



Residential Aged Care

Communiqué

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Next issue: February 2017



MONASH University



EDITORIAL

Welcome to our 40th issue as we celebrate our 10 year anniversary.

Over those 3653 days we have had many nervous and exciting moments. The support and generosity from the Ageing and Aged Care Branch of the Department of Health and Human Services (Victoria) has been amazing and without them we would not exist. The support of our subscribers and readers keeps us going to seek new ways of conveying information to improve the lives of patients, residents, family, friends and strangers. The movie 'Happy Feet' was a huge success in 2006 and in comparison our entry into the media was very low key.

Like 'Mumble' we wanted to do something out of the ordinary, to follow our heart to help the people at the point of care deliver the standard of care they would want for their loved ones. With two left feet we danced awkwardly, rather than sashaying, through the various obstacles. The wise counsel of friends and colleagues allowed us to overcome each obstacle to continue the production of the Residential Aged Care Communiqué (RAC Communiqué).

It is important to acknowledge that it is only through the support of the Coroners Courts throughout Australia and Ontario Canada that we were able to bring you the case reports.

The RAC Communiqué has had four formal evaluations published in academic journals. Over half of our subscribers (55.6%) reported changing their practice because of the information in this publication. Another measure of the worth of the RAC Communiqué is that we are registered at the National Library of Australia as being of national significance.

This is a 'bumper issue', almost two issues in one. We are extremely fortunate to have reflections and commentaries from experts in their field. You may not agree with all they have written but it is well worth your time to look at each commentary and discuss with staff and colleagues.

Rhonda Nay and Terrona Ramsay look back on the changes in aged care, Sue Evans guides us through the changes that have occurred in health care which continue to influence practice in aged care, and finally David Ranson explains changes in the forensic investigation processes.

Furthermore we have also gone through the archives to include three contributions that emphasise the reasons the RAC Communiqué exists and needs to continue. We have picked cases which cover topics commonly in play in aged care.

First we revisit a case from the first issue covering the use of physical restraints with the hope that it reminds us of the need to promote a restraint free environment.

Our second case demonstrates the complexity of care and how we address risks associated with respecting a resident's choice.

Finally, we revisit a commentary highlighting the importance of good communication between general practice, residential aged care services and acute care hospitals.

I extend our thanks to the key people who contributed as authors of a case précis or as experts or behind the scenes. They are listed in this issue, my sincere apologies if I have overlooked anyone.

Rhonda Nay and Maree Cameron deserve special acknowledgement for keeping me on track over the last 10 years.

Why 3653 days? We had three leap years.

Who is 'Mumble'? The main character in 'Happy Feet' a penguin who wanted to dance rather than do what everyone else did, which was to sing.



Commentary 1 Congratulations on the 10-year anniversary RAC Communiqué

Jane Herington PSM
Director Ageing and Aged Care,
Department of Health and
Human Services

Providing support to the Victorian Institute of Forensic Medicine to publish the Residential Aged Care Communiqué is an important safety and quality initiative to help us learn from potentially preventable deaths reported to the Coroner.

This is part of a broader approach by the Victorian Department of Health and Human Service's Ageing and Aged Care Branch for promoting safe, high quality, person-centred care for people living in residential aged care services in Victoria.

Unlike other Australian jurisdictions, Victoria is a significant provider of public sector residential aged care services, with public health services operating 5770 residential aged care places in 181 services throughout the State. Most of these services are located in rural and regional areas with a number of specialised services in metropolitan Melbourne.

This operating context has led to a safety and quality approach aligned to the Victorian clinical governance framework and the identification of clinical risks in the residential setting that require effective mitigation strategies by aged care providers.

Evidenced based
standardised care
processes are designed
to reduce care variation
in key resident risk areas
and are subject to ongoing
review and development
by the Australian Centre of
Evidence Based Aged Care
at La Trobe University.

It has seen sector leadership and development in a range of programs and resources for strengthening clinical governance and care outcomes for residents. These include a focus on the use of quality indicators, evidenced based standardised care processes, improving consumer health literacy and building workforce capacity.

Work is also occurring on the use of performance measures in aged care.

Work on quality indicators commenced in 2004 with data systematically collected since 2006. The quality indicators focus on physical restraint, falls and fractures, use of medicines, pressure injuries and weight loss. These have informed the Commonwealth's national indicator program for residential aged care services.

Training in the
comprehensive health
assessment of older people
has been developed to
strengthen nursing skills in
this important area of need

Evidenced based standardised care processes are designed to reduce care variation in key resident risk areas and are subject to ongoing review and development by the Australian Centre of Evidence Based Aged Care at La Trobe University.

These are complemented by a range of consumer resources, so that residents and their representatives can better engage and actively participate in determining their own care needs.

Training in the comprehensive health assessment of older people has been developed to strengthen nursing skills in this important area of need and is now available through La Trobe and RMIT Universities.

An organisational readiness tool for boards and executives to assess the clinical governance systems within their aged care organisations is also available.

These resources and more information can be obtained at:

<https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality>

I recommend anybody interested in safety and quality in residential aged care services [subscribe](#) to the Residential Aged Care Communiqué and congratulate the Victorian Institute of Forensic Medicine on this 10-year anniversary edition.

Readers' Comments

"I just want to tell you that I think this publication is brilliant; extremely helpful, relevant and easy to read, with great links to other resources." I hope you continue to publish. I constantly encourage people relevant to the sector to subscribe, have copies on file as resources at each Home and issue copies to key clinical personnel with every publication, and place copies in the staff rooms. I also use them when developing or reviewing policy and procedures." (2011)

"Some positive feedback about the latest version of December Communiqué. Thank you for presenting 3 different cases yet with each case highlighting the importance of the 'system' that surrounds patient care. Latent failures and or system failures contribute significantly towards patient safety. I look forward to reading many more Communiqués." (2014)

Keep up the great work! (2016)

Commentary 2

A decade in forensic pathology

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Over the last 10 years there has been a considerable difference in the way in which forensic pathology is practised. While the traditional approaches of attending death scenes, performing autopsies, undertaking medical testing and submitting samples for forensic tests remains unchanged for criminally suspicious cases, the routine workload of a forensic pathologist is now dramatically different.

The advent of new investigative modalities in particular radiological procedures and the advent of overnight testing providing toxicology and molecular biology (DNA) results in a few hours has transformed the conduct of a medico-legal death investigation for the coroner.

The advent of routine toxicological analysis has provided valuable information regarding the prevalence of therapeutic and illicit drug usage and the community and post-mortem CT scanning has been able to reveal areas of trauma that in the past were difficult to identify in a routine autopsy dissection.

In Victoria over the last 10 years the 'front end' of the investigative process has undergone significant changes. Today reports of death to the coroner are taken by medical staff who are able to collect preliminary circumstantial and background medical information that may be relevant to steering the initial direction of the death investigation.

The introduction of electronic transmission of medical records, including statements from medical practitioners and police officers regarding the circumstances of the death has also assisted in the ability to rapidly direct the course of the subsequent specialist medical investigation.

Today on the arrival of a body at the mortuary a preliminary inspection of the body is undertaken with post mortem whole body CT scanning and collection of blood samples for immediate toxicological screening. This preliminary process is undertaken in every case and means that the duty pathologist is able to review medical records and the results of the CT scan and toxicological testing and integrate these findings into a preliminary investigation report that is delivered to the coroner the next day.

A team-based multidisciplinary meeting is then held between the medical and legal teams involved in the death investigation.

This enables the coroner to make a decision regarding the subsequent investigation that is supported by being fully informed of the medical and scientific issues.

At the same time, the medical and support staff in the admissions team will have been talking to the next of kin of the deceased and ascertaining their wishes and concerns regarding the death. In addition individuals who have information regarding the death or a particular interest in the death investigation being pursued in a particular direction, such as medical and care staff or police investigators, can provide this information to the coroner who can take it into account in determining what should happen in the subsequent investigation process.

Not only can preliminary scientific and radiological investigations contribute to the death investigation directly, they can also provide a form of documentation that permits the death to be reviewed and analysed further months or years down the track even if no autopsy dissection takes place. The advent of routine toxicological analysis has provided valuable information regarding the prevalence of therapeutic and illicit drug usage and the community and post-mortem CT scanning has been able to reveal areas of trauma that in the past were difficult to identify in a routine autopsy dissection.

Today, review of cases for research purposes may not just involve trawling through medical records and pathology reports but instead involve a re-analysis of the death by undertaking further specialist radiological assessments of the whole body CT scans using a variety of new software tools and sub specialist radiological expertise.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:
racc@vifm.org

DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed.

We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.

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http://www.vifmcommuniques.org/?page_id=2356

Commentary 3 Ten years in aged care

Terrona Ramsay
Former Chief Executive Officer and
Director of Nursing of a rural health
service with residential aged care

When requested to write a piece on what has changed in residential care over the past ten years, I initially thought that there was little that had changed.

On reflection, there have been some fundamental changes in several key areas.

The approach to funding cannot be ignored or the removal of the distinction between high and low care.

This has resulted in the resident now being required to pay for their accommodation and care, regardless of where they will live.

We are seeing the emergence of large corporate players who are buying up many of the smaller independent operators.

In many cases these smaller operators are leaving the industry. The larger companies are increasingly becoming corporatized with several now being publicly listed. The impact of this trend is yet to be seen.

Over the past years it is not unusual to see stays of less than twelve months. It is imperative that care staff have the skills to provide the care needed for residents with complex multiple conditions.

Co-location of services is slowly being recognised as providing a better level of service. Childcare, medical/ ancillary services certainly enhance residential care.

This improves community connectedness, especially if the co-located services are open to the broader community.

It would be exciting to see new facilities developed on brown field sites in the future. Multi story developments in established communities, then we would really see community connectedness.

Technology has an increasing place within residential care.

This is twofold – within facilities and by families when researching possible future accommodation for their family member.

Within facilities, technology is being used to enhance and improve outcomes, i.e. care planning, medication management, outpatient reviews and food services. It is hoped that in the future providers and health professionals will recognise the significant benefits and utilise technology to its fullest extent.

The past ten years have seen significant change; it will be interesting to see what evolves over the next ten-year period.

Externally, families are searching the Internet to find the best and most affordable accommodation for their relative. With compulsory listing of accommodation prices, the influence of marketing has become a priority for many facilities, which have not had to undertake promotion of their services in the past.

With the introduction of Consumer Directed Care (CDC) and the National Disability Insurance Scheme (NDIS), it will be interesting to see how this influences service providers into the future. Services will have to be “person centred” in order to survive.

With the focus on people remaining at home for longer periods, when/if permanent care is required the acuity of residents will likely increase.

Already we are experiencing much shorter periods of residence – ten years ago it was not uncommon to have a resident in care for five years or more. Over the past years it is not unusual to see stays of less than twelve months. It is imperative that care staff have the skills to provide the care needed for residents with complex multiple conditions.

The past ten years have seen significant change; it will be interesting to see what evolves over the next ten-year period.

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Commentary 4

Patient safety from 2006 to 2016

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Ground zero for quality and safety activity in Australia was arguably the Quality in Australia Health Care Study (QAHCS), conducted 24 years ago and published twenty years ago in the Medical Journal of Australia.

This study shed a light on the number of adverse events occurring in our hospitals. It found that more than 16% of admissions were associated with an adverse event and 1% of admissions resulted in a death from poor quality of care.

From this paper came a tsunami of activity, including the creation of the Quality and Safety Council and a level of investment in quality and safety activities never before seen in Australia.

The next ten years will see even greater focus on patient-centred care and increasing attention to value-based healthcare, very much inter-related concepts.

The ensuing decade saw increasing recognition of the importance of considering errors from a systems perspective; that errors resulted from breakdown in many barriers erected to prevent them.

New terminology such as human factors engineering and clinical governance entered our vocabulary. Funding was injected into hospitals to undertake quality improvement projects and create culture change. The Australian Council on Quality and Safety in Health Care morphed into the Australian Commission ten years ago, in 2006. With this came a strategic re-direction away from the provision of grants to hospitals to a more centrally coordinated quality and safety program.

This last decade has seen the emergence of patient-centred care, from concept to expectation. It has also seen a marked change to the accreditation process of health services.

Whereas previously accreditation standards were developed and assessed by the Australian Council for Healthcare Standards, in 2011 the Health Ministers endorsed healthcare standards developed by the Australian Commission and assessed by accredited agencies.

Despite the embedding of clinical governance frameworks in hospitals, a number of notable events over the past decade have highlighted the fallibility of our health system.

Clinical registries collecting high-quality data and patient-reported outcomes will be used to benchmark performance and reduce inefficiencies and inequality across the health system.

Bundaberg Hospital exposed shoddy credentialing of health practitioners and the failing of incident reporting and monitoring processes. Camden and Campbelltown Inquiry in New South Wales (2004) and the current inquiry into Djerriwarrh in Victoria remind us that we still have some way to go in terms of providing high quality care to everyone.

The next ten years will see even greater focus on patient-centred care and increasing attention to value-based healthcare, very much inter-related concepts.

Value-based healthcare refers to a focus on ensuring that care translates to improved quality of life; assessed by the patient and not by the patient's doctor. Value-based healthcare will attempt to curb ever-increasing health spending.

Clinical registries collecting high-quality data and patient-reported outcomes will be used to benchmark performance and reduce inefficiencies and inequality across the health system.

There will undoubtedly be other failings resulting from breakdown in systems designed to prevent adverse events. It is unlikely that another Quality in Healthcare study will be conducted.

If it was, it would be fascinating to assess the impact of this last 25 years of concerted effort on frontline care delivery and patient outcomes.

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Wells	David
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Commentary 5

The good, the bad and the downright ugly: reflections on 10 years

Rhonda Nay
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This is not my usual evidence based paper; rather it is a bit of an overview of what I think have been significant improvements, mere rhetoric and, staunch resistance in aged care. The funding of aged care is always a hot topic and never resolved. Some will always want more, some can make do with less, some will play the system and the instrument is never an acceptable reflection of resident and system needs. Nothing new here!

We have slid from absolute objections to user pays to much more acceptance. It will be interesting to see how Consumer Directed Care (CDC) impacts funding. One can hope it is not simply a way of using choice to cost shift. Many readers will recall what happened to mental health when care moved from institutions to the community.

The over-riding change that should influence all aspects of aged care has been the adoption of person centred care (PCC) as the driving philosophy.

I have argued many time that for PCC to be more than rhetoric it must be embedded from bathroom to boardroom. Many organisations are taking this seriously and recognise that PCC is NOT a new task for registered nurses (RN)s and care staff to do.

Food is so much more than nourishment; planting a tomato, watching it grow and eating it is a big step up from Bingo.

Environmental design that enables maximum biopsychosocial potential and engagement is vital and growing in influence.

This is a great thing. Food is so much more than nourishment; planting a tomato, watching it grow and eating it is a big step up from Bingo.

Older people want to feel worthwhile and engage in worthwhile activities. We have moved from children's concerts to genuine older person/child interactions and two-way learning.

The use of IT in aged care has far more potential than is currently exercised. Computerised care plans still too often drive care and are themselves budget-driven.

Little use is made yet of the potential for cross-care IT communication (GP-RACF-hospital-community) which will reduce human error and adverse events.

Ideally each person will receive what they desire be it physical, spiritual, favourite colours or a great view. In reality as a society we are not prepared to pay for what we expect.

The possibility for greater access to specialists remains generally unrealised. Engagement with family, politics, entertainment and other world events is embryonic but developing.

Accreditation has certainly resulted in overall improvement in the system but is not measuring quality. Quality of life and care are demanded but not understood.

We have developed some quality indicators but nationally the approach remains ad hoc. What one person sees as essential to quality care/life another sees as an optional extra. For some physical care is number one; while for others it is a worthwhile social interaction.

Ideally each person will receive what they desire be it physical, spiritual, favourite colours or a great view. In reality as a society we are not prepared to pay for what we expect.

Advance Care Plans (ACP) are gaining some traction but are not directing care to the extent they should be. Family wishes are more likely to determine whether or not a resident is transferred to hospital than an ACP. All doctors and nurses should be comfortable talking with older people and families about their end of life wishes.

The language requires change – we are not “withdrawing care” but providing the best care for a person at the end of life.

That means excellent pain management and as much sensory pleasure and comfort as possible. I want my favourite music, a breeze through the windows, lovely soft linen...

We tolerate a level of staffing and staff mix in aged care that would close wards in the acute system. Despite years of discussion and criticism it is still possible to work with extremely vulnerable older people while having no relevant qualification. This should be an outrage.

The answer is not to simply increase staffing. The whole system requires review and a staffing system established that reflects residents changing needs.

This means exploring what GPs, nurses, allied health and PCAs can and should offer. The needs have changed drastically over the years but we still just look at disciplines independently of the each other and cry for more staff. The complexity demands more than a silo solution.

The ugly is that restraint is still used. Millions of dollars have been invested in training and still older people suffer this abuse of their human rights. It confounds me. No-one thinking about what they are doing would restrain another against their will. So clearly not thinking and just doing tasks is the other embedded habit that is so hard to break.

If I could do one thing to improve care of older people it would be to invest in whole of organisation leadership development.

The ugly is that too often the public, families, and staff think a person with dementia cannot make choices. I wrote in 1993 about benevolent oppression – or killing with kindness – in aged care. It is really ugly that it still happens. People have dementia – they are mums, dads, brothers, sisters, retired professors (even). We must KNOW the person and their life context. Choice is possible until death.

Where I have seen the best care it has been because of great leadership. Leadership that is modelled and supported across the organisation. The gardener, the cook, the cleaner, the nurse, the CEO and especially the Board members were on the same page and excited to be providing aged care. If I could do one thing to improve care of older people it would be to invest in whole of organisation leadership development.





Case from past I: A question of rights and risks

This case has been revised from the one published in Vol 6 Iss 3 Sep 2011. I include it again because it is one of those situations where we think we have every aspect of care covered and seem to be doing the best we can but the situation just seems to spiral out of control. It just does not seem real. However, we all know how little things all contribute to an ever-increasing cascade leading to disaster. It also highlights the importance of meeting the needs of residents to enhance their quality of life.

Clinical Summary

Mrs H was a 78-year-old female who lived at a residential aged care service requiring high-level care. Past medical history included dementia and a heavy smoker of up to thirty cigarettes a day.

Over the past few years Mrs H's mobility and manual dexterity had declined to a level where she was wheelchair bound and required full assistance with transfers.

Mrs H also suffered stiffness and paralysis in one arm and difficulties using her other hand. Mrs H was unable to light her own cigarettes or bring the cigarette to her mouth.

She would smoke by leaning forward to meet the cigarette or holding it in her mouth for long periods of time. Mrs H would extinguish the cigarette by flicking the butt into a nearby container of water.

The coroner found that Mrs H suffered fatal burns when her clothing accidentally caught alight while smoking in a designated outdoor area, and that the lack of supervision was a clear contributing factor in her death.

On this particular day, Mrs H rang the communication bell shortly before the evening meal. Two carers attended and took Mrs H outside, lit a cigarette and left her alone to smoke.

Minutes later, Mrs H was found ablaze by staff. She was transported by ambulance to hospital, assessed to have non-survivable injuries and died that evening.

The cause of death following a post mortem examination conducted by a forensic pathologist was severe burns and the neuropathological examination findings were consistent with Alzheimer's disease.

The coroner recommended that the formulation of a Care Plan and the details of any changes that are made, as well as any procedures and practices maintained by a facility regarding a resident's smoking habit, must be properly documented and communicated to all staff and family members.

The coroner found that Mrs H suffered fatal burns when her clothing accidentally caught alight while smoking in a designated outdoor area, and that the lack of supervision was a clear contributing factor in her death.

The Coroner made a number of recommendations including the need for risk assessments to be made of all residents permitted to smoke on premises.

The coroner recommended that the formulation of a Care Plan and the details of any changes that are made, as well as any procedures and practices maintained by a facility regarding a resident's smoking habit, must be properly documented and communicated to all staff and family members.

"Any facility that chooses to permit its residents to smoke...should ensure that in the case of each individual smoker the risk of harm to the resident, having regard to the level of dementia, the loss of manual dexterity of the resident and other matters relevant to the ability of the resident to smoke safely,... and thus the need for and level of supervision, is properly assessed".

Case from past II: A policy for procedures and practices relating to restraint

This case has been revised from our very first issue Vol 1 Iss 1 Oct 2006. I have included it because key aspects remain unresolved a decade later. The challenges that still remain are providing a restraint free environment.

Ms V, a 68 year old female with a medical history of Huntington's chorea and dementia was living at a residential aged care facility that catered for older people with a psychiatric illness, who require a high level of care. Ms V displayed significant behaviours of concern and was prescribed a range of medications, including antidepressants, anticonvulsants and sedatives with little improvement in her behaviour. Medical and nursing staff determined that it was necessary to adopt techniques of physical restraint.

At the time, the facility was trialing a restraint device known as a 'Zip-a-Bed' or 'cocoon'. The device comprises; a lower and bottom sheet and is used to prevent patients from falling out of bed. 2-3 hours after being placed in the Zip-A- Bed device, Ms V was found dead. Her body was located on the side of the bed with her arms, shoulders and upper torso outside of the strap and doona part of the Zip-A-Bed.

The cause of death following an autopsy was determined to be: *"postural asphyxia in a woman with Huntington's Chorea wearing a therapeutic restraint".*

The coroner reviewed the use of restraint and the subsequent documentation. It was found that the facility had recorded the use of physical restraint used during the daytime but did not record similar information during the night. During the inquest it became evident that the doctor was unaware of the restraint devices that were used by the nursing staff and that there was no standard for the monitoring of residents whilst in a restraint device.

The Coroner made the following observations: *"the decision of whether a patient ought to be physically restrained or not, involves a delicate balance of matters of personal safety of the patient on the one hand, with other issues of patient dignity, liberty and staff safety on the other hand."*

That there is a need for a regular and thorough medical and nursing assessment and review of the physical and psychological needs of the patient over time. Also that, regular monitoring of residents being restrained needs to be made and documented.



Commentary from the past: General Practice, Residential and Acute Care

This commentary has been edited from the original version published in Volume 3 Issue 1 Feb-2008. We have included it because this remains a major issue in providing better care for older people. Dr Wendy Bissinger, a General Practitioner wrote this and although there have been substantial improvements in communication—it remains a work in progress.

Managing information transfer between residential aged care and acute hospital care is recognised as vital for maintaining good quality care for the aged.

Medication errors are common when older residents are transferred between RACFs and hospital.

Lack of information leads to fragmentation of care, poor clinical outcomes and high readmission rates.

Generic transfer forms were developed in consultation with Residential Aged Care Facilities (RACF), General Practitioners (GP) and hospitals.

These transfer forms include the minimum required information needed to safely transfer a resident to hospital i.e., advanced care wishes, usual mental state and ability to perform activities of daily living, the capacity for care on return to RACF. This is all contained in a readily identifiable envelope.

As GPs complete more comprehensive medical assessments, we will have a recent review of the resident's physical, emotional and functional status, as well as their complete medical history.

It is important to check and list non-prescription items (e.g., vitamins, herbal and 'over the counter' preparations), patches, creams and drops.

Combined with a residential medication management review, this ensures the most appropriate and simplified medication regimen.

Together, they are the backbone of the information package needed on transfer to hospital as well as providing a clear current picture for any provider involved in the resident's care.

The importance of sending a copy of the current medication chart with the resident cannot be overstated.

Medication errors are common when older residents are transferred between RACFs and hospital.

Once residents are taking 10 or more medications, they average two medication errors per transfer, most commonly inadvertent withdrawal of drugs.

It is important to check and list non-prescription items (e.g., vitamins, herbal and 'over the counter' preparations), patches, creams and drops.

The possibility of interactions between new and existing treatment is greatly reduced with this information.

Monitoring and documenting the mental state of residents is important because changes to mental state can be a sign of acute disease and will change the approach to medical care.

Mental state documentation does not identify all patients with dementia, especially those who have not had a formal diagnosis.

Despite anecdotal evidence to the contrary, most presentations of RACF residents to ED are appropriate. Their passage through the acute system will be smoother with better quality information transfer.

List of RAC Communiqué Issues

	Vol	Iss	Year	Month	Theme
1	1	1	2006	Oct	Physical restraint
2	2	1	2007	Mar	Falls
3	2	2		Jun	Choking
4	3	1	2008	Feb	Co-ordinating care between RAC and hospital
5	3	2		Apr	Consolidation of lessons learned I
6	3	3		Jun	Pressure Ulcers
7	3	4		Sep	Diabetes Mellitus
8	3	5		Dec	Warfarin
9	4	1	2009	Mar	Pneumonia
10	4	2		Jun	Consolidation of lessons learned II
11	4	3		Dec	Health effects of extreme heat conditions
12	5	1	2010	Feb	Hazards and Internal Emergencies
13	5	2		Jun	Equipment and Health Technology Assessment
14	5	S1		Jul	Supplement I: Practice Change—Managing dysphagia and removing bed rails
15	5	3		Aug	Managing residents with unmet needs
16	5	S2		Dec	Supplement II: Practice Change—Managing diabetes mellitus and falls
17	6	1	2011	Feb	Consolidation of lessons learned III
18	6	2		May	Mobility Aids
19	6	3		Sep	Smoking and dignity of risk
20	6	4		Dec	Translation of lessons from Canada I: Suitability for transfer
21	7	1	2012	Feb	Translation of lessons from Canada II: Knowledge Translation
22	7	2		Jun	Learning from our peers and networking
23	7	3		Sep	Consolidation of lessons learned IV and some statistics
24	7	4		Dec	Interpretation of data
25	8	1	2013	Mar	Root Cause Analysis and Governance
26	8	2		Jun	Gastroenteritis outbreak
27	8	3		Dec	Diffusion of information and deaths from asphyxia
28	9	1	2014	Feb	Communication
29	9	2		Jul	Behavioural and Psychological Symptoms of Dementia
30	9	3		Sep	Falls
31	9	4		Dec	Goals of Care and End of Life Care
32	9	S5		Dec	Supplement III: End of Life Care
33	10	1	2015	Feb	Reportable Deaths and Way-finding
34	10	2		May	Resident to Resident Aggression
35	10	3		Aug	Arson
36	10	4		Nov	Consolidation of lessons learned V: Reporting
37	11	1	2016	Feb	Respite care
38	11	2		May	Holiday season
39	11	3		Aug	In care and surrogate decision-makers