

# BUILDING A SHIELD AGAINST COVID-19:

GUIDELINES FOR UNIONS TO RESPOND



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## INTRODUCTION

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Nursing homes have been extremely hard hit during the coronavirus pandemic, housing the population with the highest number of illnesses and deaths from COVID-19. Available data from 21 countries worldwide in January 2021 shows that on average 41% of all COVID-19 deaths are care home residents<sup>1</sup>, while representing only 9% of the population<sup>2</sup>. In Canada, this figure is 59%.

It is not just residents who are suffering. Scores of long-term care (LTC) workers have fallen ill with coronavirus, and tragically, thousands have lost their lives.

Since the beginning of the pandemic, unions have been fighting to get the support they need to keep workers and residents safe. Long-term care workers were not prioritized for personal protective equipment (PPE) or testing at the start of the outbreak, and there is still a shortfall of PPE in healthcare systems worldwide, especially in nursing homes.

Even with vaccination programmes underway, the factors that made nursing homes so vulnerable to COVID-19 remain. While UNI supports access to the vaccine for all workers as part of necessary PPE, it is not a panacea. There must be deep-rooted structural changes to the way nursing homes are run and financed in order to guard residents and workers against COVID-19, as well as any other infectious disease or future epidemic.

The sector is dogged by insufficient staffing, poor wages and minimal social protection<sup>3</sup>. Low union density means that workers suffer from a lack of social dialogue and collective bargaining to make long-term care safer, or a way in general to improve working conditions<sup>4</sup>. Nursing homes lack supplies, and in many countries, operate in outdated buildings that do not meet care delivery needs. Low wages contribute to poor retention rates and the inability to attract new workers to the industry<sup>5</sup>. Compared to their acute care counterparts, long-term care workers are underpaid and disrespected.

As unions, we have the opportunity to build a COVID shield to protect nursing home workers at all levels. This manual is intended to offer what we should be seeking from employers at the bargaining table and from government. From our discussions with you, our affiliates, we compiled the best practices as a list of principles.

Depending on your local, state or national context, there will be different avenues to reach these principles, and different unions will have different priorities.

The best path to improving nursing home working and living conditions is for workers to organize and gain access to collective bargaining. As we saw in Poland, workers formed a union in long-term care for the first time and won better wages and access to PPE. In the United States, unions stood up and achieved better pay for nursing home workers.

Building worker power is the most important tool for achieving sustainable and lasting change. We must lobby government and use all possible means in the workplace, including worker committees, co-determination structures, joint occupational health and safety committees, grievance procedures, and collective bargaining.

This booklet, written for union leaders and activists, lays down concrete demands that we should all seek for our workers. The case studies it contains only scratch the surface of what is possible and we will be posting more examples regularly on our website: [www.uniglobalunion.org](http://www.uniglobalunion.org), so check back often. Please let us know if you want to contribute.

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1 Comas-Herrera A, Zalakaín J, Lemmon E, Henderson D, Litwin C, Hsu AT, Schmidt AE, Arling G, Kruse F and Fernández J-L (2020) *Mortality associated with COVID-19 in care homes: international evidence*. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 1st February 2021. <https://lccovid.org/2021/02/02/updated-international-report-mortality-associated-with-covid-19-in-care-homes-data-up-to-26th-january-2021/>

2 <https://www.unfpa.org/data/world-population-dashboard>

3 Addati, L., Cattaneo, U., Esquivel, V., & Valarino, I. (2018). Care work and care jobs for the future of decent work: [https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms\\_633135.pdf](https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf) [22 de septiembre de 2018].

4 Boris, E., & Klein, J. (2006). Organizing home care: low-waged workers in the welfare state. *Politics & Society*, 34(1), 81-108.

5 van der Borg, W. E., Verdonk, P., Dauwse, L., & Abma, T. A. (2017). Work-related change in residential elderly care: Trust, space and connectedness. *Human Relations*, 70(7), 805-835. <https://doi.org/10.1177/0018726716684199>

## OUR SHIELD

An infectious disease like COVID-19 requires a lot more than masks. It presents complex problems that require layers of interventions to improve safety for both workers and residents.

The first level of defense for workers is access to proper PPE and vaccines. These protections are then complemented with priority testing, so workers can know their status and prevent putting others at risk, including their residents, colleagues, families and communities.

Care workers also need access to sick pay, to ensure they do not lose income while waiting for COVID test results or recovering after testing positive.

In addition to access to these measures, the workplace also needs adequate staffing levels. Sufficient staffing prevents rushed care, which leads to burn out as well as stress for both workers and residents. Also, a lower carer to resident ratio would mean fewer contacts for workers, which reduces their exposure and the exposure of residents.

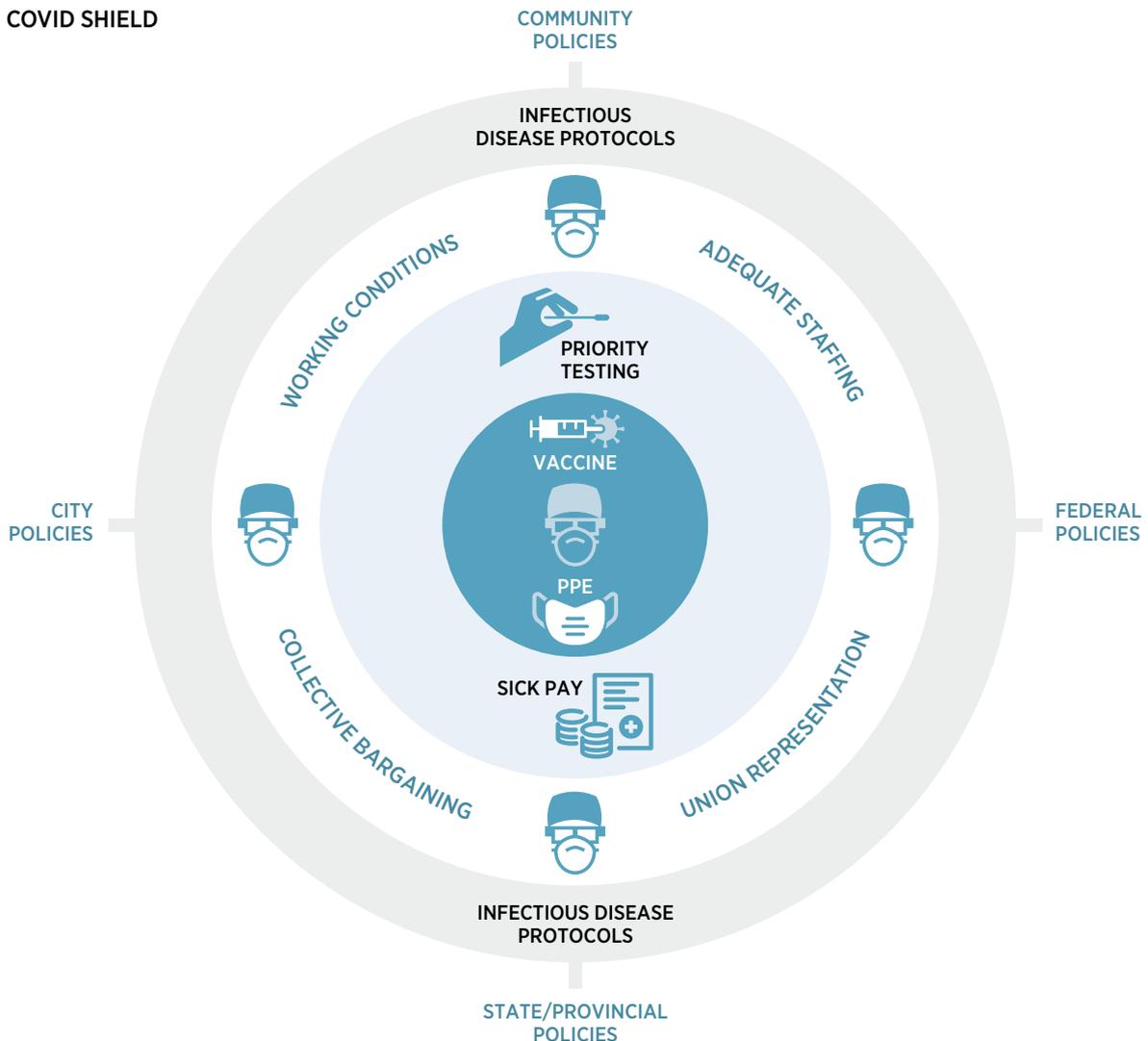
The next level of protection includes workplace and visitor protocols, which must be rigorously enforced. These protocols limit unnecessary exposure of the virus to workers and residents.

Finally, community, city, state/provincial and federal protocols lead to lower overall community viral loads.

### INFECTIOUS DISEASE PROTOCOLS

Infectious disease protocols are put in place to control the outbreak and spread of disease. Visitor and workplace protocols, in particular, are essential to safe working conditions in nursing homes. For example, limiting visitor numbers or mandatory participation by visitors in a track and trace programme can reduce infection rates. Protocols can also include compulsory mask-wearing and hand washing for all persons working or entering the building. Not only do these protocols make workers safer, they help protect residents too.

## OUR COVID SHIELD



## HOW WILL WE ACHIEVE CHANGE?

Responding is not only about battling COVID-19 but also about being ready for other pandemics, which are on the rise. Seventy-five percent of all emerging infectious diseases are zoonotic, in other words were transmitted from animals to humans. Zoonotic diseases are set to increase further due to climate change and environmental destruction<sup>6</sup>.

The COVID-19 pandemic has illuminated our knowledge gaps globally, specifically our lack of preparedness, our slow response time, and our data collection weaknesses. To improve our surveillance of emerging diseases, we must better measure and report infectious diseases' impact on workers. Insufficient data related to worker infections and deaths has made it impossible to understand the scale of COVID-19<sup>7</sup>. We need to work with our national health systems to improve these gaps and, as unions, we have a role in participating in these data collection efforts and improving evidence-informed policy decisions.

## PPE (MASKS, GLOVES, VACCINES)

Lack of PPE has been the most significant concern for the majority of care workers, and supplying adequate protections is level one for building a shield against COVID-19. We need to negotiate clear language about PPE provision and the proper training to use it. Any existing provisions for occupational health and safety in collective agreements should be used to get access to PPE and vaccines.

Principles:

1. PPE should be worn for all resident care; mask type should be determined by the clinical situation.
2. Workers require PPE when COVID-19 is present in the community.
3. Workers need contact and droplet precaution PPE, e.g.: gowns, gloves, masks and eye protection for some care jobs, such as dental hygiene. When higher levels of PPE are required, safety protocols and training must be provided to ensure workers use it correctly.
4. COVID positive residents must be isolated, and nursing homes are responsible for providing a safe space to deliver care while protecting other residents and workers.
5. Airborne protocols need to be followed when there is a confirmed COVID case in the nursing home.
6. All staff require training (not just familiarization) on all the above.
7. Access to vaccines should be guaranteed for all workers.

The best way we can prepare for future problems in long-term care is by organizing and building power today. Our collective power is our most significant asset, and we need to consider what changes we can achieve at the bargaining table and through lobbying our governments. We must actively expand our membership in nursing homes, organizing more workers. We know that unionized nursing homes are safer for workers and residents today<sup>8</sup> and will be in the future.

### CASE STUDY

### NEGOTIATING BASIC ACCESS TO PPE

UNI Global Union affiliates, SEIU and UNIFOR, were part of a coalition of five healthcare unions in Ontario, Canada, that fought for improved access to PPE for workers. Many hours of negotiations led to a new directive in October 2020, which requires the provision of PPE and training on how to use it to all healthcare workers. The directive also binds employers to ensure there is sufficient PPE for their staff, and if supplies run short, the parties, including the unions, must work together to find solutions and ensure safety. The document also includes visitor and infectious disease protocols. Although there are challenges with implementation, the unions now can deal with employers who resist providing the appropriate PPE.

The directive did not include access to vaccines for workers, and even though nursing home workers have priority, the vaccination programme has so far been slow to roll out.

<sup>6</sup> <https://news.un.org/en/story/2020/07/1067711>

<sup>7</sup> <https://www.icn.ch/news/icn-calls-data-healthcare-worker-infection-rates-and-deaths>

<sup>8</sup> [https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01011?utm\\_medium=press&utm\\_source=mediaadvisory&utm\\_campaign=CovidFasttrack&utm\\_content=Dean&](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01011?utm_medium=press&utm_source=mediaadvisory&utm_campaign=CovidFasttrack&utm_content=Dean&)

## PRIORITY TESTING AND SICK PAY (WAITING FOR TEST RESULTS, RECOVERY TIME, FAMILY RESPONSIBILITY)

Priority testing and sick pay are essential to an infectious disease protocol and key to reducing contagion in nursing homes among both residents and workers. Unless workers are given paid time to self-isolate or recover from COVID-19, financial hardship will force many to continue working, despite the risks.

Principles:

1. Access to employer-funded priority testing when a worker self-identifies as having possible COVID-19 symptoms or has a confirmed exposure.
2. Paid sick leave while a worker waits for test results.
3. Paid sick leave for positive cases until a worker recovers and is cleared by a doctor to return to work.

### CASE STUDY

### ACCESS TO PRIORITY TESTING

Throughout the pandemic, workers have faced barriers to access testing. Workers in Zimbabwe have reported that COVID tests are more than one month's salary if they can even get one. In Austria, healthcare workers have reported a lack of access to testing, despite a government initiative giving them priority.

In the United Kingdom, testing of staff and residents is done weekly at the care home. This is usually done during worktime, however, there may be occasions where someone has to attend work on their day off to be tested. This should be done at no financial expense to the member. Recently more funding has been committed by the national government, which will provide two additional rapid tests per week per staff member. These tests can be used for workers that need to work at more than one site reducing the risk of transmission as they travel between locations.

## ADEQUATE STAFFING

Adequate staffing prevents the spread of the virus by giving workers enough time to follow infectious disease protocols and change PPE as needed between residents. It also allows workers more time to care for residents' emotional and social needs, especially those who may be deprived of visitors during a lockdown. Adequate staffing also helps to prevent burnout among workers and allows residents to receive dignified care.

Principles:

1. Workers must be empowered to request extra staffing when the number of coronavirus cases and patient acuity (meaning that each resident will require more direct care hours) increase.
2. When considering worker-to-resident ratios, it should be assumed that these ratios will become the new working normal, so the levels must be able to support resident needs, and have safeguards that allow ratios to be increased in emergency situations, like we have seen during the COVID-19 pandemic. Agreements on ratios must also have regular review timelines as to address changes in the resident population's health.

During the pandemic, workload increased sharply, not only because of COVID-19 but also because family and volunteer programmes were suspended. Therefore, if new ratios are going to be contemplated, they need to consider delivering care during crisis times.

### CASE STUDY

### FIGHTING HARD FOR IMPROVED STAFFING

In Torun, Poland, a nursing home experienced a severe outbreak of COVID-19, resulting in extremely high levels of resident and worker infections. The OPZZ Konfederacja Pracy union engaged the local mayor and leveraged their relationship with the community to demand action on PPE, staffing levels and infectious disease protocols. Within days of reaching out to the mayor, the workers received adequate PPE, but problems remained. Low staffing levels, made worse by workers being off sick with COVID-19, led those still at work to rush from patient to patient, increasing the risk of transmission. Increased stress and being overworked were significant problems, which added to the level of exhaustion. Workers were penalized for taking time off to recover from COVID-19, receiving sick pay that was only 80% of their regular wage.

As the campaign escalated, the union held a press conference to draw attention to the situation and reached out to UNI Global Union for international exposure. The union was able to successfully negotiate with both the mayor and the director of the facility to achieve:

- A wage increase
- Additional staffing
- Increased PPE and infection disease protocols
- Significant bonus pay for all workers who worked with COVID-19 infected patients

## INFECTIOUS DISEASE PROTOCOLS

Workplace and visitor protocols are part and parcel of good infectious disease protocols. Workers must trust that these practices represent the best efforts of their employer to keep them safe. Having strong, enforceable safety regulations will also help to prevent stress and psychological harm<sup>9</sup>.

In January 2021, the World Health Organization (WHO) released updated infection prevention and control guidance for long-term care facilities in the context of COVID-19<sup>10</sup>. The guidance now includes adequate staffing, one-facility working policies, vaccines as part of PPE, and training for staff. All of these aspects are covered in this booklet and are necessary parts of comprehensive protocols.

Principles:

1. **Visitor protocols must be implemented when infectious diseases are reported in the community and viral loads are deemed to be dangerous for either workers or residents. Protocols should remain in place until a public health professional declares them safe to be removed.**
2. **Workers have the right to refuse unsafe work if they have inadequate PPE during an outbreak of an infectious disease.**
3. **Workers require minimum levels of rest, including safe break areas to recover from stressful working conditions.**
4. **One-facility protocols, meaning workers do not work at multiple LTC centres, must be accompanied by full-time job offers.**



### CASE STUDY

### ENSURING WORKERS MAKE ENDS MEET WHEN INTRODUCING ONE-FACILITY POLICIES

To curb the spread of COVID-19, the Ontario government tried to restrict workers to one facility. However, there were several disastrous unintended outcomes to this rule. Firstly, the long-term care system has many part-time workers, who must piecemeal together several jobs to make ends meet. Limiting the number of facilities does nothing to secure full-time employment and limits workers' income.

The other problem was that available staff immediately dropped, and nursing homes had to rely on agency staffing as a stop-gap measure, thus reintroducing the very problem they were trying to avoid. If workplace protocols are going to be implemented, they must consider the broader context of the system and the HR situation. If one-facility protocols are going to be suggested as a means of infection control, the facilities must provide full-time, permanent, living-wage jobs.

Unless we can address the over-reliance on part-time and agency staffing as a stop-gap measure, workers will continue to be blamed as vectors of transmission. Australia and Korea had similar problems, workers there were asked to work in one facility and, in some cases, even stay overnight without compensation.

Different policy initiatives were tried in other countries. In the state of Michigan in the U.S., the United Steelworkers were able to bargain policy changes in late 2020 to protect the health and safety of both workers and residents at the Teal Lake Senior Living community. The union implemented three strategies. The first was a staggered start and break time schedule which supported resident needs and stopped the split shifts which could increase exposure. They also paid a premium to workers to work at one facility only, offering more hours to balance the losses they had from letting go of work elsewhere. And finally, there were isolation units created for COVID-19 positive residents.

9 <https://onlinelibrary.wiley.com/doi/abs/10.1111/hsc.12430>

10 <https://apps.who.int/iris/handle/10665/338481>

## INFECTIOUS DISEASE TRAINING

Training is needed to understand proper PPE protocols so workers know how to best protect themselves, their residents and their families.

Principles:

1. All workers require annual infectious disease training if involved in direct patient care or if they come into contact with patient areas (including cleaning staff or other workers).
2. Workers must be given up-to-date infectious disease information, for example, as more is learned about coronavirus, workers should be made aware and protocols should be updated accordingly.

### CASE STUDY

### IMPROVED TRAINING RESULTS IN BETTER CARE AND A BETTER WORKER EXPERIENCE

Establishing staffing ratios can be an essential step to setting minimum care standards. FATSA in Argentina negotiated rules for nursing assistants to be assigned to a maximum of twenty-four beds during daytime hours and thirty-five beds for night hours. If a geriatric assistant attends more than twenty-four beds during the day and more than thirty-five at night, they will receive a 5% salary increase for each extra person they must look after.

In conjunction with the Argentinian government, the union is offering a training programme focused on geriatric care, which includes modules on infectious disease protocols. This training will be updated as information on COVID-19 emerges. Union delivered training is an essential step for connecting with workers and organizing within the workplace.

## FREEDOM OF ASSOCIATION IS AN ESSENTIAL HUMAN RIGHT

Nursing homes with union representation have better COVID-19 outcomes for workers and residents<sup>11</sup>. Unions make nursing homes safer, showing that workers who have access to collective bargaining are able to deliver better care. We must help more workers organize in the sector and hold more employers accountable. Workers in union environments are more empowered to speak up when they notice problems, with less fear of retaliation because union protection and greater job security. Union workers also have better wages and benefits meaning that they are less likely to work at multiple facilities.

In November 2020, the International Labour Organization (ILO) released a brief highlighting critical issues in long-term care<sup>12</sup> that need immediate attention. The report outlines many of the systemic problems in nursing homes and underscores the benefits of social dialogue and collective bargaining in improving conditions for workers and residents.



11 [https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01011?utm\\_medium=press&utm\\_source=mediaadvisory&utm\\_campaign=CovidFasttrack&utm\\_content=Dean&](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01011?utm_medium=press&utm_source=mediaadvisory&utm_campaign=CovidFasttrack&utm_content=Dean&)

12 [https://www.ilo.org/sector/Resources/publications/WCMS\\_758345/lang--en/index.htm](https://www.ilo.org/sector/Resources/publications/WCMS_758345/lang--en/index.htm)

## OCCUPATIONAL HEALTH AND SAFETY COMMITTEES

Occupational health and safety committees have long been recognized as a key feature of safe workplaces. It is clear they are an important tool enabling unions to address the challenges of COVID-19. These committees should be legally mandated for every workplace of a minimum size, with deference to policies adapted through collective bargaining.

ILO Convention 155 establishes the concept of joint responsibility between workers and employers for health and safety<sup>13</sup> and proposes joint health and safety committees. The convention provides that workers must be protected from retaliation in connection with their health and safety role, and they must receive paid time during working hours to address health and safety. Workers also must have access to a specialist when needed.

Apart from the provisions of Convention 155, many unions have negotiated language within their collective bargaining agreements<sup>14</sup> to define the roles and responsibilities of elected worker health and safety representatives at the work place. These representatives might participate in joint management health and safety committees or a committee of only worker representatives. But in both cases, the role of well-trained and empowered worker representatives is crucial.

Whether a joint committee with the employer or a worker committee/representative, the key principles remain the same:

- 1. Elections of worker representatives should be conducted under circumstances that protect employee freedom of choice. Worker representatives should make up at least half the members of joint health and safety committees. Where workers are represented by a union, committee members should be selected in accordance with the procedures of the union.**
- 2. The committees should be empowered to adapt and implement safety and health standards; should have the discretion to request negotiation over new standards; and file safety complaints internally and with government agencies.**
- 3. In the case of joint committees, workers and employers must equally share decisional power and have an equal responsibility to implement programmes or recommendations.**
- 4. Worker representatives should participate in any inspections or audits by a government agency, and, in connection with COVID-19, in testing and tracing plans.**
- 5. The scope of responsibility of the committees should include both the physical psychological health of workers.**

Unions have negotiated language within their collective bargaining agreements which establish worker committees and expanded their influence in the workplace to include such functions as procurement, accident investigation, reporting, member training, counselling, among many others<sup>15</sup>.

## COVID-19 AS AN OCCUPATIONAL DISEASE

Several countries have recognized COVID-19 as an occupational disease which means that workers may have better access to fully-funded medical treatment and paid recovery time. It may also provide pension or death benefits for surviving family members if a worker dies from a COVID-related cause. For health workers, the risk of getting infected at work is exponentially higher than in other economic sectors. It is also crucial that workers are not denied coverage because the infection is suspected to be of community origin instead of occupational.

It is also vital that illnesses that result from COVID-19 are included. Recent studies have shown that about 50% of care home workers in northern Italy are experiencing symptoms of PTSD<sup>16</sup>. Care workers who have experienced lack of PPE have also been shown to suffer higher levels of depression and anxiety. Although most COVID-19 disease symptoms clear up in about two weeks, some severe cases can last up to six weeks, and there is evidence now that some people end up with prolonged illness<sup>17</sup>. And ultimately, there are cases where people do not regain their previous levels of health, resulting in chronic disability. These situations show why we need the recognition of COVID-19 as an occupational disease, and we must be able to offer long-term solutions for those who are most severely affected.

Principles:

- 1. COVID-19 must be recognized as an occupational disease regardless of causation, and this includes all future sickness or disability that may result from COVID-19 exposure and illness.**
- 2. Unions should track and register positive cases of COVID-19 to understand the long-term impacts on workers.**

13 [https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_ILO\\_CODE:C155](https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C155)

14 <https://www.bls.gov/opub/mlr/cwc/joint-local-labor-management-safety-and-health-committee-provisions-in-private-sector-collective-bargaining-agreements.pdf>

15 <https://www.bls.gov/opub/mlr/cwc/joint-local-labor-management-safety-and-health-committee-provisions-in-private-sector-collective-bargaining-agreements.pdf>

16 <https://royalsocietypublishing.org/doi/10.1098/rsos.200880>

17 [https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update-36-long-term-symptoms.pdf?sfvrsn=5d3789a6\\_2](https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update-36-long-term-symptoms.pdf?sfvrsn=5d3789a6_2)

## CONCLUSION

The reality is that no one was prepared for the coronavirus pandemic, which left unions, governments, and employers scrambling to respond to an unprecedented situation. Together, we must find ways through collective bargaining and legislation to protect our workplaces.

Unions have an indispensable role in building more resilient workplaces, and they will play a significant role in institutionalizing the experience and knowledge gained from this pandemic. Together we can make a difference and improve the future of nursing home care.





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