challenges arising for the health service and particularly Care of the Older Person services during COVID-19. In evidence to the Special Committee on COVID-19 in May 2020, Nursing Homes Ireland (NHI) said *"Key State organisations left the nursing home sector and its residents isolated in those early days and the dismay will live forever with us."*[6] Furthermore, the NHI highlighted other key challenges arising for the nursing home sector during the pandemic which included *"the challenges of personal protective equipment, PPE, testing, aggressive recruitment of nursing home staff and discharges from acute hospitals."*

4.1.1 A significant study was published by Brady et al in 2022 which sought to quantify the mental health of nursing home staff during the COVID-19 Pandemic in the Republic of Ireland.[7] The study found moderate-severe post-traumatic stress disorder symptoms were found in 45.1% of all staff. It also identified Healthcare Assistants (HCAs) reported a higher degree of moral injury than other grades of support staff working within nursing homes. Worryingly, the study found that *'thoughts of suicide were reported by 13.8% of staff over the past seven days and 9% reported at least some planning to end their lives, with no difference between the groups.'*

4.1.2 We contend the following issues have played a part in the experience of COVID-19 within this sector:

Communication Barriers: There was confusion within the sector on the management of staff, in particular communication and training of staff about COVID-19 and how the disease is transmitted. At the outset of the pandemic, there was no clear communication line for health workers within the nursing home sector to express concerns to the HSE, Department of Health or HIQA. It is acknowledged that due to the nature of the pandemic, advice was constantly being reviewed and restructured. This had the potential to cause confusion within the sector, particularly given most staff within the private sector are support staff and not directly engaging with the HSE.

Lack of Training: Appropriate training was not widely available within the sector at the onset of the pandemic. Staff often felt overwhelmed with the challenge of meeting their residents needs while striving to maintain services in an ever-changing environment.

Availability of PPE: It is broadly accepted PPE was not available when the crisis first hit in mid-March 2020. The effect of this was felt across the health service including long term residential services. In addition, select distribution of PPE in some facilities was dependent on grade in several cases.

Safe Staffing/Skill-Mix: The challenges with staffing and skill-mix were exacerbated due to staffing deficits when staff had to take leave due to COVID19 infection or awaiting test results. In many cases, reports suggested a significant reliance on a small number of staff in long term residential centres and a reliance on

[6] *Available at https://data.oireachtas.ie/ie/oireachtas/debateRecord/special_committee_on_covid_19_response/2020-05-26/debate/mul@/main.pdf*

[7] *Brady C, Fenton C, Loughran O, Hayes B, Hennessy M, Higgins A, Leroi I, Shanagher D, McLoughlin DM. Nursing home staff mental health during the Covid-19 pandemic in the Republic of Ireland. Int J Geriatr Psychiatry. 2022 Jan;37(1):10.1002/gps.5648. doi: 10.1002/gps.5648. Epub 2021 Nov 2. PMID: 34729818; PMCID: PMC8646737.*

redeployment from elsewhere within the public health system. As a result, fatigue became a factor which would also have contributed to the challenge in containing the spread of the virus. SIPTU argue there is a need for minimum safe staffing levels to be determined for every nursing home. Within a report from the Health Information and Quality Authority (HIQA) entitled 'The impact of COVID-19 on nursing homes in Ireland' published in July 2020, it refers to staffing and skill-mix by stating *"The regulation governing staffing requires nursing homes to have sufficient numbers and skill-mix of staff in order to meet the assessed needs of the residents. However, the regulation does not set out minimum staffing requirements, nor does it offer guidance on how staffing levels should be determined."*[8] While examination of this subject has been progressed in the intervening years within the HSE, SIPTU remains concerned that funding, conditions of employment and a right to organise in a union will continue to be factors affecting the workforce of private nursing homes in the future. If the pay and conditions of the private sector remain unaddressed, the HSE will continue to remain the optimum employer of choice within the industry.

Decanting of Acute System: It is evident the focus of the health system was to free up bed space to ensure there was enough capacity if the surge from COVID-19 was a worse-case scenario.

Delay in Availability of Testing: SIPTU was at the forefront in calling for robust testing within the nursing home sector. While capacity was an issue and resources were required to be put in place, both in Ireland and abroad, this may have been a detrimental factor in the spreading of the virus and formation of clusters within the sector.

Agency: There was an over-reliance on agency staff in all grades frequenting numerous nursing homes facilities.

Occupational Health: Staff reported little access to Occupational Health and a lack of COVID-19 screening of staff, particularly early in the pandemic.

Workplace Anxiety: Exposure to stress and anxiety as health workers had no choice but to assist patients at end-of-life situations and family members could not be present with their loved ones.

Financial supports: An unavailability of financial support for health workers with underlying health issues or those presenting COVID-19 symptoms was evident in the private sector when compared with arrangements in the public service.

Impact on Residents

4.2 In a major research paper by Walsh and Connolly of the ESRI in 2024, they claimed "The COVID-19 Pandemic had a significant impact on the LTRC sector in Ireland and internationally. LTRC residents saw high rates of COVID-19 infection and disproportionately high rates of deaths from COVID-19."[9] Residents of nursing homes represented a disproportionately high percentage of deaths during the first waves. The challenges presented by the pandemic made nursing homes uniquely vulnerable within the health system as it catered for residents who were predominantly at an advanced age, had pre-existing health conditions, shared living spaces and were in close-contact care environments. Members reported that many residents suffered the effects of severe claimed loneliness because of the introduction of many of the public health protective strategies. Interestingly, the authors argue there was 'no difference was observed between public and voluntary/private homes in the probability of experiencing a COVID-19 outbreak'. (page 69)

[8] *Available at The impact of COVID-19 on nursing homes in Ireland via www.hiqa.ie/sites/default/files/2020-07/The-impact-of-COVID-19-on-nursing-homes-in-Ireland_0.pdf*

[9] *Walsh, Brendan & Connolly, Sheelah. (2024). LONG-TERM RESIDENTIAL CARE IN IRELAND DEVELOPMENTS SINCE THE ONSET OF THE COVID-19 PANDEMIC. 10.26504/rs174.*

4.2.1 The Health Protection Surveillance Centre issued a report for the years 2021 and 2022.[10] Within their report they cite "There were more COVID-19 outbreaks in nursing homes and community hospitals/long-stay units in 2022, compared to 2021 (Table 6). This coincided with the emergence of the Omicron variant in late 2021. In 2022 there were with 1,413 outbreaks with 23,627 associated cases*. In 2021 there were with 427 outbreaks with 9,771 associated cases. However, the number of deaths associated with outbreaks in these settings was higher in 2021 than in 2022 with 599 and 317 deaths, respectively." The Oireachtas Special Report on COVID-19 response published its final report in October 2020 wherein it stated "The Committee, despite devoting more meeting time to this single issue than to any other, was unable to get satisfactory answers as to why 985 residents of nursing homes died after they contracted COVID-19. This amounts to 56% of all deaths in the State from COVID-19, which is totally disproportionate for a group comprising of 0.65% of the population who were unique in terms of frailty and vulnerability."[11]

Impact on Workers

4.3 Frontline workers within the nursing home sector, including HCAs, cleaners, catering staff and maintenance teams, were exposed both physically and emotionally to high infection rates among staff and had limited access to PPE at the onset of the pandemic. Workers also had a distinct fear of bringing infection home, suffered a loss of residents with whom they had long relationships and resulting burnout and moral distress. Workers felt abandoned to a great degree and feared the absence of occupational supports in the private sector in the beginning of the pandemic amplified these concerns.

4.3.1 Throughout the pandemic, workers had to carry the burden of caring for residents in an environment where family members were not permitted to visit. Staff were often the only form of contact a resident would have in the final moments of their life. Despite healthcare workers being very experienced with the life/death cycle, this burden was a significant psychological burden to be carried by, in may circumstances, support staff. Workers within nursing homes effectively became the surrogate family of residents by providing emotional support and the only daily contact for vulnerable citizens.

4.3.2 Many members working in nursing homes stated to SIPTU they were unaware of the mental health or psychological supports which were available within their workplace. Workers reported the loss of income incurred due to the lack of sick leave supports, particularly in the private sector. Workers reported suffering from the effects of stress, grief, fear and burnout because of having to deal with repeated waves of infection and outbreaks.

Failure to Recognise Non-Clinical Workers

4.4 Government and public commentary initially focused on nursing and medical staff. However, SIPTU represents many of the workers who clean and maintain homes and individual rooms, served meals to residents, disinfected common spaces, turned residents to prevent bedsores, delivered end of life support and transported laundry and medical waste. Despite this, HCAs, cleaners and multi-task staff were frequently excluded from decision-making, contributing their lived experience and often from public recognition. Our Union also had to ensure our members were not excluded from any Government recognition payment introduced. When this was conceded, our members within the private sector still had to ensure many months of a delay before any payments were received.

5. OPERATIONAL FAILURES DURING THE PANDEMIC

Delayed Government Intervention in Nursing Homes

5.1 Although hospitals received immediate national level crisis planning, nursing homes, particularly private ones, did not. A two-speed system was created where hospitals had emergency command structures, members within nursing homes often felt they were left waiting for guidance or PPE shipments.

[10] *COVID-19 Annual Report 2021-2022_Final_v6.0.pdf*

[11] *Available at 2020-10-09_final-report-of-the-special-committee-on-covid-19-response-sccr004_en.pdf*

PPE Shortages and Distribution Inequity

Early scarcity

5.2 At the onset of the pandemic, workers consistently reported issues such as the need to reuse disposable masks or gowns, had an inconsistent access to face shields and a lack of adequate training on correct PPE use. Members reported their concern at the lack of access to PPE or use of surgical masks during confirmed outbreaks because FFP2/FFP3 masks were unavailable.

5.2.1 It is noted the CEO of NHI raised several concerns to the secretary general of the DOH and the Minister for Health, including the issue of access to PPE. He noted that there was 'considerable anxiety' among NHI members and that suppliers could not supply PPE equipment as the HSE has exclusive supply 'at this time'.

5.2.2 In its report published on 6 October 2020, the Special Oireachtas Committee identified the delays "in reacting to an evolving and deteriorating situation in nursing homes, especially in the provision of supports like replacement staff and PPE' as key issues."[12]

Public-private disparity

5.3 PPE distribution was channelled through the HSE. As a result, many private homes had no direct pipeline to a guaranteed supply of protective equipment. Private nursing homes could not procure PPE at scale during global shortages. Despite delivery of equipment being sourced nationally, many centres stated they had to wait for periods before delivery of emergency stocks. Our members contend this experience materially increased infection risk for residents and staff.

[12] *Houses of the Oireachtas Special Committee on Covid-19 Response, Final Report on Covid-19 in Nursing Homes (October 2020) available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/special_committee_on_covid_19_response/reports/2020*

Infection Prevention and Control (IPC) Failures

Inadequate training

5.4 Feedback from our members suggests IPC training before the pandemic was inconsistent between employers. There was also confusion on the current advice at any time given the changing nature of the national response to the pandemic.

Outdated infrastructure

5.5 Infrastructure within nursing homes contributed to the spread of the virus during an outbreak. This arose due to many reasons, but concerns were raised which suggested many nursing homes lacked adequate isolation rooms, proper ventilation, clinical waste management capacity and sufficient space to provide for residents.

Vaccine Distribution

5.6 SIPTU received significant contact from members during the pandemic expressing their concerns at the perceived delays in distributing the COVID vaccine to residents and staff. This feedback appears to be consistent with the statement to the Joint Oireachtas Committee on Health by Nursing Homes Ireland in February 2021 when they said *"We do feel a critical window of opportunity was missed. With nursing home residents, the most susceptible to the virus, just 10% of the initial 77,000 vaccinations administered by mid-January were within nursing homes. It is appropriate to remind that the National Immunisation Advisory Committee agreed nursing home residents and staff would be priority 1. The first vaccines arrived in Ireland on 26th December yet the first was only administered in a private or voluntary nursing home on 7th January 2021. Every day is vital for our nursing home residents and staff."*[13]

[13] *Available at 2021-02-02_opening-statement-tadhg-daly-chief-executive-nursing-homes-ireland_en.pdf*

6. SIPTU HEALTH DIVISION SURVEY: FRONTLINE WORKERS EXPERIENCES DURING THE PANDEMIC

6.1 In preparation of our submission, SIPTU conducted a survey of our members within nursing homes to ensure their experience is presented to the Independent Enquiry. The findings of the SIPTU Health Division survey of members working in nursing homes during the COVID-19 Pandemic are outlined within this submission. The survey received 207 responses from members across public, private and voluntary/not-for-profit homes. Our key findings include:

- a very high incidence of outbreaks within this sector widespread changes to work patterns and duties during the pandemic
- significant staffing challenges experienced by our members
- mixed experiences of infection control training and guidance
- generally reliable access to PPE with notable exceptions
- variable access to clinical supports
- substantial negative impacts on staff mental wellbeing and perceptions of recognition

6.1.1 The results of our survey highlight systemic vulnerabilities within the nursing home sector. The feedback from our members informs recommendations for governance, workforce resilience, infection prevention and control (IPC), occupational health and emergency preparedness. We will provide a synopsis of the questions raised with members through our survey and the key findings arising.

6.2 We asked members what their role was within the nursing home sector. 70.10% of respondents were healthcare assistants (HCA). 2.94% were nurses, 17.65% were support staff, 1.96% were activities staff and 7.35% were recorded as 'others'.

6.2.1 From the total responses received, 61.27% worked in the public sector, 33.33% worked in the private sector, while 5.39% worked in the voluntary sector. Furthermore, 60.84% of our HCA respondents worked in the public sector, while 32.87% worked in the private sector. 6.29% of HCA respondents worked in the voluntary sector.

6.2.2 66.67% of nurses who responded to our survey worked in the public sector, while 16.67% worked in the private nursing home sector and a similar proportion worked in the voluntary sector.

6.2.3 63.89% of respondents employed as support staff worked in the public sector, while 33.33% worked in the private sector. 19.055 of respondents worked in the voluntary sector.

6.3 61.65% of respondents worked in public sector nursing homes, 33.01% worked in private sector nursing homes and 5.34% worked in the Voluntary or Not for Profit sector.

6.4 The highest level of responses we received to our survey were from Cork, Dublin, Galway and Donegal.

6.5 We asked members if they had experienced an outbreak within their workplace during the pandemic. 93.88% of respondents said they did while 6.12% said they did not. From a grade specific perspective, 83.33% of HCA respondents said they had an outbreak within their workplace.

6.6 A significant 85.15% of respondents responded to our survey to say their work had changed during the pandemic to meet the needs of residents. This included doing extra overtime, doing different work or changing their working hours.

6.7 We asked members if there was enough staff within their workplace to meet the care needs of residents during the pandemic. 30.96% responded to say rarely or never, while 10.63% said 'always'. A further category of 25.60% responded to our survey to say they sometimes had enough staff to meet the care needs of residents during the pandemic. From a grade specific perspective, 25.17% of HCA respondents said they sometimes had enough staff to meet the need of patients, 20.98% said they rarely had enough staff and 12.59% said they never had enough staff to meet the needs of residents. Activities staff said they rarely had enough staff to meet the needs of residents on 50% of occasions, while 25% of support staff said they rarely or never had enough staff, with only 8.33% saying they always had sufficient staff. 16.67% of nurse respondents said they never had enough staff to meet the needs of their residents. One member responded to our survey to say "it was Hard to Work there. PANDEMIC or No PANDEMIC. Short Staff always working on our own in Dining Room if Short Staffed."

6.8 We asked if members were trained in infection-control measures within their workplace. 20.39% responded to say 'Yes, but a long time after the pandemic started' or 'no'. 18.88% of HCA members who responded to our survey said they did receive training in infection control measures, but it was sometime after the pandemic started, while 4.20% of HCA respondents said they never received training. Similarly, 13.89% of support staff respondents said they did receive training, but it was sometime after the pandemic started and 2.78% said they never received the training. The training provided to agency staff was also an issue raised repeatedly throughout our survey. One member commented to say "The training and standard of agency staff was a big problem during the pandemic and still is a problem. This needs to be addressed properly in order to maintain our high standards of care."

6.9 We asked members about the rate of infection control training and guidance they received in their workplace during the pandemic. While 32.37% of respondents advised they had received clear, comprehensive and easy to follow instructions, 36.23% said it was 'mostly clear but there were gaps', 20.29% said 'some guidance was provided, but it lacked clarity or consistency'. A further 7.73% of respondents said guidance was unclear or insufficient while, 3.38% stated they did not receive any training or guidance during the pandemic.

6.10 Our survey sought feedback from members if they felt safe at work during the pandemic. 40.29% of respondents stated they felt safe 'sometimes', 'rarely', while 9.71% said 'never'. 16.02% of respondents said 'always'. Examining grade specific responses, 16.67% of nurse respondents stated they never felt safe at work during the pandemic. 52.12% of HCA respondents stated they 'sometimes, rarely or never' felt safe in the workplace during the pandemic. Many of our members contributed comments to provide additional information to the question raised. In reference to safety and recognition within the workplace, one member commented 'Very few staff and minimum wage after working so many years for the same company." While another stated "I just remember the fear of residents and staff but also the whole team pulled together to make things better. The sight of elderly people being removed in body bags and having no one to give comfort to them will forever stay with me. And on reflection, I could have held someone's hand and given comfort but the fear of Covid at the time was frightening. I think the medical advisor and the Government kept this fear going to make sure hospitals weren't overwhelmed." Another member raised their concern of working in the sector and the fear of bringing infection home to their family. They also highlighted the poor conditions of employment within the predominantly private sector when they said "Very, very, hard job with a high risk of getting sick and transfer to members of family and money is very, very, poor."

6.11 We asked if respondents had access to PPE throughout the pandemic. 65.7% said 'always'. 30.91% said 'usually', 10.14% said 'sometimes' and 2.9% said 'rarely'. 0.48% said they never had access to PPE during the pandemic. 60.14% of HCA respondents stated they always had access to PPE in the workplace, while 11.19% said sometimes, 4.2% said rarely and 0.7% said never. Demonstrating an interesting insight into the early stages of the pandemic, one member responded to our survey to say "A very scary time, a very sad time we lost a lot of residents due to COVID-19 and ppe was not provided at the start of the outbreak. Staff were threatened by management not to wear it and as a result we had a major outbreak." Another member said "At the begging stage we had one suit and one mask to ware for 12 hours. That lasted at least a few weeks. Lessons have to be learned in case of future pandemics"

6.12 Respondents to our survey were asked if there was a dedicated infection control specialist supporting their facility. 46.83% said 'Yes'. 22.93% said 'No', while 30.24% said they did not know. 66.67% of nurse respondents stated they did not have a dedicated infection control specialist supporting their facility during the pandemic. 48.59% of HCA respondents stated there was access to this support within their facility.

6.13 We asked members if there were GP or medical reviews readily available in their workplace during the pandemic. 42.72% said 'Yes', while 22.82% said 'No' and 34.47% said they did not know. 48.59% of HCA respondents stated there was access to this

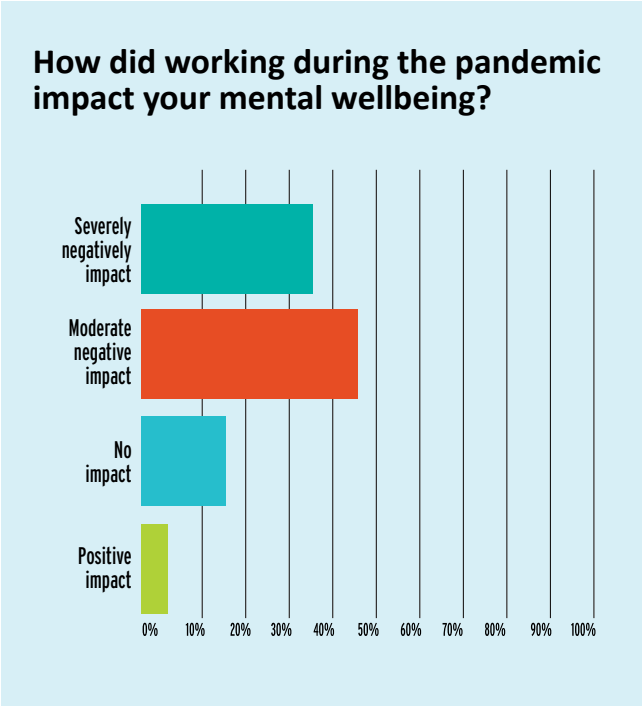
support within their facility, with 22.54% stating no such support was available.

6.14 Our survey asked if public health teams were accessible to our members nursing home when needed? 45.10% said 'Yes', while 13.24% said 'No' and 41.67% said they had no knowledge if these supports were available.

6.15 Respondents were asked if clinical escalation (hospital transfers) was handled appropriately within their workplace during the pandemic. 43.96% said 'Yes', while 28.99% said 'No'. A further 27.05% said they did not know what procedures were used.

6.16 We asked members if they received paid sick leave if they contracted COVID-19 or were symptomatic during the pandemic. 77.61% responded to say 'Yes', while 22.39% said they did not receive pay if they contracted or were symptomatic with COVID-19 during the pandemic. When considering this question, it is noted the public sector had universal pay protection during the pandemic as per the rules established by the Department of Public Expenditure and Reform (DPER). This suggests the members who did not receive pay if they contracted or symptomatic with COVID-19, they were likely employed within the Voluntary or private sector. Of the responses received, 23.74% of HCAs stated they did not receive pay if absent and 20% of nurses stated the same.

6.17 Respondents to our survey were asked about the impact of the pandemic on their mental wellbeing. 35.75% said their mental wellbeing was 'severely negatively impacted'. 46.86% said their mental wellbeing was 'moderately negatively impacted', while 14.49% said there was no impact on their mental wellbeing during the pandemic and 2.9% said there was a positive impact. One member responded to our survey to say "I never questioned going to work because I knew someone had to look after the residents but it was so difficult only seeing my family through a window, having to keep 2m distance away from all staff at all times except for when giving personal care, being watched when leaving the building as we were told we were not allowed to walk together or carpool. Twelve hour shifts, they were mentally draining even more so than usual." The mental anguish for workers who were concerned for their children and family while working in the health service during the pandemic was highlighted throughout our survey. One member responded to say "Staff were not supported. No consideration taken for workers with kids or vulnerable people at home. Expected to come to work regardless with no empathy for workers own families at home during lockdown. As a single parent with two kids, I was denied a longer lunch break to check on my kids and denied any shift changes to accommodate my home life and children at home on their own. Was an absolute disgrace." The impact on members mental health is also evident when you consider some of the feedback received which highlights the effects of the pandemic on residents. One member commented to say, "Just the times when family weren't allowed in when a resident was dying, they were dying on their own I think that was the worst part for me personally."

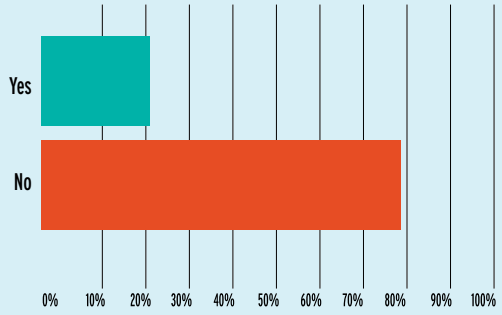


6.18 Our survey asked members how they rated mental health supports provided by their employer during the pandemic. 33.98% said they felt the support provided by their employer was 'poor', while 27.67% said they did not feel their mental health was supported by their employer during the pandemic. Only 9.22% responded to say they felt the level of support provided by their employer was 'excellent'. One member highlighted the significant challenges for workers within the nursing home when they responded to our survey by saying "I felt so alone at times. I had no control over our situation. Night duty was awful because of the amount of times you would have to put on and take off PPE. I felt I was suffocating."

How would you rate the mental health support offered by your employer during the pandemic?

6.19 A significant 79.13% of responses received confirmed that workers did not feel their work was adequately recognised during the pandemic. 20.87% stated they did feel their work was adequately recognised. One member responded to our survey to state "under appreciated by management. Never thanked for working long hours and living on your nerves." Another member commented on the general pay provisions of the private sector nursing homes by stating "Worked very hard for very little money in private nursing home."

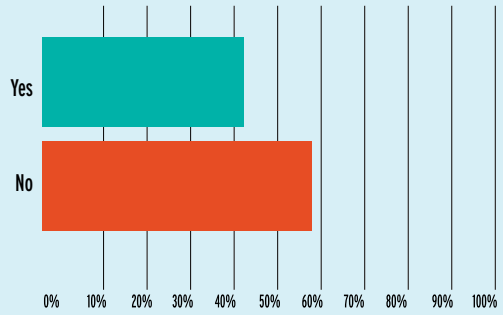
Do you feel your work during the pandemic was adequately recognised?



6.20 We asked respondents if they felt they could raise issues in their workplace or did they fear getting in trouble if they did. 58.05% said they did not feel they could raise issues of concern to them within their workplace without getting in trouble. 41.95% said they felt they could raise issues of concern without the fear of reprisal. One member responded to our survey to state "A bit slow to act usually reacting to situations, we were concerned in the beginning having an open-door policy, so we suggested to lock the door and I felt because of my grade our concerns aren't taken seriously." We received consistent responses from members who felt they could not raise issues within their workplace, or they would not be listened to because of their grade. One such member said "The whole thing was managed poorly. They did not listen to advice given from staff working on the floor. Nursing unit should have been closed to visitors a lot earlier than it had been. Very poor communication with staff, after care of staff terrible."

6.21 53.09% of respondents felt that union members were better protected from victimisation by management if they raised issues within the workplace. 46.91% said union members were not better protected from victimisation.

Could you speak up about issues at work without worrying that it would get you into trouble?



7. FRONTLINE WORKER FEEDBACK FROM THEIR EXPERIENCES DURING THE PANDEMIC

7.1 This section presents feedback given to our officials from workplaces across the country of the experience of our members working in nursing homes. The workers referenced include healthcare assistants, domestic staff, cleaners, catering and support teams.

7.1.1 Public Health data at the time demonstrated that healthcare assistants and cleaners were among the most exposed workers within the workplace. This was due to them undertaking tasks which resulted in prolonged and close contact with residents. There was also a high volume of service cleaning required, frequent bedding changes and the requirement for waste handling.

7.1.2 Of significance, members reported their experience of providing support to residents during the pandemic, particularly at end of life. Members stated they were acutely aware of the importance of their role given family members were not allowed to visit and hold their loved one's hands for example. Moral injury was a factor for workers given the need to make critical decisions about resident's care and the need to protect against further outbreaks as much as possible.

7.1.3 The difference between workers employed in public and private nursing homes was demonstrated when supports introduced during the pandemic are examined. For example, public sector workers received protected pay, based on an average of their normal rostered earnings, if they were not on duty due to a diagnosed infection or were symptomatic. In contrast, many members working in the private sector reported they did not receive any special supports and often had to stay out of work with no income. Early in the pandemic, SIPTU called for the same supports for staff to be given to the private sector which relies on public funding, such as nursing homes, however, this was not implemented. We strongly believe the pandemic supports introduced in the public sector, such as essential staffing levels, enhanced sick leave and protected pay, would have significantly contributed to staff and resident, wellbeing within the private nursing home sector. It also further demonstrates the significant gulf between the public and private sectors during the pandemic that remain significant factors today.

7.1.4 Members also reported significant challenges in maintaining safe staffing levels in the private sector due to the difficulty in attracting staff and the reliance on key workers from international countries. This resulted in many instances were teams continued to work with reduced resources which compounded physical and mental distress for workers. Reduced staffing levels resulted in an increased reliance on overtime, burnout and inexperienced staff having to fill gaps. Due to the presence of agency and part-time work within the sector, SIPTU also noticed the presence of many workers working in multiple sites which compounded the challenge of managing outbreaks and cross-contamination.

7.1.5 There is no nationally agreed minimum safe staffing levels for the nursing home sector. Equally, skill mix is an issue. Members also reported a considerable variance between the public and private sector of minimum safe staffing levels and skill-mix. SIPTU supports the need for a national framework for the sector which will deliver the appropriate safe staffing levels and skill-mix.

7.1.5 Members reported the absence of structured supports within the private sector when compared with the resources put in place within the HSE and public funded health service. Within the HSE, there was direct access to occupational health supports, clinical guidance and peer support programmes, while the private sector would not have automatically had access to such assistance.

7.1.6 Members reported feeling overlooked during the pandemic with many stating they felt they did not have an opportunity to contribute their own experience into the developing management of the crisis. Due to staffing issues, workers noted the challenge in meeting the needs of the organisation through increased workloads, constant evolving training modules and the sense of responsibility to their own families.

7.1.7 Given the reliance on them, it is important to consider the challenge presented for migrant workers during the pandemic. Noting the effects of the pandemic worldwide and the different international response from countries around the world, migrant workers often had to provide their service with increased emotional distress due to not being able to provide direct support at home. In Ireland, many migrant workers lacked family support in this country. Due to the cost of accommodation in Ireland, shared living was common due to the low wages within the sector. This increased the risk of transmission as a result. In addition, migrant workers are a significant percentage of the workforce in Irish healthcare and the private sector is no different. Unfortunately, in the private sector many of the supports agreed in the public sector were not introduced and sick pay was limited at best. Job security is also a factor in the private sector as many workers depend on a work permit to gain employment.

8. OVERVIEW OF THE GOVERNMENT RESPONSE FROM A WORKER PERSPECTIVE

8.1 The Government response to COVID-19 consisted of emergency measures, guidelines, procurement systems, public health directives and targeted supports. It is acknowledged the pandemic created unique challenges globally however, we contend that learning can be achieved when the sequencing, timing and co-ordination of measures introduced to address the pandemic are considered.

8.1.2 Our members within the nursing home sector lacked structural supports at the outset of the pandemic. Coupled with this was the reality that no direct pathway for the provision of PPE was available until some-time into the crisis. Our members

within the private sector also reported a lack of fit testing for respirator masks and concerns at the lack of testing capacity, particularly in the early stages of the pandemic.

8.1.3 As stand-alone private entities, private nursing homes were outside the HSE national command system. In addition, given the challenges arising it was essential to address key issues such as guaranteed supply chain, emergency workforce pool, infection control support and an input into decision making forums.

8.1.4 During the pandemic, unions engaged nationally with the HSE and Department of Health on a regular basis. We sought to have a single, coordinated and whole sector approach implemented. Despite this, the Government approved certain supports for public sector workers which were not implemented within the private nursing home sector. One aspect that was implemented across both settings was the Pandemic Recognition Payment of €1,000. Unfortunately, there was a different approach in payment of the scheme which resulted in many workers in private nursing homes receiving the money some 12 to 18 months after the HSE paid its own staff.

8.1.5 SIPTU also called for greater supports to be given to health workers generally during the pandemic. This included the need for protected transportation to ensure that healthcare workers could get to work or the provision of secure childcare to give peace of mind to the healthcare worker that their children would be cared for while they were at work. We received many calls from healthcare workers who advised of the challenge in providing care for their children given they could not depend on

their elderly family members. This matter was exacerbated when there were multiple healthcare workers in the same household.

8.1.6 The TAPS (Temporary Assistance Payment Scheme) was a government financial support programme for private and voluntary nursing homes which was introduced during the COVID-19 Pandemic to assist cover the costs for infection control, PPE, staffing and other related recommendations. SIPTU understands over €151 million in supports was provided and claims were administered by the National Treatment Purchase Fund. While such supports were welcomed by our members during the pandemic, concern was expressed at the reactive nature of the scheme. It was also noted the scheme did not guarantee minimum safe staffing levels or mandate the protection of pay for workers who may be out of work due to a workplace sourced illness.

9. WORKER AND TRADE UNION REPRESENTATION IN THE NURSING HOME SECTOR

9.1 it is important to note within this submission that worker and trade union representation within the nursing home sector are not automatic rights. While the public sector has well established trade union and collective bargaining processes, the private nursing home sector is at variance with this practice. Members employed in private sector nursing homes have regularly outlined their fears of reprisal if they confirmed their interest in having a union represent their interests. As a result, union organising within this sector has proven difficult due to an environment of fear within the workforce. This fear is compounded when efforts to identify workplace Shop Stewards within private sector nursing homes is examined.

9.1.1 Trade unions play a positive and essential role within the workplace by ensuring that workers have a voice at the table with management. They also provide a valuable source of information to management of the key issues arising within the workforce and proposals of how they can be resolved.

9.1.2 SIPTU firmly believes the failure of the private nursing home sector to embrace the rights of workers to be represented by a trade union should be addressed. As stated previously, the workforce within this sector is largely made up of a vulnerable section of our national workforce, i.e. migrant workers and their right to have union representation given many do not have the cultural connection and family support with this country should not be understated.

9.1.3 SIPTU contend a structured system of worker representation, reporting and information sharing would have greatly enhanced the ability of the system to react to challenges arising and identified many risk factors earlier. It would also have contributed to a more positive workplace environment given it would provide workers with a direct input into decision making and resolution of concerns arising.

10. SYSTEM LEVEL FINDINGS

10.1. From the totality of our membership evidence, SIPTU identified the following structural weaknesses were evident within the nursing home sector:

- The nursing home sector is fragmented across public, private and voluntary settings. As a result, there was inconsistency with the inclusion of the sector within the health service decision making process, particularly at the beginning of the pandemic.
- There was a focus on acute services, the expansion of ICU beds and testing capacity at the onset of the pandemic.
- Private sector workers within the nursing home sector did not receive the same financial protections as their counterparts within the public service.
- The delay in providing quality PPE, IPC and testing support to the nursing home sector resulted in significant outbreak events.
- Everchanging guidance and training requirements resulted in information chaos for many working in the sector.
- Private sector workers working in the nursing home sector did not receive the same mental health support as the public service.
- Workers voices were often not heard. The nursing home sector depends on a high percentage of support staff and migrant workers. Workers often felt they had no vehicle to share their lived experience with management and decision makers.
- Workers within the private nursing home sector are regularly denied the right to be represented by a trade union. SIPTU believe this had a detrimental effect on the ability of workers to contribute and the sharing of information.
- The pandemic revealed weaknesses in structural deficits which pre-dated COVID-19. This resulted in magnifying the impact of the pandemic on the system, residents and staff.
- Future resilience depends on treating long-term residential care as a core pillar of the health system and ensure there is a sufficient reform to integrate all settings, including public, private and voluntary.

11. CLINICAL SUPPORTS, INFECTION CONTROL AND INTEGRATION WITH THE PUBLIC HEALTH SYSTEM

11.1. Due to the fragmented nature of the nursing home sector in Ireland, on-site medical supports were severely strained due to wide ranging pressure within the system. This was compounded by the lack of capacity in accessing swabbing, diagnostics and testing at the onset of the pandemic. Equally, while hospital settings had dedicated IPC departments and resources available, nursing homes did not. As a result, repeated outbreaks caused significant challenges for many homes while they sought to attain the necessary support from the main health system.

11.1.2. SIPTU strongly recommends:

- The appointment of a clinical lead for every nursing home in the State.
- The requirement to create and/or support regional geriatric teams with guaranteed resources across all elements of the nursing home sector.
- The need to fully integrate all nursing homes into HSE clinical governance structures.
- Fund and maintain national PPE stockpiles dedicated to long-term care settings.

- Regular mandatory and accredited IPC training for all nursing home staff.
- Regular audits on ventilation, building safety and capital upgrades.
- Implement regular mandatory outbreak drills within the nursing home sector.
- Assign dedicated public health liaison officers to every cluster or region of the nursing home sector.
- There is 24/7 access to public health support during public health crises for the nursing home sector.
- Development of national protocols to ensure there is a standardised approach to dealing with any future public health crisis.
- Development of national guidance on visiting policies for the nursing home sector which recognise and respect the balance of public health protection with the needs of residents.
- Development of national policies on bereavement, counselling, mental health and psychological supports for residents, families and staff.

In conclusion,

12. SUMMARY OF SIPTU HEALTH DIVISION SUBMISSION: KEY FINDINGS AND RECOMMENDATIONS

12.1 SIPTU Health Division's submission to the Independent Evaluation of the Government Response to COVID-19 highlights the profound impact of the pandemic on Ireland's nursing home sector, encompassing public, private and voluntary facilities. Drawing on the experiences of our members within the frontline staff, including healthcare assistants, cleaners, catering and support workers, our submission underscores the sector's vulnerability and the critical lessons for future resilience.

12.2 Our Key Findings:

- **Systemic Weaknesses Exposed:** The pandemic revealed longstanding structural issues in the nursing home sector, such as chronic understaffing, pay inequality, fragmented governance, and inconsistent infection prevention and control (IPC) standards. Private sector nursing home staff faced lower pay, weaker sick pay and delayed access to government recognition payments compared to their public sector counterparts.
- **Delayed and Uneven Government Response:** Early in the pandemic, nursing homes, especially private ones, lacked timely access to PPE, clear guidance and integration with public health decision-making. While government interventions like crisis support teams and PPE distribution eventually stabilised the sector, these measures often arrived after major outbreaks had already occurred.
- **Psychological Impact on Staff:** Many workers described the pandemic as the most traumatic period of their careers, citing persistent psychological distress, burnout, and moral injury. The lack of mental health supports, particularly in the private sector, exacerbated these challenges.

Continued on page 26.

12.3 Recommendations:

- **Strengthen Public Sector Role:** Expand public provision and reduce reliance on private nursing homes for long-term care.
- **Establish Safe Staffing Ratios:** Implement legally enforceable minimum staffing levels and a national framework for skill mix across all nursing home settings.
- **Standardise Roles and Training:** Create a national standard for healthcare assistants, including regulation, training, certification, and pay, underpinned by regulatory frameworks.
- **Address Pay and Other Conditions of Employment within the Private Sector:** Support our claim for a Joint Labour Committee (JLC) which will provide nationally agreed rates of pay and conditions of employment to support recruitment and retention within the sector.
- **Guarantee PPE and IPC Standards:** Ensure stockpiles, clear protocols and regular accredited IPC training for all staff.
- **Integrate Governance and Supports:** Mandate clinical governance in private homes, integrate all nursing homes into HSE emergency operations and ensure equal pay and protections for all care workers.
- **Support Staff Wellbeing:** Provide timely access to trauma, counselling and bereavement support and develop national policies for staff mental health and contingency planning.
- **Support Staff right to join a Trade Union and Organise**: Workers within the private nursing home sector are being denied the right to join a Trade Union and organise. There is a distinct level of fear within the sector which is driven by an anti-union stance by many employers within the sector.

12.4

The submission highlights that meaningful reform, informed by frontline workers experiences, is essential to protect residents and staff in any future crisis.

We conclude by reflecting on our own members contributions to this submission wherein one stated *"I hope we have learned."*

Fairness at Work and Justice in Society

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