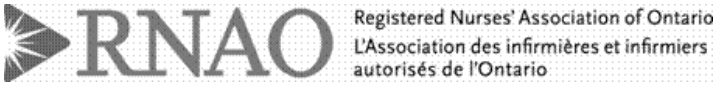
Dignity, Security, Safety and Comfort for All: Long-Term Care Homes Act, 2006

Submission to the Standing Committee on Social Policy

January 16, 2007

Registered Nurses' Association of Ontario (RNAO)



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List of recommendations

1. Amend the preamble to include a commitment to upholding the principles and conditions of the Canada Health Act; and to promoting and supporting not-for-profit provision of long-term care.

2. Strengthen Part VII by incorporating in Section 93 a governing principle of supporting not-for-profit ownership of long-term care homes so as to meet the commitment to promote not-for-profit care.

3. Strengthen Part VII, by including a right of first refusal for not-for-profit homes in any granting of new beds. This would include any provisions for competitive bidding under Section 113 and any undertaking to issue a license under Section 98.

4. Amend Section 113 to ensure that any competitive process should not disadvantage the establishment of not-for-profit homes or reduce the number or share of not-for-profit beds in Ontario.

5. Exempt from Section 177 members of boards or directors of not-for-profit licensees. In the event of a conviction under the Act, these Board members should be subject to a maximum fine of $1,000 and no imprisonment.

6. Include corresponding collective rights for all residents in the Residents' Bill of Rights, in the event that the exercise of individual resident rights conflicts with the safety or wellbeing of other residents.

7. Extend the right of enforcement of the Residents' Bill of Rights to family members and advocates, given that many residents are not able to advocate for themselves.

8. Add a right to long-term care for all who need it, including an obligation for government to measure long-term care need, to report on progress in meeting it, and to guarantee and provide access to long-term care for all who require it.

9. Create an independent Elder Health Ombudsperson's Office, to receive and process complaints, both from long-term care residents and from other seniors.

10. Guarantee the independence of Residents' and Family Councils by flowing funding and support through a third party such as an Elder Health Ombudsperson or the Advocacy Centre for the Elderly.

11. Require licensees to give board minutes, and copies of regulated standards to Residents' and Family Councils. Allow Councils to speak with inspectors.

12. Make available to Residents' and Family Councils: reports on expenditures from all funding envelopes; level of care needs; facility and funding agreements; and inspection and compliance reports.

13. Include both physical and chemical restraints in the requirement for a written policy on minimization of restraints.

14. Require long term care facilities to have defined policies and procedures for administering chemical restraints. These should include: obtaining informed consent from the resident or the substitute decision-maker prior to the administration of a chemical restraint; the rationale for inclusion of a chemical restraint in the plan of care; and, a requirement for regular review of the continued use of chemical restraints that involves residents and families in decision making.

15. Consider perimeter barriers to be safety measures and delete the phrase 'unless the resident is prevented from leaving' from Section 28(5).

16. Include in the legislation a statement that the objective of mandated data collection is to efficiently and effectively deliver improved quality of care, oversight and accountability. The required data should be specified in regulation, after open public consultation. By putting this in regulation, data requirements can more readily be adapted to needs that change over time.

17. Include in data collected: staff-to-resident ratios, the number of registered nursing hours per resident, the number of registered practical nursing hours per resident, and the number of non-registered nursing care hours per resident. Determine whether the levels of care provided are meeting the assessed needs of residents.

18. To avoid unintentionally reducing services, enhance funding to cover a fair share of the costs of the additional requirements. An open public consultation process about regulations on these new requirements would help to both refine additional requirements as well as identify the costs that must be shared by government.

19. Reinstate a minimum standard of care in long-term care, and set that standard at 3.5 hours per resident per day.

20. The Minister shall provide for formal agreements between long-term care homes and universities, community colleges, and professional associations to jointly provide financial support for the training of health care workers in the care of the elderly. The Ministry of Health and Long-term Care shall provide through a funding formula outside the formula for resident care that provides financial support to enable all long-term care homes to participate in these teaching arrangements. Long-term care homes provider and professional associations shall be invited to participate in the development and promotion of such affiliation agreements.

21. Amend Bill 140 by adding Section 38 from Bill 36 which requires public consultation before making regulations.

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional organization for registered nurses who practice in all roles and sectors across Ontario. Our mandate is to advocate for healthy public policy and for the role of nursing in shaping and delivering health services. RNAO is pleased to present this submission on Bill 140, the *Long-Term Care Homes Act,* 2006, to the Standing Committee on Social Policy.

Bill 140 is an ambitious and complex piece of legislation. It would roll together the three Acts governing the long-term care sector: the *Nursing Homes Act*, the *Charitable Institutions Act* and the *Homes for the Aged and Rest Homes Act*. The Bill's fundamental principle is that long-term care accommodations are residents' homes, and should be operated so that residents have dignity, security, safety and comfort.

RNAO endorses this principle, and offers this submission in the hope that the resulting legislation realizes the stated principle. In writing its submission, RNAO is guided by its own set of principles:

- Long-term care is an essential health care service, and should be delivered as part of Canada's universally accessible health care system.
- Not-for-profit health care delivery should be supported by the Bill.
- Long-term care residents should receive strong individual and collective protection under the Bill, and should be empowered by the Bill to control their lives to the greatest feasible extent.
- Both long-term care facilities and the government owe transparency and accountability to residents, to residents' families, and to the public.
- Adequate standards of care in long-term care should be specified in this legislation.
- There must be sufficient funding for long-term care to realize adequate standards of care and to pay for accountability requirements. The government must, at minimum, meet its 2003 campaign commitment to increase funding in the sector by $6,000 per resident per year.
- Facilities' reporting requirements should be chosen to efficiently and effectively realize our multiple objectives: accountability and oversight; protection of residents' rights; and a high quality of life for residents.
- There must be adequate public consultation about the Bill itself, as well as any related regulations.

Bill 140 takes a number of steps to protect resident's rights and to enhance accountability and oversight. As it is a large and complex piece of legislation, stakeholder consultation is crucial to ensuring that provisions in the Act will best realize its stated objectives. In the following, RNAO reviews some key elements of the Bill and suggests amendments.

A. RNAO's Approach to Long-Term Care and Elder Care

RNAO believes that reform of long-term care must occur in the context of overall seniors' strategy and elder health framework. Long-term care legislation must be a part of a health care transformation focusing on health promotion and quality of life.[1] We support

an inclusive Bill of Rights for older persons as part of an elder health strategy to benefit all older persons, and not just those in long-term care homes.

RNAO endorses the principles of the National Forum on Ageing:

1. Dignity
2. Independence
3. Participation
4. Fairness
5. Security

Policy and service delivery decisions should be guided by the core values of healthy ageing, ageing in place and choice for older persons. In the case of long-term care facilities, this implies a resident-centred philosophy. These facilities require sufficient staff, including caregivers who are appropriately educated to provide effective and culturally sensitive care. This would include adequate levels of regulated staff. The preferred model would include nurse practitioners in each facility, and registered nurses to provide clinical leadership.[2] Moving towards 70% full-time employment for nurses in long-term care is particularly important for: continuity of care, early detection of complications, commitment to resident-centred care, and positive relationships between nurses and residents. Quality of care is enhanced by staff access to advanced practice nurses, orientation programs and ongoing education.

B. Supporting Not-For-Profit Delivery

Based on outcomes research and values that include health care as a fundamental human right,[3] RNAO has long been a supporter of not-for-profit delivery of health care.[4] There is a strong tradition of support for this stand in Canada, which is reflected in the stance of Canada's leadership. Commissioner Roy Romanow in his final report called for not-for-profit delivery of health care services.[5] The Ontario government has demonstrated its commitment to Medicare and not-for-profit delivery through legislation such as the *Commitment to the Future of Medicare Act* and *Local Health System Integration Act*.

Nevertheless, in Ontario, the trend has been towards increasing for-profit delivery of long-term care. Over 65% of the 20,000 new beds awarded in Ontario went to for-profit agencies, raising the share of for-profit beds to 52% from 48%.[6]

There is considerable evidence on the differences between for-profit and not-for-profit delivery in the long-term care sector. Canadian evidence found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,[7] and health outcomes were better in not-for-profit facilities.[8] [9] As one set of researchers concluded, differences in staffing were likely to result in the observed differences in health outcomes.[10] A review of North American nursing home studies for 1990 to 2002 similarly concluded that for-profit homes appeared to deliver poorer quality care in a number of process and outcome areas.[11]

These results are consistent with the literature on for-profit and not-for-profit delivery. A systematic review and meta-analysis of all available peer-reviewed literature on for-profit vs. not-for-profit health care delivery has served to eliminate all reasonable doubt about the evidence. The first two papers produced by this review showed that people were more likely to die in for-profit than not-for-profit hospitals[12] and haemodialysis units.[13] The third article concluded that for-profit health hospitals charge significantly more than not-for-profit hospitals – 19% more.[14] Research has come to the same conclusion about health plans: a study of plans enrolling American Medicare beneficiaries found that not-for-profit plans delivered higher quality care in all four clinical services assessed.[15]

As written, the Bill does very little to support not-for-profit provision of long-term care. RNAO calls for four steps to enhance this dimension of the Bill:

1. **Amend the preamble to include a commitment to upholding the principles and conditions of the Canada Health Act; and to promoting and supporting not-for-profit provision of long-term care.**

2. **Strengthen Part VII by incorporating in Section 93 a governing principle of supporting not-for-profit ownership of long-term care homes so as to meet the commitment to promote not-for-profit care.**

3. **Strengthen Part VII, by including a right of first refusal for not-for-profit homes in any granting of new beds. This would cover any provisions for competitive bidding under Section 113 and any undertaking to issue a license under Section 98.**

4. **Amend Section 113 to ensure that any competitive process should not disadvantage the establishment of not-for-profit homes or reduce the number or share of not-for-profit beds in Ontario.**

We are concerned about the impact of the Bill on volunteer directors of not-for-profit long-term care homes. Section 67 obliges all directors and officers to take all reasonable care to ensure compliance with the Act, while Section177 establishes penalties for individuals and corporations convicted for offences under the Act. The Bill would expose directors and officers of not-for-profit licensees to the possibility of substantial fines (up to $25,000) and lengthy prison terms (up to a year). This would be a serious disincentive to becoming a volunteer board member of a not-for-profit long-term care home.

Instead, RNAO recommends**:**

5. **Exempt from Section 177 members of boards or directors of not-for-profit licensees. In the event of a conviction under the Act, these Board members should be subject to a maximum fine of $1,000 and no imprisonment.**

C. Residents' Rights, Care and Services

The **Residents' Bill of Rights** in Section 3, provides a comprehensive list of rights, similar to those in the predecessor Acts. The rights are enforceable by the residents, although there are no penalties associated with failure to protect these rights. Moreover, these rights are not enforceable by family members or other advocates.

RNAO makes the following recommendations to strengthen these rights:

6. **Include corresponding collective rights for all residents in the Residents' Bill of Rights, in the event that the exercise of individual resident rights conflicts with the safety or wellbeing of other residents.**

7. **Extend the right of enforcement of the Residents' Bill of Rights to family members and advocates, given that many residents are not able to advocate for themselves.**

8. **Add a right to long-term care for all who need it, including an obligation for government to measure long-term care need, to report on progress in meeting it, and to guarantee and provide access to long-term care for all who require it.**

Bill 140 imposes a series of requirements on behalf of residents. It requires licensees to assure residents' right to safety and security. The Bill specifies a range of required organized programs of care and services. These include nursing and personal support (with a reaffirmation of the requirement for 24-hour RN care); restorative care; recreational and social activities; dietary services and hydration; information and referral assistance; accommodation services (housekeeping, laundry, and maintenance); and a volunteer program. There is a requirement that the facilities be clean and sanitary; that equipment be in a safe condition and in good repair; and that residents' linen and clothing be collected, sorted, cleaned and delivered.

RNAO welcomes the strong protections. It urges the Committee to consider the concerns of home operators when refining the language around some of the protections and obligations. For example, under Section 17, there are concerns that an obligation to protect residents from abuse *by anyone* is not feasible, given a competing obligation to protect privacy of residents.

The Bill would provide protection to whistle blowers, be they residents or employees. RNAO supports this, as the Association has been calling for whistleblower protection for the health care system since 1998.[16] The Bill would also bar any action that sought to discourage reporting of complaints. Under the Bill, an inspection must be ordered under a number of circumstances, including: actions resulting in or risking harm to residents and violations of whistle-blower protection. Inspectors should be explicitly given the power to speak with residents, families and staff, as well as administrators.

Under the Bill, the Minister may create an Office of the Long-Term Care Homes Resident and Family Adviser. The Office would assist and provide information to residents, families and others, and would advise the Minister on issues affecting

residents. The step is welcome, but RNAO would prefer the creation of an Office of an Elder Health Ombudsperson, which could receive and process complaints.

9. Create an independent Elder Health Ombudsperson's Office, to receive and process complaints, both from long-term care residents and from other seniors.

D. Residents' and Family Councils

The Bill would require each facility to ensure establishment of a Residents' Council, and appoint an acceptable assistant to the Council. The Bill would also require each facility to assist in establishing a Family Council when requested by a family member, former resident, or person of importance to a resident. Both Councils' powers would include: advising residents of their rights; resolving resident-licensee disputes; recommendations; activities; and review of inspection reports and funding allocations.

RNAO supports the creation of these Councils, and calls for the following measures to strengthen them:

10. Guarantee the independence of Residents' and Family Councils by flowing funding and support through a third party such as an Elder Health Ombudsperson or the Advocacy Centre for the Elderly.

11. Require licensees to give board minutes and copies of regulated standards to Councils. Allow Councils to speak with inspectors.

12. Make the following information available to Residents' and Family Councils: reports on expenditures from all funding envelopes; level of care needs; facility and funding agreements; and inspection and compliance reports.

E. Restraints

Section 27(1) of the Act requires a written policy to minimize use of restraints and describes when they can be used. It also describes the circumstances when personal assistance service devices (PASD) may or may not be used.

Several studies have found that restraints increase the severity of falls and can increase confusion, muscle atrophy, chronic constipation, incontinence, loss of bone mass and decubitus ulcers.[17] Restraint use is also linked to emotional distress, including loss of dignity and independence, dehumanization, increased agitation and depression. In severe cases, clients have been seriously injured or have died after becoming entrapped in a restraint such as bed rails. Coroners' inquests in North America have cited the use of restraints as the cause of numerous deaths due to strangulation. There are no studies that demonstrate that the use of restraints results in increased client safety. [18] RNA0

strongly supports the requirement of a written policy to minimize the restraining of residents.

Section 28(4) states that *"the administration of a drug or pharmaceutical agent to a resident as a treatment set out in the resident's plan of care is not a restraining of the resident."* We are concerned about potential lack of informed consent prior to administration of anti-psychotics. Unlike physical restraints, chemical restraints are not necessarily obvious and family or substitute decision makers may be unaware that they are being administered to the resident. We are also concerned that the strong limitations on physical restraints and lack of any limitation on chemical restraints could result in an increased reliance on chemical restraints in these facilities.

RNAO recommends**:**

13. Include both physical and chemical restraints in the requirement for a written policy on minimization of restraints.

14. Require long term care facilities to have defined policies and procedures for administering chemical restraints. These should include: obtaining informed consent from the resident or the substitute decision-maker prior to the administration of a chemical restraint; the rationale for inclusion of a chemical restraint in the plan of care; and, a requirement for regular review of the continued use of chemical restraints that involves residents and families in decision making.

RNAO supports the use of perimeter barriers as a mechanism to enhance the safety of those living in long term facilities and supporting freer movement of residents. As a result, we are concerned with the portion of section 28(5) that reads 'unless the resident is prevented from leaving'. It is imperative that consideration is given to the health and safety of all residents in long term care facilities including those with impaired judgment such as those suffering from Alzheimer's disease and related dementias. Often it is necessary to prevent these individuals from leaving the facility because of a threat to their personal safety. If perimeter barriers are not permitted, the confinement of movement by a more intrusive mechanism may be required to ensure safety.

RNAO recommends:

15. Consider perimeter barriers to be safety measures and delete the phrase 'unless the resident is prevented from leaving' from Section 28(5).

Successful implementation of a least restraint policy will result in significant increases in workload for staff including: direct care, documentation and evaluation of interventions. In order to meet these legislated requirements and to provide the kind of support and care that Ontarians living in long term care deserve, it is imperative that there is increased support to the long term care sector.

F. Accountability and Oversight

Accountability is essential with all uses of public money, and long-term care is no exception. The population served in long-term care is vulnerable and requires enhanced protection and oversight. Bill 140 seeks to deliver strong protection for residents of long-term care homes, and to impose uniform standards on licensees. The drafters of the Bill have been mindful of the importance of mandatory reporting; voluntary reporting has been shown to allow poor performers to conceal their poor performance.[19] It is very important to carefully choose what must be reported. The choices must efficiently and effectively deliver improved quality of care, oversight and accountability.

RNAO believes that standards must be specified and met, and that there must also be mechanisms for improving performance of all facilities. Data must be collected to identify best practices, and both high and low performers. That data must be used to help low-performers to improve and reward high performers. Better information makes it easier to compare facilities and pinpoint problems. RNAO's recommendations are consistent with those of the Canadian Healthcare Association, who suggest the following measure to improve quality of care in long-term care facilities:[20]

- Improve collection of information on staffing ratios, level of care being delivered, admission waiting lists, discharges, deaths, health of residents and quality of care.

- Conduct research and education within long-term care facilities to evaluate and improve care.

- Widely implement practices that have been shown to result in high quality care.

- Develop and promote minimum standards of care through accreditation and appropriate licensing of long-term care facilities. Accreditation means that facilities have to meet certain standards for environment, programming and developing home-like atmospheres. Licensing will help protect vulnerable citizens from receiving care in unregulated facilities and prevent cases of abuse/neglect.

Accordingly, RNAO recommends:

16. Include in the legislation a statement that the objective of mandated data collection is to efficiently and effectively deliver improved quality of care, oversight and accountability. The required data should be specified in regulation, after open public consultation. By putting this in regulation, data requirements can more readily be adapted to needs that change over time.

17. Include in data collected: staff-to-resident ratios, the number of registered nursing hours per resident, the number of registered practical nursing hours per resident, and the number of non-registered nursing care hours per resident. Determine whether the levels of care provided are meeting the assessed needs of residents.

G. Finance

There has been a general consensus that funding has lagged need in long-term care, as implicit in the 2004 Provincial Auditor's report.[21] Unfortunately, long-term care is not yet covered under the *Canada Health Act*, and there is not yet an obligation under the Act on provinces to adequately fund the sector. The government has increased funding to the sector as part of its promise to raise spending $6,000 per resident per year. We expect the government to meet that commitment.

Providers of long-term care argue that the Bill is highly prescriptive and would greatly increase reporting and compliance requirements. It must be recognized that there will be costs associated with these additional requirements. For not-for-profit providers, this will necessarily come out of existing programs, unless there is a corresponding increase in funding.

18. To avoid unintentionally reducing services, enhance funding to cover a fair share of the costs of the additional requirements. An open public consultation process about regulations on these new requirements would help to both refine additional requirements as well as identify the costs that must be shared by government.

Furthermore, there is a need to review the adequacy of base funding to meet the assessed needs of residents. Concerning per diem funding, the 2004 Provincial Auditor's report called on the Ministry to:[22]

- verify the reasonableness of the current standard rates for each funding category and develop standards to measure the efficiency of facilities providing services;
- track staff-to-resident ratios, the number of registered-nursing hours per resident, and the mix of registered to non-registered nursing staff and determine whether the levels of care provided are meeting the assessed needs of residents; and
- develop appropriate staffing standards for long-term-care facilities.

Full action on these recommendations would strongly address needs in the sector. Until 1996, the minimum standard of care was legislated at 2.25 hours per resident per day. It is time to reinstate a minimum standard of care.

19. Reinstate a minimum standard of care in long-term care, and set that standard at 3.5 hours per resident per day.

H. Operation of Homes

In accordance with regulations, licensees would be expected to limit the use of temporary, casual or agency staff. RNAO welcomes all measures that would limit the use of temporary, casual or agency staff.

The Bill specifies a lengthy list of areas in which licensees are required to train staff, including: the Resident's Bill of Rights; the home's mission statement; the home's policy

for zero tolerance of abuse and neglect; the duty to make mandatory reports; the policy on minimizing restraints; and other health and safety procedures. RNAO welcomes these measures, but cautions that sufficient funding is required for training, and there must be a mechanism to assure that there will be staff coverage during training absences.

RNAO recommends:

20. The Minister shall provide for formal agreements between long-term care homes and universities, community colleges, and professional associations to jointly provide financial support for the training of health care workers in the care of the elderly. The Ministry of Health and Long-term Care shall provide through a funding formula outside the formula for resident care that provides financial support to enable all long-term care homes to participate in these teaching arrangements. Long-term care homes provider and professional associations shall be invited to participate in the development and promotion of such affiliation agreements.

I. Public Consultation on Regulations

Given the complexity and scope of the Bill, the intended and unintended consequences of the Bill will significantly impact a range of stakeholders. RNAO urges the Committee to consider carefully suggestions of stakeholders when refining provisions in the Act, so that the following goals are met efficiently and effectively: protection of residents; quality improvement; oversight; and accountability. There should be a full public consultation process about any related regulations. Bill 36, the, provides a template for consultation on regulations.

21. Amend Bill 140 by adding Section 38 from Bill 36 which requires public consultation before making regulations.

[1] See: Registered Nurses' Association of Ontario. (2004). Letter addressed to Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care. December 15, 2006. Retrieved January 10, 2007, from http://www.rnao.org/Page.asp?PageID=122&ContentID=1094.
[2] Ibid. The RN role entails ensuring achievement of standards of care that address all resident needs: physical, psycholsocial and spiritual. That includes setting caregiving goals, identifying relevant care practices for the residents, mentoring, coordinating services and providing supervision.
[3] Registered Nurses' Association of Ontario. Mission Statement. Retrieved January 15, 2007, from http://www.rnao.org/Page.asp?PageID=122&ContentID=615&SiteNodeID=108&BL_ExpandID=
[4] Note: for the purposes of this document, unless otherwise specified, not-for-profit provider refers to not-for-profit nursing homes, charitable homes for the aged, and municipal homes for the aged.
[5] Commission on the Future of Health Care in Canada. (2002). *Building on values: The future of health care in Canada.* November.
[6] Ontario Association of Nonprofit Homes and Services for Seniors. (2006). *OANHSS Remarks to Standing Committee on Social Policy: Bill 136*. January 30, p. 7.
[7] The study was based on evidence from British Columbia. McGregor, M. J., Cohen, M, McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M., Ronald, L., Cvitkovich, Y., & Beck , M. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter?, *Canadian Medical Association Journal*, 2005; 172: 645-649
[8] This study is based on evidence from Manitoba. Shapiro, E., & Tate, R. B. (1995). Monitoring the outcomes of quality of care in nursing homes using administrative data. *Canadian Journal of Aging* 14: 755-768.
[9] McGregor, M. J., Tate, R. B., McGrail, K. M., et al. (2006). Care outcomes in long-term care facilities in British Columbia, Canada: Does ownership matter? *Medical Care*, 44: 929-935.
[10] McGrail, K. M., McGregor, M. J., Cohen, M., Tate, R. B., & Ronald, L. A. (2007). For-profit versus not-for-profit delivery of long-term care. *Canadian Medical Association Journal*, *176*: 57-58.
[11] Hillmer, M. P., Wodchis, W. P., Gill, S. S., Anderson, G. M., & Rochon, P. A. (2005). Nursing home profit status and quality of care: Is there any evidence of an association? *Medical Care Research and Review*, *62* (2), 139-166.
[12] Devereaux, P. J., Choi, P. T., Lacchetti, C., Weaber, B., Schunemann, H. J., Haines T., et al. (2002). A systematic review and meta-analyss of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*, *166* (11), 1399-1406.
[13] Devereaux, P. J., Schunemann, H. J., Ravindran, N., Bhandari, M., Garg, A. X., Choi, P. T., et al. (2002). Comparison of mortality between private for-profit and private not-for-profit haemodialysis centres: a systematic review and meta-analysis. *Journal of the American Medical Association*, *288* (19), 2449-2457.
[14] Devereaux, P. J., Heels-Andell, D., Lacchetti, C., Haines, T., Burns, K. E. A., Cook, D. J., et al. (2004). Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *Canadian Medical Association Journal*, *170* (12), 1817-1824.
[15] Schneider, E. C., Zaslavsky, A. M., & Epstein, A. M. (2005). Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries. *American Journal of Medicine*, *118*: 1392-1400.
[16] Registered Nurses' Association of Ontario. (1998). Putting Out the Health Care Fire: A Proposal to Re-invest in Nursing Care in Ontario. Submitted to Premier Michael D. Harris, March, p. 16.
[17] Registered Nurses' Association of Ontario. (2002). Prevention of Falls and Fall Injuries in the Older Adult. *Nursing Best Practice Guideline*. Author.
[18] College of Nurses of Ontario. Practice Standard on Restraints. Author.
[19] Thompson, J. W., Pinidiya, S. D., Ryan, K. W., McKinley, E. D., Alston, S., Bost, J. E., et al. (2003). Health plan quality-of-care information is undermined by voluntary reporting. *American Journal of Preventive Medicine*, *24* (1), 62-70.
[20] Canadian Healthcare Association. (2004). S*titching the patchwork quilt together: facility-based long-term care within continuing care.* Endorsed by the National Advisory Council on Aging.
[21] 2004 Annual Report of the Office of the Provincial Auditor of Ontario, 385-386. Retrieved January 12, 2007, from http://www.auditor.on.ca/en/reports_en/en04/404en04.pdf.
[22] Ibid, 385.