FRONTLINES

ISSUE 01
2016

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THE MAGAZINE FOR NURSES BY THE MANITOBA NURSES UNION

Message from the President

In November 2015, MNU submitted a legislative proposal to the Minister of Labour and Immigration calling for the inclusion of psychological health and safety requirements for health care facilities in Manitoba's *Workplace Safety and Health Act and Regulation*.

The proposal was based on the principles of the *National Standard of Canada for Psychological Health and Safety in the Workplace*, released in 2013 by the Mental Health Commission of Canada, an initiative commissioned by the federal government.

After we submitted our legislative proposal, we received a response from the Executive Director of Labour Programs on behalf of the Minister. The letter confirmed receipt of the proposal and stated that upon review our legislative proposal would not be considered at this time.

This is disappointing.

There is an absence of psychological and psychosocial supports in Manitoba's health care facilities. This legislative amendment would not only help address the social stigma of mental health in the workplace, but it would also ensure that nurses, along with other health care professionals, have timely access to appropriate support and resources to help them deal with the increasing prevalence of mental health hazards in the workplace.

Furthermore, studies show that psychologically safe workplaces result in decreased rates of absenteeism, mental health disability claims, stress leave, psychological workers compensation claims, and issues related to presenteeism. In short, a commitment to psychological safety helps ensures a strong and healthy health care workforce.

The letter did confirm that the Workplace Health and Safety Branch is monitoring pilot projects in the area of psychological health and safety, however it was not made clear as to whether these projects are occurring in health care settings.

The letter went on to say that the government is also working to identify and develop effective approaches and strategies to legislation, prevention and enforcement related to psychological health and safety in the workplace.

While it is disappointing that the Department of Labour and Immigration did not give this proposal further consideration or at the very least, more discussion, we are prepared to pursue this further. We hope that we can have a more collaborative relationship in respect to the development of workplace psychological health and safety initiatives because this is an issue directly affecting our members, and according to the stats this is an issue that is on the rise. ■

Sandi Mowat

FRONT LINES

Front Lines is published by the Manitoba Nurses Union (MNU). Founded in 1975, MNU continues to be an active member driven organization dedicated to meeting the needs of its members. Approximately 12,000 nurses province-wide belong to MNU. That's 97% of unionized nurses in Manitoba.

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Publication Agreement #40021526

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Manitoba nurses Union

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Victoria Hospital IAC CONCLUDES

Triggered by Heavy Workload Issues and Mandatory Overtime

The Victoria General Hospital in Winnipeg.

Now that the Independent Assessment Committee (IAC) has submitted their recommendations, nurses at the Victoria General Hospital are finally on their way to establishing permanent solutions for the many issues plaguing the Medicine Program.

The journey began more than a year ago (November 26, 2014) when the Manitoba Nurses Union wrote a pre-IAC letter to advise that the local union representatives from the Nursing Advisory Committee (NAC) would be referring the unresolved workload staffing concerns from the Medicine Program to the Facility Executive Management Committee, as per Article 1103 3 (c) of the collective agreement.

"The nurses have been struggling with less than favourable working conditions for a long time," said local president Shawna Castillo. *"One nurse even said that it's becoming harder and harder every year to check the 'yes' box in regards to upholding the standards of practice, when registering for her RN licence."*

Over the years, the (4) South Unit has filed countless workload staffing reports (WSR) which eventually resulted in the employer increasing the evening staff baseline from four to five nurses, however, this improvement was short lived because the number of patients was subsequently increased from 28 to 30.

"When they had a hole on (4) South they would pull a nurse from (5) North or (5) South to fill in," said Karen Fleming, MNU Labour Relations Officer. *"Staffing issues on this unit were starting to have an impact on some of the other Medicine Units."*

The Hearing:

Nurses are given a voice

On May 11, 2015, the Victoria General Hospital Medicine Program IAC hearing began with a tour of the Medicine Units. This was followed by MNU's presentation which included a workload staffing report analysis, the results of a staff survey, mandatory overtime statistics, Nursing Advisory Committee meeting minutes, publications from the College of Registered Nurses of Manitoba as well as the College of Licensed Practical Nurses of Manitoba and several articles relevant to workplace safety and health.

The following day, 13 nurse witnesses from the Medicine Program testified by presenting information to the committee. As previously agreed upon in the guidelines, there was no cross-examination of the witnesses.

"I am so proud of all the nurses who came forward and testified. It took a lot of courage. Their stories were honest, moving and heartfelt," said Castillo. *"In my view, the most important thing that came out of the IAC process was that it gave the nurses a voice."*

Fleming added that the insight the nurse witnesses provided into the daily workload issues affecting patient care, ethical dilemmas and staffing challenges on their units was invaluable.

Next, the employer had a chance to address the committee. Their presentation included information about the efforts that have been implemented and/or trialed to address the workload issues, the use of extra staffing for heavy care, over census data, bed map changes, vacancy and sick time data. The employer had eight witnesses which included managers, directors, and regional staff.

After the union and employer presentations, there was an opportunity for follow up and final questioning as well as clarification from the committee.

MNU Labour Relations Officer Karen Fleming *(right)* **and Victoria Hospital Local President Shawna Castillo** *(left)***.**

Recommendations

The non-binding recommendations were provided to the parties on June 9, 2015. MNU and the employer met promptly to review the recommendations and established a plan to meet jointly with the medicine nurses to review the recommendations.

The recommendations were broken down in to six key areas:

1. *Issues on 4 South*
2. *Issues on 5 North and South*
3. *The Central Relief Team*
4. *Mandatory Overtime*
5. *Clinical Resource Nurse*
6. *Space and Equipment*

The parties then met on June 25, 2015 with the affected nurses to discuss the IAC report. The 52 page report included summaries of the presentations as well as appendices from both the union and employer's written submissions.

The parties agreed to focus on the recommendations.

"The employer provided genuine commitment and engaged in meaningful dialogue with exploring the ability to adopt and implement the recommendations," said Fleming.

"A further commitment was made to meet in November to assess the progress of the implementation."

Progress Report:
Mandatory overtime still an issue

The parties met on November 25, 2015 to evaluate the progress so far. Fleming reported that some of the recommendations on (4) South have been implemented, but that there is still a high level of turnover and concern over the use of mandatory overtime and heavy workloads.

The recommendation for (5) North and South has been implemented and the nurses have reported an improvement in communication with management. Furthermore, the employer has committed to making all attempts to meet baseline staffing, including offering overtime.

"Mandating has slowed down on the units directly involved in the IAC, however, it still occurs. Also, reassignment on the 5th floor is still happening, as is working under baseline," said Fleming. *"So even though the staff has noticed an overall improvement it's an ongoing, daily challenge to meet baseline, due to staff shortages."*

In regards to the Central Relief Team some of the recommendations have been implemented.

"The nurses and union were pleased to have the employer's acknowledgment and commitment to have relief nurses available, above baseline, to assign to unexpected immediate staffing needs," said Fleming.

On the other hand, much to the disappointment of the (4) South staff, the committee did not support the implementation of a clinical resource nurse.

Finally, the recommendation regarding space and equipment has not been implemented.

"The local will continue to monitor the implementation of the recommendations regularly at the NAC meetings," said Fleming. *"We are committed to working with the employer on solutions to further decrease the use of mandatory overtime and workload staffing issues."* ■

Bill 35:
PTSD Legislation Update

In addition to the new legislation, the WCB revised its psychological injury adjudication policy and guidelines.

What does this new legislation mean for WCB psychological injury claims?

On December 18, 2015, the WCB met with MNU President Sandi Mowat to discuss how the new legislation will impact the adjudication of psychological claims. It was confirmed that the WCB will continue to adjudicate PTSD claims in the same manner as all other psychological injuries however, the presumption may apply to cases in which workers developed PTSD as a result of prolonged, cumulative exposure to trauma and the cause of their PTSD is unclear.

This means that the presumption would not be necessary if it is clearly found that PTSD was a result of a chance event, a willful and intentional act, or an acute reaction to a traumatic event. In cases such as these, the claims would be applicable and adjudicated under WCB's existing psychological injury policy.

How are psychological injury claims currently adjudicated?

The WCB's policy identifies specific criteria they consider in adjudicating psychological injury claims. The WCB adjudicates psychological injury claims in the same manner as physical injury claims. This means the WCB must determine:

A *Whether an accident occurred out of and in the course of employment;*

B *The worker has suffered an injury; and*

C *The injury was caused by the accident.*

The WCB's definition of "accident" is broad in order to capture all of the possible scenarios that may cause psychological injuries. As per the legislation, a psychological injury can be cause by:

- *A chance event (i.e. collisions, gas leaks, building collapses);*
- *A willful and intentional act (an act that involves malice or bad faith); or*
- *An acute reaction to a traumatic event or PTSD.*

How will the WCB adjudicate PTSD claims under the new presumption?

Claims in which the PTSD diagnosis was a result of a lengthy, cumulative exposure to trauma at work, or the cause of PTSD is unclear may be eligible for the new presumption. When considering a claim under the new presumption, the WCB will be responsible for determining:

1. *That the worker was exposed to a traumatic event or events as specified in the most recent version of the Diagnostic Statistical Manual (the Manual) as a trigger for PTSD;*
2. *The worker has received a diagnosis of PTSD by a physician or psychologist;*
3. *If there is evidence to rebut the presumption. The presumption will be rebutted in cases in which there is evidence that a worker's employment was not the dominant cause of PTSD.*

The WCB will review all of the evidence in the claim file to determine if the diagnosis and triggering event(s) fulfills the criteria of the Manual which is currently in its fifth edition.

As of January 1, 2016, Manitoba's new presumptive post-traumatic stress disorder (PTSD) legislation is now in effect. Under this legislation, if a worker in Manitoba is exposed to certain types of traumatic events and is diagnosed with PTSD, the Workers Compensation Board (WCB) can presume that PTSD is caused by the worker's employment, unless the contrary can be proven.

What are traumatic/triggering events?

The Manual identifies the trigger to PTSD as the exposure to actual or threatened death, serious injury, or sexual violation. The exposure must result from one or more of the following scenarios:

- *An individual directly experiences the traumatic event;*
- *An individual witnesses the traumatic event in person;*
- *An individual learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or*
- *An individual experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies **unless work-related**).*

It is important to note that many events that have a traumatizing effect on individuals may not involve actual or threatened death, serious injury or sexual violence. As the MNU has pointed out in its PTSD research, trauma and PTSD triggers are highly subjective in the fact that what may be traumatizing and the cause of PTSD for one person may have a different effect on another. The WCB recently updated its psychological claim policy in which it is noted that such events that fall outside actual threatened death, serious injury or sexual violence may still be compensable under the "acute reaction to a traumatic event" branch of the definition of the occupational disease.

What if I was diagnosed with PTSD before January 1, 2016?

In recent correspondence, the WCB has confirmed that workers will be entitled to re-submit a claim that has been previously denied. To access the presumption, a diagnosis from a physician or psychologist/psychiatrist must be received on or after January 1, 2016. If a worker receives a diagnosis of PTSD on or after January 1, 2016, the presumptive legislation applies to his or her claim, provided that the statutory criteria are met. This general principle applies regardless of whether there is a previously denied claim of a pre-2016 diagnosis of PTSD.

MNU will continue to closely monitor the impact of this legislation on current and future PTSD claims for our members, and will continue to engage in conversation with both the Government of Manitoba and WCB to address any arising issues.

Who do I contact if I have more questions?

If you have any questions about the presumptive PTSD claim process or any questions related to WCB, please contact Mary-Lou Cherwaty, Labour Relations Officer – WCB at MCherwaty@manitobanurses.ca

As always, please ensure that you file a WCB claim for any physical or psychological injuries you encounter in the workplace during the course of your employment. To file a claim with the WCB:

1. *Report the injury to your employer as soon as possible*
2. *See a healthcare provider*
3. *Contact the WCB*

For more information on filing a claim, please visit the WCB website: http://www.wcb.mb.ca/

Legalizing the Right to Die

Last year, the Supreme Court of Canada ruled that Canadians have the constitutional right to escape unendurable suffering.

It would no longer be illegal for a physician to assist a competent adult to die, in situations where the adult experiences enduring, intolerable suffering from a grievous, irremediable condition and consents to the termination of their life.

The Conservative federal government was given a full year to draft regulations for physician assisted death (PAD) and barring any set-backs the law would come into effect on February 6, 2016. However, on January 15, 2015, the Supreme Court of Canada accepted the new Liberal federal government's request for an extension. The federal government has received an additional four months to draft PAD legislation and in the meantime, any individual who meets the criteria can apply for judge approval to receive PAD.

Recommendation Report Released

The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group) released its final report featuring 43 non-binding recommendations on what the new legislation should entail.

While we will not know the full role nurses will have until the legislation is finalized, the Advisory Group identified recommendations for changes in areas that could have a direct impact on nurses. These include:

1. Amendments to the Criminal Code of Canada

As it stands, only physicians will be protected under the *Criminal Code* when it comes to the provision of PAD.

However, other health care providers, notably nurse practitioners, have an exclusive scope of practice through which they can assess the patient and prescribe medication when appropriate.

Furthermore, in situations where access to physicians and nurse practitioners is limited, registered nurses may be able to act under the direction of a physician.

What this means is that there is the likelihood that registered nurses and nurse practitioners will be involved in the provision of PAD.

It is recommended that the *Criminal Code* be amended to explicitly permit regulated health professionals such as registered nurses, who act under the direction of a physician, and nurse practitioners to participate in the provision of PAD. Changes to the *Criminal Code* need to ensure health care professionals can provide the support services they normally would, such as a pharmacist dispensing medication or a nurse drawing medication into a syringe without facing legal consequences. If this is not made clear, health care professionals that are not physicians will face increasing uncertainty as to their role and expectations and could be potentially exposed to criminal liability.

2. Liability Protection for all Health Care Professionals

It is recommended that provinces and territories ensure that all health professionals involved in PAD are protected from liability for acts or omissions done in good faith and without negligence.

Furthermore, provinces and territories should also ensure that health care providers' liability insurance does not discriminate against them on the basis of whether they are involved in providing PAD.

3. Develop Physician-Assisted Dying Competencies and Education Programs

While it was not a specific recommendation in the report, the Advisory Group identified necessary activities for organizations and institutions to adopt and implement related to PAD.

For instance, it was identified that licensing bodies for registered nurses should develop physician-assisted death competencies and education programs. Furthermore, all professional associations should revise their *'Codes of Ethics'* to be consistent with the new legislation, while health institutions/facilities should develop or revise their policies and procedures for PAD to be consistent with the law.

In respect to faith-based institutions who object to PAD, these institutions should develop and clarify the plan for transfer of patients to another institution, as access to PAD is an important requirement for legislation.

To view all of the recommendations along with the recommended service pathway model, please consult the final report accessible here:
http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf

The Matter of Conscious Objection

While the report identifies that PAD will affect other health professions besides physicians, it does not explicitly apply the requirement for the right to consciously object to PAD from the perspectives of nurses and other non-physician health care professionals.

This is important to consider as while a nurse could not refuse to care for a patient/resident/client who has communicated their request for physician assisted death, it still remains unclear on the type of role nurses will have in PAD.

For instance, if future legislation permits nurses to assist in the preparation of a patient/resident/client for the administration of PAD, a nurse should be entitled to consciously object at that point to having any involvement in preparing a patient/resident/client for PAD.

Who to contact if you have questions:

While the Expert Group's report emphasized the role of registered nurses, MNU recognizes that PAD may have implications for all categories of nurses. As the legislation unfolds, MNU will continue to advocate on behalf of all of its members for all relevant issues related to PAD.

If you have any questions related to how PAD may impact your practice as a nurse, we encourage you to contact your regulatory body:

College of Registered Nurses of Manitoba
Deb Elias *RN*
Director of Practice and Standards
204-784-5182
delias@crnm.mb.ca

College of Registered Psychiatric Nurses of Manitoba
Laura Panteluk *RPN*
Executive Director
204-888-4841
lpanteluk@crpnm.mb.ca

College of Licensed Practical Nurses of Manitoba
Jennifer Breton *LPN RN*
Executive Director
204-663-1212
jbreton@clpnm.ca

CA Premiums 2016

Looking Ahead: Wages and Shift Premiums to Increase

As of April 1, 2016 MNU members covered by the Central Table Agreement will receive a 2 per cent (2%) general wage increase as negotiated in the last collective agreement. Nurses will also receive a 1 per cent (1%) market adjustment wage increase on October 1, 2016.

In addition to the 2 per cent wage increase, the following shift premiums will also come into effect as of April 1, 2016:

Article 1701

(a) The evening shift premium will be increased to $1.75 (from $1.00) per hour and will be paid for all hours actually worked on any shift when the majority of the hours on that shift fall between 1800 hours and the next succeeding 2400 hours.

(b) The night shift premium will be increased to $2.50 (from $2.05) per hour and will be paid for all hours actually worked on any shift when the majority of hours on that shift fall between 2400 hours and 0600 hours.

Article 1704

The weekend premium will be increased to $2.00 (from $1.65) per hour and will be paid for all hours actually worked on any shift where the majority of the hours on that shift fall between 0001 hours on the Saturday and 2400 hours on the following Sunday.

The Central Table Agreement expires March 31st, 2017 and covers approximately 12,000 nurses throughout Manitoba.

NCLEX Update

"Since the NCLEX was introduced, MNU has continuously heard from nursing students that the exam is causing distress and is a barrier to their ability to practice," said MNU president Sandi Mowat. "These complaints are a cause for concern because these experiences are being communicated by nursing students who did exceptionally well throughout their nursing education program yet failed the nursing exam, even on the second attempt."

Similar to the experiences of nurses across Canada, Manitoba's grad nurses identified a number of challenges they have experienced in passing the NCLEX-RN. These challenges are specifically related to exam content, the maximum number of written attempts and the provision that the College of Registered Nurses of Manitoba (CRNM) suspends the graduate nurse licence if a grad nurse fails the exam a second time, and restricts a nurse from practice if the exam is failed a third and final time.

MNU president Sandi Mowat met with the Minister of Health to discuss the diminishing pass rates and challenges Manitoba's graduate nurses are experiencing since the implementation of the NCLEX-RN, the new American-based RN licensure exam, introduced in January 2015.

Policy changes needed

More writes and temporary licence

"There is an opportunity for CRNM to amend their existing policy to permit multiple written attempts (greater than the current three)," said Mowat. *"The introduction of a temporary licence would also be helpful because it would ensure that graduate nurses still have the ability to accumulate practical work experience should they fail the examination."*

It's a perspective that aligns with other provincial jurisdictions such as New Brunswick and Nova Scotia who have taken a progressive approach in amending regulations and policies to address the challenges with the NCLEX-RN.

So far, the most progressive approach has been implemented in New Brunswick – the province which recorded the lowest pass rates with 54.3%.

Late last year, the Nursing Association of New Brunswick (NANB) Board of Directors in collaboration with the New Brunswick Nursing Union (NBNU) and education institutions approved a regulation permitting multiple exam writing attempts over a two-year period, retroactive to January 2015. The new regulation also permits the opportunity for graduate nurses who fail the exam to practice under a temporary registration for a maximum of two years.

Prior to that, Nova Scotia amended their regulations to re-issue a temporary licence to practice, valid for four to 12 months, to a nurse who fails the NCLEX-RN exam a second time.

Elsewhere in Canada, since 2012, The College of Registered Nurses of British Columbia (CRNBC) has permitted nurses to write their registration examination more than three times, provided they are granted permission by the CRNBC board.

Across the border, 39 out of 50 American states give students the opportunity to rewrite the exam an unlimited number of times.

"Revisions to the CRNM's examination policy would help ensure Manitoba is equipped with a stable nursing workforce in a time of increasing nursing shortage," said Mowat. *"It would also help alleviate some of the barriers many new graduates are experiencing as they embark on their careers as nurses."*

Manitoba's Recent Results

As of September 30, 2015, Manitoba's NCLEX-RN pass rate was 72.19% which represents over a three point increase from June 30, 2015 (68.6%). The overall Canadian pass rate however, dropped from 70.6% to 68.65%.

Manitoba now represents the fifth highest pass rate in Canada while New Brunswick and Saskatchewan continue to represent the lowest.

While Manitoba's pass rate has increased since the spring, the results are still far below the pass rates for the former Canadian Registered Nurse Exam (CRNE) in which Manitoba's graduate nurses experienced a 90% pass rate for first attempts and a 73% pass rate for second written attempts. ■

Pension & Benefits

Bob Romphf

This year, the first Baby Boomer will turn 70 and like clockwork the MNU office has started receiving questions about retirement. It is clear that nurses are concerned about both their pension and retirement, and while we do not provide custom retirement counseling we can offer you some tips – things to consider and questions to ask when preparing for retirement. In fact, these tips are valuable to all nurses regardless of what age group they represent.

Hiring a Financial Advisor

The decision to hire a financial advisor rests with the investor – you.

You might be doing a fairly good job of managing your investments on your own, and if you are then you are already ahead of the game. However, there is a lot to be said about working with an expert – many people who believe they don't need a financial planner could in fact benefit from one anyway.

So, how do you find an advisor that's right for you? Ask around – talk to family and friends and even colleagues, if you are comfortable. You can also ask a Certified Public Accountant or a lawyer for a referral. It makes sense to compile a list of a few possible candidates and then give them a call to find out if they work with clients at your financial level; some advisors require minimum amounts that might be more than you have or are willing to invest.

Once you have gone through the preliminary screening process and have set up a meeting here are **a few key questions to ask your prospective advisor:**

1. Do you have a certified designation?

   Many planners or advisors only sell financial products. In fact, the term "financial planner" has been a much-abused term. A person can label himself or herself as a financial planner, but not be a certified financial planner unless he or she has fulfilled the necessary credentials. When choosing an advisor it is crucial that you understand what qualifications and certifications he or she actually has. Don't pick an advisor based on the title on their business card. For your reference, certified financial planners have passed a national test covering insurance, investments, taxation, employee benefits, retirement and estate planning administered by the CFP Board of Standards. They must meet experience requirements and abide by a code of ethics.

2. How long have you been in business?

3. **How will you handle my account, including reporting and communication?**
4. **How are your services paid?**

   Some advisors charge a straight commission every time a transaction is recorded. Others charge a fee based on the amount of money they have been given to manage. Some fee advisors assess an hourly fee, meaning they can be very expensive.
5. **Will you write an engagement letter outlining scope and fees?**
6. **Will you provide three references?**

Talk to your employer

Now that you have your finances sorted out, it's time to contact your employer to clarify some pertinent information.

You will need to:

1. Find out your start date of employment with your employer
2. Find out your paid pre-retirement value (severing allowance)

Note: *Some funds may be put into your RRSP (pre 1996) or paid in combination with salary continuance or cash, which is taxable, for full and part-time staff with a minimum of 10 years of employment.*

3. Give notice – normally a three to four month **Notice to Retire** is submitted to the employer.
4. In your Notice to Retire it's important that you include:
   - **a.** your last actual day of work in the facility;
   - **b.** your expectation of your first pension cheque (1st of the next month paid retroactively by HEB); and
   - **c.** your direction of your pre-retirement paid LOA funds, where applicable, as to how you wish them dispensed.

HEB

HEB has a helpful calculator tool that can be used to get an approximation of your HEB monthly pension (alternatively ask for a pension quote). Once you have received your pension quote, in consultation with your spouse and/or financial advisor, choose the pension option most useful to you. At this point, make sure to decide if you want the HEB Post Retirement Group Health and Group Life Plans.

Please note that you must inform HEB of your intent to retire. A three to four month Notice to Retire is sufficient. To make sure your bases are covered, it is recommended that you inform HEB of your intention to retire at the same time you inform your employer.

The HEB pension calculator can be found at www.hebmanitoba.ca

Things to keep in mind

CPP

You are eligible for early CPP at age 60, however this includes a 36 per cent penalty. If you choose to wait until age 65, you will receive your full CPP i.e. no penalty.

OAS

You might recall that the previous Conservative federal government introduced some changes to the OAS system. Most notably, they increased the age at which you can start to collect OAS to 67, from 65. This was supposed to go into effect in April 2023, however it is currently under review by the new Liberal federal government.

As it stands, you are currently eligible for OAS at age 65, providing you are a Canadian citizen or legal resident and meet the minimum residence requirements. You can find more information on the Service Canada website.

The more you know

It's always a good idea to stay informed as well as gather as much information as possible on retirement and related issues. Whether that is through online resources, reading books or attending the Retirement in a Nutshell workshop by MNU, there is a wealth of resources and knowledge at your disposal – it's never too early to start planning for your retirement.

NEW WSH REGULATION BEING ROLLED OUT

Alert Assessment Tool for Violent Patients

An op-ed piece by Winnipeg Sun Columnist Tom Brodbeck, published on Sunday, January 17, 2016 – *Provincial policy ignores patients' rights* resulted in a wave of discussion and comments on the Manitoba Nurses Facebook page.

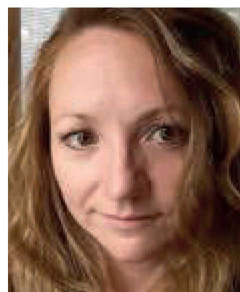
The column talked about a new work place safety and health regulation that is being rolled out in all health care facilities across the province.

The regulation, which is in various stages of implementation at each regional health authority, is based on one of MNU's recommendations from a 2011 report – *Violence against nurses in Manitoba*. It is a screening tool that will give nurses the ability to place an alert on the medical charts of patients deemed to be violent or verbally abusive.

In some cases, violent patients might have to wear special bracelets to warn staff of their behaviour.

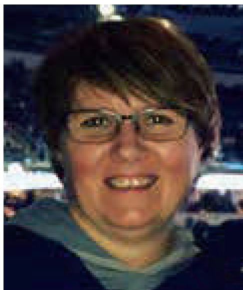
While the details of this policy are still being worked out, and Brodbeck's analysis is clearly premature, his belief that this "Orwellian" policy has overlooked patients' rights in its effort to protect nurses from workplace violence resulted in our members standing up and speaking out.

Here is what some of them had to say:



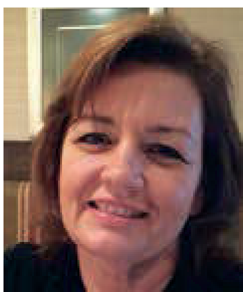
Trish Gillespie Hamm
Health care workers are assaulted more than police officers and we are expected to just deal with it as part of the job! This is a tool to alert staff of possible aggressive behaviour to try to keep them safe. People seem to think it's ok to yell, swear, pinch, hit etc. the nurses and health care aids who are only there to try to help them when they are in pain or scared. If they did the same thing to a cop they would be charged appropriately for their behaviour. It seems like this reporter would like us to remove our warning tool from our policy for the "rights of the patient". Would he prefer if the health care staff started calling the police and charging every patient who is aggressive? Hospitals and care homes would have to employ full time officers to deal with all the calls they would receive.

Heather Bell *Typically I am an advocate for my patients, but I believe there are consequences for behaviour. If a patient has assaulted a staff member at another facility then there should be a red flag system in place. It does not need to impact care; this is a system to protect staff and alert them to dangerous past behaviour. Nobody has the right to assault a nurse or a health care personnel, zero tolerance for staff abuse means nobody tolerates aggression. This way we know who has hurt others and perhaps are able to put safety precautions in place. This doesn't affect treatment.*



Maggie Moore
Tom Brodbeck sounds like he really doesn't think of nurses as professionals. I'm more than capable of determining if a patient is a violent risk vs swearing at me because he/she is in pain.

Bolanle Abayomi Green *Any patient with a history of aggression and/or a repeated episode will always have a recurrence, no matter how long, especially when it comes to mental illness, both in young and elderly. As a nurse you are defenceless, so preventive interventions are still better than active ones or having had to lose any part of your body or been charged for assault or unintentional murder.*



Laurel Johnson
We have already started the process where I work and it involves a regional assessment tool to determine risk of violence and ongoing monitoring every shift. Our leadership team will ultimately determine if the violent designation is to be maintained. As of yet, there have been no visible flagging of rooms, residents or charts. Only the nursing staff and leadership team have access to the info at this point.

Census of Population Program

Helps determine health and social funding.

Every five years Statistics Canada conducts a Census of Population, which collects demographic information on every man, woman and child living in Canada.

Information from the Census of Population is used in the administration of government programs and in planning pensions, healthcare, employment programs, new schools, public transit, hospitals, daycare centres, etc.

Furthermore, population estimates obtained from the census are used to allocate transfer payments from the federal government to the provinces.

There are four main transfer programs: the Canada Health Transfer (CHT), the Canada Social Transfer (CST), Equalization and Territorial Formula Financing (TFF).

The CHT and CST are federal transfers which support specific policy areas such as health care, post-secondary education, social assistance and social services, early childhood development and child care.

The Equalization program enables less prosperous provincial governments to provide their residents with public services that are reasonably comparable to those in other provinces, at reasonably comparable levels of taxation.

In 2016-17, the Government of Manitoba will receive $3.5 billion through federal transfers.

Participation is mandatory

All residents of Canada are legally required to complete either the short- or long-form census questionnaire. Starting May 2, 2016, Statistics Canada will send census letters and packages to all Canadian households.

You can complete your census questionnaire online or on paper.

Please note, Statistics Canada is bound by law to protect the confidentiality of the information respondents provide in the census. Only Statistics Canada employees have access to census questionnaires.

Yellow Ribbon award

Every year, MNU recognizes those members (either a group or an individual) who have exemplified the spirit of the Yellow Ribbon throughout the year. The Yellow Ribbon has become a symbol throughout Manitoba of MNU Nurses' willingness to stand together in support of each other and as advocates for patient care, and as strong union activists. The Yellow Ribbon award was first awarded during our Standing Up For the Front Lines of Health Care campaign to recognize exceptional grassroots leadership.

The awards will be presented at our Annual General Meeting held each year.

In selecting the recipients of the award, the Selections Committee will take into account the following:

1. The nominee should be an active member of the MNU.
2. The nominee must, through their actions, exemplify the spirit of the Yellow Ribbon. That is, the willingness to stand up for nurses and patients.
3. The nominee should have clearly demonstrated special initiative in standing up for nurses and patients.

The award will only be presented if there is a candidate(s) that clearly meet the specified criteria. Nominations should be received no later than March 31st.

To nominate a MNU member for the Yellow Ribbon Award, visit www.manitobanurses.ca/yellow-ribbon-award.html

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