ON GUARD FOR PUBLIC HEALTH SECURITY

CUPE Local 5430 Submission

to Saskatchewan Health Authority regarding the Review of Health Security Services

CUPE Research

JULY 2018

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INTRODUCTION

CUPE Local 5430 is a provincial local representing almost 14,000 health care workers in Saskatchewan. Our members worked for the five former health regions of: Regina Qu'Appelle, Sunrise, Sun Country, Prince Albert Parkland and Prairie North.

Among our members, CUPE represents about 92 security officers. In addition to these security officers, many of our members who work in maintenance or trades positions often fulfill some of the duties of security services.

We were extremely disappointed that neither the Saskatchewan Health Authority (SHA) nor the consultant conducting this review of security services did not ask for formal input from our union members who daily deal with the health and safety of clients, patients, staff and visitors to our health facilities. CUPE first learned of this review when the VP of Infrastructure for the SHA, Will Drew, was quoted in The Leader-Post in April about the need for a review because of increased violence in health care.

Although the Saskatchewan Health Authority (SHA) did not formally request that CUPE prepare a submission for the security review, we believe it is critical to express our concerns about security services and make recommendations for improved public security services in Saskatchewan health care.

In particular, we are extremely concerned that the goal of this review is to privatize health care security services. The consultant who has been hired to conduct this review did a similar review in Alberta in 2010 and recommended a centralized, mostly-privatized security service, which was implemented in that province.

In this submission, we will show why privatization of security services would be a grave mistake and why the best model is a public security service that is integrated into the public health care system.

Evidence shows that integrating security services into the health care team strengthens the health care team and can reduce potentially violent incidents. It is critical that health care and security staff be trained together so that they can work together effectively.

The Saskatchewan Health Authority has a legal responsibility to provide a safe and secure workplace. It should not, under any circumstances, contract out its responsibilities for safe workplaces.

Status of security services in health in Saskatchewan

In most provincial reviews of health services, the government or health authority releases a consultation paper or an assessment of the status of services being reviewed. With this review of security services, unfortunately, the Saskatchewan Health Association (SHA) has not provided a consultation paper nor an assessment of existing services. In fact, the SHA has not even provided a copy of the mandate of Tony Weeks, the consultant charged with reviewing security services, so we do not know the scope of his review.

We will focus our comments, therefore, on the areas in the province where we represent health care workers and the status of security services in these areas.

Not every area (former health region) in health care has security officers on staff. Even within the areas that have security officers, not all health facilities or communities have security officers. In the areas where there are no security officers on staff, facilities rely on maintenance or trades staff, commissionaires or the local police or RCMP detachment for security.

Region 3 – former Regina Qu'Appelle Health Region

The majority of security officers represented by CUPE are in the former RQHR (about 68). The job description and actual tasks of security officers in Regina are broad and wide-ranging. They provide security to over 30 sites in the area; they respond to alarms and violent incidents, search for missing patients, monitor and manage parking, provide in-house training on defensive and de-escalation techniques, patrol buildings, conduct fire inspections, deliver medications after pharmacy hours, provide morgue services, inspect and maintain the helipad so STARS helicopters can land safely.

Region 4 – former Sun Country Regional Health Authority

There are no security officers who work as health authority staff in this region. Instead, maintenance staff are called by nursing staff to assist in code white situations (violent person), code [yellow] (missing person) and code red (fire incident). Sometimes maintenance staff are asked to hold violent patients down and, at times, nurses simply want their presence in the room to calm down an aggressive or drunk patient. The hospital pharmacy in Estevan has an emergency button that calls directly to the police.

Region 1 – former Prairie North Regional Health Authority

In the former Prairie North RHA, CUPE represents 13 security officers at the Saskatchewan Hospital. Other facilities contract with Commissionaires or rely on maintenance and trades staff when violent situations arise. We understand that the Commissionaires' job

is to monitor and call for assistance from the RCMP – under no circumstances are they allowed to respond or intervene in violent incidents.

Region 5 – former Sunrise Regional Health Authority

The only in-house security staff in this area work at the Yorkton Regional Hospital. CUPE represents about seven security staff who provide support to health care staff in the facility and, in particular, to the mental health unit. No other health care facilities in this area have security services except for Kamsack Hospital and Nursing Home which uses Impact Security, a private company. Previously this facility used Commissionaires but after a person threatened staff in February 2017, stronger security measures were put in place. Impact Security provides services overnight (from 4 p.m., to 4 a.m.) and early morning (from 4 a.m. to 8 a.m.). There is also a Meth Clinic at Kamsack Hospital, which requires security protection.

Region 2 – former Prince Albert Parkland Regional Health Authority

This region does not have paid security officers but instead relies on maintenance staff, Commissionaires and local police to deal with violent and other security-related incidents. In a code white situation, nursing or medical staff will call maintenance to assist. They are not allowed to intervene but are asked to be present to provide a calming effect on the violent patient or member of the public. When a situation becomes dangerous, health staff call the local police.

Electricians on staff also install security devices in health facilities: cameras, card swipes and automatic locked doors. The number of surveillance cameras installed has increased significantly in the last two years, particularly on mental health and detox units. Commissionaires are responsible for monitoring the cameras.

Key security issues in Saskatchewan health care

People come to health care facilities for various health care reasons: an emergency health incident or accident, surgery, treatment for acute illnesses, mental health issues, and for residential long-term care when they can no longer remain independent in their homes. It is ironic that health facilities, places for healing, are not always the safest place to be. Too often, patients and members of the public can assault their care providers or other patients.

Our members working in health care have told us that they are seeing an increase in violence in the workplace, more patients or residents with violent or aggressive behaviours, and increased risks to health providers when patients are engaged in criminal

behaviour. We will briefly describe some of the security issues our members have identified in health care facilities in the province.

Violence against health care staff increasing

Violence should not be part of anyone's job yet members regularly deal with patients and long-term care residents who are verbally abusive, who slap, pinch, punch or spit at them, or who threaten them with violence. Security officers and maintenance staff report that they are often called to assist with violent patients, to calm down agitated patients, and to deal with patients or members of the public under the influence of alcohol or drugs.

We have not been able to obtain provincial statistics on the number of violent incidents against staff in health care facilities but can report on the former RQHR. In March 2017, the health region reported that the number of incidents of violence increased by 74%, or from 307 in 2014-16 to 535 in 2016-17 (RQHR: 2017).

We hope that this review of security services will provide statistics on incidents of violence in health care across the province and examine the trends over the years.

The Saskatchewan Association for Safe Workplaces in Health also reported a dramatic increase in the number of health and safety contraventions for violence in health care workplaces. In 2015, there were 4 contraventions for violence issued, 11 in 2016, and 19 in 2017. We emphasize that these are contraventions of the health and safety legislation and not the total number of violent incidents that took place. The report also noted "all indication from the front line is that violence and aggression is severely under-reported." (Cripps: 2018)

Reports from other provinces show that violence in health facilities is increasing, and has become a critical issue. *The Georgia Straight* paper in Vancouver obtained statistics through access to information requests that revealed that Code White, or violent incidents, more than doubled at Vancouver General Hospital from 306 in 2011 to 482 in 2016 and were projected to increase to 570 in 2017 (Georgia Straight: 2017). In a survey of health care workers in North Bay, Ontario, 85% of nurses and personal support workers said they had experienced physical violence in the past year (Brophy, Keith, Hurley: 2017).

We also know that health care workers are more likely to experience violence at work than workers in other sectors. An article from the *Canadian Medical Association Journal* reports that health workers make up 10% of the labour market in Ontario, yet suffer 30.6% of workplace injuries from violence (CMAJ: 2016). The article points out that violent incidents are under reported because of a "persistent belief that abuse must be tolerated as 'part of the job'".

Patient on patient violence

Patients who come to health facilities for medical treatment sometimes need to be kept safe from other patients or residents and, in some cases, from themselves. Patients with dementia or mental health disorders can suddenly attack another patient or resident for no reason. A W5 television investigation in 2013 reported that across the country, there were over 10,000 cases across the country of residents attacking other residents, sometimes fatally (CTV News: 2013).

Our CUPE members working in security have encountered numerous violent situations. For example, they reported a couple of incidents where a long-term care resident had access to gardening tools and began to aggressively swing a five-foot rake in the dining room threatening residents and staff. The police were called and were able to apprehend the violent resident and remove the rake, which he used as a weapon against the police.

Despite the unpredictable nature of this resident, he still had access to gardening tools and instigated another danagerous incident some months later. This time the resident had a five-foot long pointed spade that he began swinging at residents and staff while yelling threats. The Security Officers responded to the situation, were hit by the shovel, but were able to use a capture shield to control the resident and then remove the shovel. Police were called and removed the violent resident.

In-house Security Officers in the former RQHR are taught defensive tactic techniques along with capture shield training and verbal judo to defuse violent situations and prevent serious injuries.

The heavy workload and understaffing in long term care can also contribute to an increase in violent and aggressive patient or resident behaviour if care cannot be provided in a timely manner.

External threats (public)

There are also many security threats that come from members of the public. A family member may become agitated and aggressive if they feel their loved one is not getting the medical attention they should. Our members have also reported an increase in gang activity, guns and drugs in or around health care facilities. Security officers and trades positions across the province have confiscated guns and drugs from individuals trying to enter the facility. There is a dangerous situation in a long-term care facility in Prince Albert where one of the residents is a known gang member.

Another external security threat is the potential for individuals attempting to steal narcotics, other drugs or personal belongings from health facilities.

Finally, staff or members of the public could face dangerous situations late at night in the parking lot or on the streets near the health facility. Security services in the former RQHR provide safe rides or walks home to anyone who requests assistance.

What do security officers do?

There are two security officer classifications in the CUPE provincial health care agreement: Security Officer (pay band 11) and Senior Security Officer (pay band 13). Both positions require a Security Officer Applied certificate and the Senior Security Officer requires two years experience in security services. The Senior Security Officer plays a leadership role managing the work of security officers and providing training on violence de-escalation strategies and other skills to staff.

The official job description lists the wide-ranging duties and skills of a security officer. The key activities of a security officer fall under three areas:

a. **Provide security for staff, patients, clients and visitors**

- Guard and observe patients, help to locate missing or wandering patients;
- Guard lock-up areas;
- Respond to incidents that occur which may result in injury to persons;
- Defuse violent or aggressive situations;
- Restrain combative patients;
- Ensure patient census is accurate;
- Provide assistance to the safe drive/safe walk programs.

b. **Protect and secure facility and property**

- Monitor security cameras;
- Secure entrances and offices throughout the facility;
- Patrol grounds to deter theft, vandalism, illegal parking and damage;
- Apprehend and detain suspects, remove and document contraband;
- Remove and catalogue dangerous weapons;
- Ensure safety of the hospital and outlying buildings;
- Monitor suspicious activities;
- Respond to all emergencies;
- Escort staff moving cash;
- Manage key control procedures;
- Unlock and lock all doors at regular intervals;
- Enforce parking regulations and control;
- Provide daily and pre-landing inspections of heliport.

c. **Related key work activities**

- Liaise with various professional and community groups (police, fire department);
- Document incidents and activities (e.g. patient activity logs);
- Report incidents to police, agency and/or department when required;
- Issues parking passes, tickets, lockers, keys;
- Count cash;
- Perform photo identification checks;
- Deliver and pick up medications;
- Admits/discharges bodies from the morgue;
- Complete maintenance requisitions;
- Monitor fire systems and check fire equipment;
- Assist with emergency preparedness plan;
- Call codes during emergencies

The above list of job duties goes beyond what a security officer working in a non-health care setting would do. We want to emphasize that the work of our security officers is very specific to health care and complements the tasks of other members of the health care team.

Why a public in-house security is the best model

The best model for security services in health care is an in-house model, in which security staff are employees and integrated as part of the health care team. There is significant evidence showing why this model is the best.

Part of the health care team

A 2015 article in the *Healthcare Quarterly* profiled the success of a workplace violence prevention (WVP) program implemented at Toronto East General Hospital (TEGH). The article highlights many aspects of the WVP including a strong commitment and involvement from senior leadership, strategic partnerships with unions, workplace violence prevention committees, risk assessments, patient flagging, improved incident reporting, employee training and personal support provided to staff after an incident occurs.

Another key aspect of the success at TEGH was the comprehensive in-house training of Protection Services (security) staff in de-escalation and other techniques and the inclusion of security personnel as part of the health care team. The authors write:

> "Healthcare providers engage security personnel to work as part of the patient care team much earlier; **resulting in a 58% reduction in the requirement for security to apply force** from 113 use of force incidents in 2011 to 65 in 2014, and increased success in verbal conflict resolution strategies." (Bujna, Casselman, Devitt, Loverock and Wardrope: 2015)

In other words, when security officers are considered part of the patient care team, they are called upon to de-escalate a potentially violent situation before a critical incident occurs. If security staff is seen as a separate entity, they might not be called until a dangerous situation is already out of control.

Integrating security in health care

A study of security practices in U.S. hospitals concluded that the effectiveness of hospital security is based on security personnel's relationships with other hospital work groups. The study reviewed security practices at 340 U.S. hospitals, which were private, public or non-profit. The majority of hospitals (72%) directly employed in-house security personnel. Although the reality of security in U.S. hospitals is quite different from Canada (such as greater likelihood that security officers have hand guns, pepper spray, and TASERs), the study makes similar conclusions as the study of Toronto's East General Hospital on the importance of interpreting security with other health care staff.

In the U.S. study, the most common recommendation from participants on improving hospital security and workplace violence was to provide more training of security personnel and hospital staff (63% of responses). Participants felt it was critical that security and non-security hospital staff be trained together to improve how they work together to address security and violence in the workplace.

The authors write, "Participants commented on the importance of integrating security programs in a hospital system, rather than independent efforts… We seek to have security in depth and have designed some redundancies into the systems deployed. However, the critical element is an aware and engaged hospital community" (Schoenfisch and Pompeii: 2016).

Why private security in health care is problematic

Contracting-out security services to a private company is contrary to the recommendations made in the studies mentioned above. If the best model is one where security officers are integrated into the health care team, then it makes no sense to privatize security services.

Perception of bias in this review

There is a valid concern that, by appointing Tony Weeks to review security services in the province, the Saskatchewan Health Authority is weighing the scales towards privatization.

It is impossible to view Mr. Weeks as an independent, unbiased individual when it comes to this review of security services. In 2010, Mr. Weeks was in charge of a similar review in Alberta that led to a more privatized model of security services in the province. Paladin Security, the largest security firm in the country, won the provincial contract with Alberta Health Services (AHS). We are deeply concerned that the outcome of this review is already predetermined with the selection of Mr. Weeks. We hope that we are wrong and that a fully public model for security remains in place.

The Alberta experience with privatized security

Mr. Weeks and others may cite the Alberta experience as a model for Saskatchewan but there were and remain many problems with the privatized model: it did not provide the expanded coverage it promised, it did not reduce costs, and there was a loss of public accountability and control over security services. We will expand on these points.

- ### Privatization does not improve security coverage

Prior to the formation of the new provincial health authority in Alberta, security services were fragmented. In three health regions (Calgary, David Thompson and Northern Lights) had in-house unionized security, two regions (Aspen and East Central) had no security staff or coverage at all, three regions (Chinook, Palliser and Peace Country) had contracted security, and the Capital region had a hybrid of in-house and contracted security (Alberta Labour Relations Board: 2011).

One of the stated goals in the restructuring of protective services in Alberta was to improve security coverage across the province. Alberta Health Services said that with the new hybrid model, 100 percent of hospitals, or an additional 72 hospitals, would have access to security services (AHS: 2010).

A rural newspaper at the time reported: “Weeks said the switch is part of a new seven day a week, 24-hour, province-wide security control centre that covers alarms, security cameras and dispatching for all of Alberta’s acute care facilities. He said the changes would save money and provide coverage to areas that previously has no security, as well as providing a level of cohesion.” (*High River Times*: 2010)

Instead of hiring more security officers to meet expanded coverage, the Alberta Union of Provincial Employees (AUPE) reported that more than 100 security positions were

eliminated (AUPE:2009). The Union of Nurses of Alberta (UNA) more recently reported that rural hospitals are not being adequately serviced by Paladin Security. In their February 2013 newsletter, UNA reported that Paladin Security Officers often do not show up at rural health facilities when called or that their officers leave at the end of their shift without being replaced (UNA:2013).

The United Nurses of Alberta reported that, after years of raising concerns about inadequate security services, Alberta Health Services was entering into a contract with a security service provider to improve rural security (UNA: 2017). Our search on the AHS website showed a contract worth $8 million was awarded to Paladin Security Group to "develop a strategy to improve the Watch Services component of the RFP." It appears that Paladin was provided $8 million to come up with a solution to address the inadequacies of the Paladin security contract.

- **Privatized security does not reduce costs**

When it announced the new security model, AHS boasted it would save $3.5 million in annual costs (AHS: 2010). AUPE requested a copy of the security business case but it was not released and cannot be found on the Alberta Health Services website. There has not been transparency about the true cost for security services in Alberta but we expect, like many privatized services, the contract costs have increased and there have not been savings.

We have not been able to obtain a copy or the cost of the initial contract with Paladin, but found the value of the one-year renewed contract with Paladin from April 1, 2015 to March 31, 2016 was worth $18,584,558 (AHS website). We do not know how much the cost increased since the initial contract. It is important to note that in October 2016, AHS gave an additional six-month contract to Paladin worth $8 million – almost half the annual Paladin contract --to develop a strategy to improve rural security services. Considering this amount, we think it is implausible that AHS has saved $3.5 million annually on security services. It is more likely that overall costs increased.

We also would like to know the cost of maintaining a parallel public structure through the development of Community Peace Officers. The hybrid model for security services in Alberta comprises the private Paladin security contract and the use of in-house Community Peace Officers who have the powers to arrest and act on provincial statutes such as the *Gaming and Liquor Act*, *Mental Health Act, Trespass to Premises Act* and the *Tobacco Reduction Act* (AHS: 2010). How many Community Peace Officers and security managers exist within AHS? What is the total budget for the public provision of security services, separate from the Paladin contract?

- **Lack of accountability and public control with privatized services**

When Paladin Security responded to the initial Request for Proposal (RFP) from Alberta Health Services, it rejected key elements outlined in the RFP by AHS. This raises concerns about the ability of private security staff to work in a collaborative way within a public health care model.

AHS wanted to be able to hire, train and direct Paladin security officers but Paladin refused and insisted on maintaining control of all aspects of security operations. As outlined in evidence at a labour board hearing (Alberta Labour Relations Board: 2011), Paladin wanted to have complete control and authority to:

- Recruit and hire employees;
- Provide its own proprietary security training program. Paladin "opposed centralized training and the concept of AHS conducting training of Paladin employees.";
- Direct and control its employees through its own shift supervisors and managers (Paladin refused to have its employees report to AHS team leads);
- Schedule its own staff using its own software;
- Use its own incident reporting software system rather than use the AHS system.

The position of Paladin Security is contrary to the studies we referred to earlier in this submission that the best security model is one where security officers are integrated into the health care team. The studies we cited discuss the importance of providing the same training to all health care staff and security. Paladin Security, however, would not allow this to happen.

It is also critical that there be common incident reporting forms that managers and health and safety committees can review and from which make recommendations. It is completely counterproductive to have a separate private security agency developing its own incident reporting systems that are proprietary and not part of a coordinated Violence Prevention Strategy.

The fact that Paladin hires, fires and manages its own security staff leaves the public health care system without the flexibility to adjust the security workforce, amend or expand job descriptions as new situations arise or to ensure collaboration with other health care staff. As the current job description for security officers in the CUPE agreement in Saskatchewan illustrates, security officers do a broad range of tasks that meet the needs of health care facilities that would be eliminated from the job duties of a private security staff. This could result in the SHA having to hire additional staff to do those tasks that used to be done by in-house security.

Overall, privatized security services results in less flexibility, less public accountability for the services provided and a major loss of public control over a critical part of the health care workforce.

- **Paladin Security**

We are also concerned that decision makers are already leaning toward a province-wide contract to Paladin Security. Paladin already has developed the camera security systems in two of the former health regions. Paladin Security received $356,122 from the Prairie North Regional Health Authority (PNRHA) from 2013-14 to 2016-17. BMS Integrated Services, which was bought out by Paladin Security in 2015, had contracts with Regina Qu'Appelle Health Region (RQHR) over three years worth over $1 million.

Year	PNRHA payment to Paladin Security	RQHR payments to BMS Integrated Services
2013-14	$82,212	
2014-15	$92,815	$57,107
2015-16	$98,078	$657,307
2016-17	$83,017	$295,874
TOTAL	$356,122	$1,010,288

Source: Annual Reports PNRHA and RQHR, 2013-14 to 2016-17

We are also concerned about the aggressive series of acquisitions made by Paladin Security – five in 2017 alone – that has made it the largest security firm in the country. In February 2017, the company acquired Victoria-based KC Security Services and then merged with Marcomm Systems Group Inc., and CONTAVA. IN March 2017 Paladin acquired B.C.-based Concord Security and Parking and later in March bought out an American company, Criterion Security. Paladin now has over 10,000 employees in nine provinces and 16 states.

Paladin is not a publicly-traded company and therefore its financial information is not public. With all of the acquisitions, it will aggressively be searching for new contracts to secure its profitability. When a company has a near monopoly in a service, it can negotiate the terms it wants and the Saskatchewan Health Authority will be a "price taker". Even if the SHA can negotiate favourable terms in the first contract, it will be powerless against a near monopoly company in the future.

CONCLUSION

In our submission we have made the case for maintaining security services as an in-house, publicly-managed service. Safe and secure workplaces are critical in health care and the best model is a security regime that is integrated into the public health system and where security services are seen as part of the health care team.

Evidence shows that violence in health care facilities is increasing in this province and across the country. The reasons for increased violence are numerous. But the approaches the Saskatchewan Health Authority takes to ensure patients, residents and workers are safe in health care must be strategies that engage everyone to find collaborative solutions. Team work and collaboration is key.

Security services play an important role in health care and our in-house staff do much more than provide muscle at the door. They are trained on how to de-escalate potentially violent incidents, they support health care teams with aggressive patients or residents, they serve as secure porters of medications after hours, they ensure the physical surroundings are safe for everyone and that the STARS helicopters can make emergency landings in accordance with federal regulations.

Contracting-out your responsibility for secure and safe workplaces to a private company is not the solution. Private security officers will not be integrated into the health care team, they will not collaborate with other health care workers to reduce potentially dangerous situations, and they will not go beyond their defined job description.

We urge the Saskatchewan Health Authority to maintain and improve public, in-house security services in the province.

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SUMMARY OF RECOMMENDATIONS

The Canadian Union of Public Employees recommends that the Saskatchewan Health Authority:

Recommendation #1:

Keep security services in the province public and under the direction of the Saskatchewan Health Authority.

Recommendation #2:

Expand the number of security officer positions in the province to areas that currently have no, or minimal coverage.

Recommendation #3:

Develop a provincial data base of workplace violence incidents and issue an annual report that shows the trends in violent incidents and what approaches the SHA is taking to address violence in the workplace.

Recommendation #4:

Ensure strong and consistent workplace violence policies are in place and encourage workers to report incidents, even if there is no time loss.

Recommendation #5:

Genuinely involve workers and their unions in the development and regular review of workplace violence policies. Section 3-21 of the *Saskatchewan Employment Act* (SEA)outlines the employer's responsibility to develop, *in consultation with workers*, a policy to prevent workplace violence. There should be a recognition that different facilities and regions will have unique circumstances and challenges that require different responses and procedures.

Recommendation #6:

Streamline the process and incident forms for reporting violent incidents in health care facilities. Staff should not be burdened with filling out three to five forms when a violent incident occurs. There should be one form that can be shared to all who need to review and act on the report, from managers to health and safety committees.

RESOURCES

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