"We have come too far to fade away" – a key message in my December address to our membership. This theme remains a key focus for 2009. Initiatives are underway to brighten our future, not just as individual practicing Gerontological nurses but also as an organization that can become a credible force in Canada’s health care system. To adopt President Obama’s mantra “we can” and we will find ways to promote our mission:

To address the health concerns of older Canadians and the nurses who participate with them in health care.

We must be steadfast in our aim to contribute to the health care system by:

- promoting high standards of gerontological nursing practice,
- promoting education programs in gerontological nursing,
- participating in affairs that promote the health of older adults,
- promoting networking opportunities for nurses,
- promoting and disseminate gerontological nursing research, and
- presenting the views of CGNA to government, education, professional, and other appropriate bodies.

Your support is needed – please find a way to volunteer.

Changes in our organization are occurring to keep us focused on our aims. We welcomed Alice DaSilva as our interim office support replacing the Granville Street Business Office manager Gwen Turpin who retired in December. The executive has been planning and considering other business management arrangements. A short list has been created and we are in the process of evaluating those options. More news on this work will be reported at the AGM in Banff.

…… Cont’d on page 2…
President’s Message cont’d ……

We continue to keep our eye on the future in the following ways:

1. As I reported in my last message, the power from committed, interested, and generous people in our organization makes our proposals reality. This shines through in our efforts to review our existing Gerontological nursing standards. We have established a Gerontological Nursing Standards Working Group – representatives from across Canada and international partners are participating in this work. The working group will review and collate existing documents in an attempt to refresh our national standards with new evidence. The timelines are tight but possible. Read more about our process in this edition of the newsletter.

2. The International Federation of Gerontological Nurses (a project established by Dr. Sandi Hirst in 2006) is gaining momentum. International nurses attending the Banff conference in May will come together to discuss possibilities for the future.

3. The 2007 AGM motion to open up CGNA membership to all categories of nurses has received considerable attention by the executive and board. After discussion and debate, a way has been found that will be announced during our 2009 AGM.

I would like to express well wishes for Bev Laurila President Elect who is recovering from surgery. We hope to have her back real soon. To the executive and board members who have rallied together to keep CGNA services to members active during Bev’s leave of absence, thank you; your effort made a difference.

Please think about what CGNA means to you – what do you want your organization to be in the future? I continue to believe that all effort, no matter how small, pointed in the same direction adds up to a mighty force. Let us create our own sustainable force.

Dr. Belinda Parke
CGNA President
Faculty of Nursing
3rd Floor, Clinical Sciences Building
Edmonton, Alberta
Canada T6G 2G3

NOTE FROM THE EDITOR

Just like the Spring flowers above, this April issue shows how The Canadian Gerontological Nurses Association (CGNA) is growing, both as an organization, and in terms of research and related submissions to our national newsletter. We plan to bring copies of this Newsletter to showcase at the Canadian Gerontological Nursing Association Conference in Banff from May 27-30, and to the IAGG conference in Paris for July 5-9. Be sure to review all feature articles, the contributions from students interested in Gerontology, the submissions from nurses in other countries, such as Finland, and much much more. Please note especially: (1) FUNDING opportunities, such as the Call for Conference Grant applications to attend our May 27-30 conference, and/or the CGNA Scholarship; (2) CALL FOR NOMINATIONS for a Position on the CGNA Board (3) MEMBERSHIP RENEWAL: Reminder to Renew your Annual Membership, which is due April 1st –see CGNA website or last page of this Newsletter for where to send your completed membership form. Finally, I look forward to meeting with many of you at the CGNA Conference. Let me know if you are having any difficulties finding accommodation. And as always, I look forward to receiving your submissions to the next newsletter, which will go out in late June/early July. I would need your submission (in Word 2003) by 1 June/09. Send to me at: cllenave@ucalgary.ca

Submitted by Carole-Lynne Le Navenec, RN, PHD
Canadian Gerontological Nursing Standards Working Group Established

On behalf of CGNA executive and Board I would like to thank the following people for their willingness to participate in this project.
At present the membership is:

**CGNA provincial presidents:**
Gloria Connolly – Nova Scotia
Heather Hutchinson – British Columbia
Ruth Graham – Alberta
Dawn Winterhalt – Saskatchewan
Dawn Fenton – New Brunswick
Mary Mac Swain – Prince Edward Island
Annette Morgan – Newfoundland

**CGNA Members**
Anna Enman – Prince Edward Island
Sohani Welcher – Nova Scotia
Helle Tees – Alberta
Bonnie Hall - Ontario

**NICE representative** – Kathy McGilton

**International members**
Judith Hertz – President NGNA (United States)
Gwi-CRyung Son Hong – KGNS (Korean Gerontological Nursing Society)

**CGNA President** – Belinda Parke

**An overview of our project and process:**

Our aim: In the next 12 months review and revise the Gerontological Nursing Standards in Canada. We draw on our international colleagues for their wisdom and assistance. Judith Hertz has been working with nurses in America to produce a similar set of standards. We have the potential to bring this forward to an international level through CGNA activity in the International Federation of Gerontological Nursing.

**Proposed activity and timeline:** Two teleconferences prior to Banff conference in May; one face to face meeting at the conference; two post conference teleconferences.

**Activity process**
1. Gather existing information relevant to our project and circulate this information before meeting one
2. Goal of teleconference meeting one – assess what we have and plan out the strategy that includes determining if a literature review is required – determine if there are any budget implications – budget implications will need to go to CGNA executive and board for approval
3. Goal of teleconference meeting two – develop or adopt a conceptual framework - identify key dimension of the standards
4. Face to face meeting in Banff (one or two meetings of 2 hr duration)
5. Goal of teleconference meeting three – review documents produced during the face to face meetings
6. Goal of teleconference meeting four – finalize documents, develop review process (this includes an external review process that includes key stakeholder groups)
It is noted that our international members might have difficulty with the time zones – we will find a way for people to contribute if participating in the teleconference is not an option.

I appreciate that the timelines are tight but I am committed to finding ways for people to participate in this process. Feedback and dialogue is critical to our success. If you are aware of documents you would like the working group to examine please send them electronically to Belinda.parke@ualberta.ca

If you would like to make any suggestions about this proposed plan, I would be interested to hear from you at the email address above.

Again, I wish to express my appreciation for everyone’s contributions.

Dr. Belinda Parke
President CGNA

New Brunswick, NBGNA Report

Here in New Brunswick Spring officially arrived today. It is sunny and still a little cool. We have been working hard at membership renewal and attracting new members. I am attending the Old Age in a New Age conference in Saint John, NB in April and hope to bring back some new information to the nurses that work within our program. I will also have a small booth at the Saint John Conference and hopefully will recruit some new members for NBGNA

Report submitted for Lois Carson by Dawn Fenton (Dawn.Fenton@serha.ca) RN, Treasurer/ Membership.

British Columbia, GNABC Report

In May 2008, Gerontological Nurse Association of BC was given official status by the government of BC with the approval of our Constitution and Bylaws. With the formation of GNABC we became a stand alone Association and we also welcomed Licensed Practical Nurses and Registered Psychiatric Nurses as full members. A great majority of these people work in the field of Gerontological Nursing and need the support of this organization to ensure competent and responsible care for the Older Adult. Once again, I extend my congratulations to the Transition Team who worked hard to make this change possible.

This year the Transition Team and executive have continued to work organizing the day to month operation of the Association. In the meantime the 8 provincial wide chapters are providing education and support for those working with the Older Adult. There are very few health care professionals that don’t encounter someone from our aging population on a daily basis. As well, there are many study groups, initiated by the chapters for those RNs that are writing the CNA (G) certification exam in April.

The Victoria Chapter has partnered up with the Yakomovich Wellness Center to offer one public forum on Foot Care. They choose this topic because there is much to be done in the area of preventing foot care problems in the older adult and knew that nurses too are "on their feet" and foot health is very important. Foot well being is essential for issues such as peripheral vascular disease, diabetes, and even falls prevention. Feet are often neglected when we plan our health care. It is hoped this educational session will raise awareness. The forum will be held in Victoria on Monday, April 4th from 7-9pm.

Cont’d … page 5 ..
Thanks to our new Education Chair, Marcia Carr, Gerontological minded people in Alberta, BC, the Yukon and the Territories have been able to access education about Continence and High Alert Drugs via videoconferencing with Telehealth which is available at many health care sites.

This year our AGM and Educational Conference will be held at the Coast Bastion Hotel in Nanaimo. “Into the Future - Innovations for Senior’s Health” will be held Sept. 17th and 18th, 2009. Check out www.gnabc.com for more information.

Respectfully submitted by
Heather Hutchinson, President GNABC

Alberta: AGNA Report

Time is flying so fast. It is hard to believe that it is time to register for the 15th CGNA Conference on Gerontological Nursing, Making Moments Matter in Banff May 27th to 30th. This is a chance to hear from inspiring speakers and to learn from your peers. As well, it is in a beautiful location. AGNA is pleased to be sponsoring this years conference. Go to the CGNA web-site for information on the conference and to register. I have been to many CGNA conferences over the years and have always come away with new ideas and information, and new contacts. When the conference is here in our province, it is too good an opportunity to pass up.

AGNA will not be holding an education day this year. AGNA’s annual meeting will be a breakfast meeting on Thursday morning during the CGNA conference. At last year’s annual meeting, the following resolution was passed “We move that the executive, in conjunction with CGNA, explore the issue of expanding the membership to include all regulated nurses.” The AGNA executive has met with the College of Licensed Practical Nurses of Alberta, and the College of Registered Psychiatric Nurses of Alberta. Both associations welcome the proposal. We have reviewed the bylaws for the required changes should the membership be expanded. At this years annual meeting members will be asked to make a decision in regard to the issue of expanding the membership and, if the decision is positive, approve the bylaw changes.

At the annual meeting we will also be introducing a new logo for AGNA and electing new Executive members.

AGNA chapters continue to be active, holding regular educational meetings and certification study groups. Membership has increased by 20 percent from last year.

See you in Banff in May!

Ruth Graham, President, AGNA: mrgraham@telusplanet.net

TREASURER’S REPORT

We are nearing CGNA’s 2008-2009 year end. Detailed information will be available at the AGM or by contacting me personally. Here is some preliminary information:

National membership appears stable. We have been working hard to solve the issues about membership which arose from the Winnipeg 2007 conference. Options will be discussed in Banff. CGNA needs membership support to remain strong, not just for the financial bottom line but also for the morale of its volunteer executive and board. Support us by telling your local and national groups what you need and want from membership, attending meetings, renewing memberships in a timely manner and taking on a role for the organization. When
attending the AGM, please forgive us for errors during our check-in process as it is difficult to compile a current and complete list of members. Bringing your membership card/receipt with you to the AGM will expedite the check-in.

We were generous when budgeting for certain unknown costs. Fortunately, expenses for many categories were lower than anticipated. We also trimmed or eliminated some optional expenses and, as a result, found funds to reimburse the Banff registration fees for our provincial presidents. For the last 2 years, your Board has met by teleconference. It is time to meet in person.

The Ann C. Beckingham Scholarship Fund is now entirely invested in GIC’s. This will make it easier to predict how much money will be available to be awarded each year. This fund will get publicity by sponsoring an event during the Banff conference. I am hoping the posting process will be changed. I would like to have this scholarship fund posted year-round with a subcommittee reviewing applications quarterly. Presently, the fund has a surplus of interest to be awarded. If you meet the qualifications, apply now!


Respectfully submitted by Denise Levesque, CGNA Treasurer, March 2009

FUNDING OPPORTUNITIES

CALL FOR CONFERENCE GRANT APPLICATIONS

The CGNA Board of Directors invites the membership to apply for conference grant support to attend the 15th National Scientific and Education Conference- Making Moments Matter, in Banff, Alberta - May 27 to 30th 2009.

For more information, please visit the CGNA web site at www.cgna.net.
http://cgna.net/?action=viewNews&id=18

SUBMIT APPLICATION FORM AND COPY OF COMPLETED CONFERENCE REGISTRATION FORM VIA EMAIL TO: alice.dasilva@ualberta.ca please put: CGNA conference grant in subject line DEADLINE: April 21st, 2009

Nurses say the darnedest things

When I was in high school I was working as a nurse’s aide at our small-town hospital. It was my job to go around and get everyone’s vital signs and chart them. I walked into one gentleman’s room and said, “Good morning! I’m just here to grab your vitals.”

His wife was sitting at his bedside and started laughing hysterically. Then she said, “Why don’t you leave that to me honey? I was so embarrassed.

Nurse on the Net
The former President of CGNA, Dr. Sandra Hirst, a Faculty of Nursing associate professor at the University of Calgary has won the prestigious College and Association of Registered Nurses of Alberta (CARN A) Lifetime Achievement Award for 2009.

Sandi Hirst has taught at the undergraduate and graduate levels in the Faculty of Nursing for more than 25 years, influencing the professional development of hundreds of nursing students. She has been the supervisor or participated in thesis committees for more than 35 students, many of whom now hold important clinical, administrative or faculty positions in Calgary and beyond.

“This recognition is so well deserved,” said Dianne Tapp, the faculty of Nursing’s interim dean. “With this achievement, Sandi brings credibility and prestige not only to our faculty, but also to the profession.”

Hirst’s expertise and passion is in the area of gerontological nursing. She was a founding member of the Canadian Gerontological Nursing Association and also of the Alberta Gerontological Nurses Association, holding key positions in both organizations. As one of the first Canadian nurses to become certified in gerontological nursing in 1999, she has offered her expertise and encouragement to dozens of Calgary nurses, enabling them to achieve their certification.

Recognizing clearly that care of older adults requires an interdisciplinary approach, Hirst has reached out beyond the nursing realm. She has been a leader with the Canadian Association on Gerontology, a national multidisciplinary scientific and educational association, and with the National Initiative on the Care of the Elderly, a new interdisciplinary venture that brings together academic and community-based professionals whose focus is to share research about evidence based practice. As an appointee to the government’s Seniors Advisory Council of Alberta for three two-year terms (to 2005), Hirst contributed to the development of the province’s Protection of Persons in Care Act. In 2007, her expertise was acknowledged by a three-year prime ministerial appointment to the newly founded National Seniors Council. And in October, a $1.1 million donation to the faculty created the Brenda Strafford Centre for Excellence in Gerontological Nursing, with Hirst as its director.

“This award recognizes the growing importance of care of older adults in our society,” says Debbie Lee, clinical specialist for the Older Adult with Alberta Health Services – Calgary, who nominated Hirst for the award. “It acknowledges the significant contribution that Sandi has made to older adult care over the years with learners from a variety of settings, with many different organizations and with ongoing passion and dedication”.

The CARN A Lifetime Achievement Award will be presented to Hirst during a ceremony in Edmonton in April 2009.
VIEWS ON OLD AGE MAY BECOME REALITY LATER: What you think now could determine your health as you age, study shows.

By Randy Dotinga, HealthDay Reporter

Secondary Source: Health Day: News for Healthier Living, March 1, 2009
http://www.healthday.com/Article.asp?AID=624557

Primary Source: Becca Levy, Ph.D., Associate Professor, Epidemiology and Psychology, Yale School of Public Health, New Haven, Connecticut and S. Jay Olshansky, Ph.D., Professor, School of Public Health, University of Illinois at Chicago; March 2009, in Psychological Science

FRIDAY, Feb. 27 (HealthDay News) -- New research suggests that young people who assume life is rough for seniors are more likely to suffer from heart attacks and stroke when they reach that age themselves.

"If people hold more negative views of aging, they may be less likely to walk the extra block or engage in healthy behaviors as they get older," explained study author Becca Levy, an associate professor of epidemiology and psychology at Yale School of Public Health. See rest of story at above website.

INVITATION TO PARTICIPATE IN SILENT AUCTION WHILE AT CGNA CONFERENCE

15th National Conference on Gerontological Nursing
May 27-30, 2009
Banff Conference Centre

Information on Canadian Gerontological Nursing Conference
(www.cgna.net)

Canada has:
- An aging population
- A shortage of gerontological nurses.

The Canadian Gerontological Nursing Association (CGNA) is a national organization that represents Registered Nurses who work with older adults in a wide variety of settings across Canada. Our mission is to address the health concerns of older Canadians and the nurses who participate with them in health care.

CGNA hosts a convention every two years. Nurses from across Canada and North America meet to discuss issues affecting Seniors and their caregivers.

CGNA awards scholarships yearly to nurses pursuing education in the field of aging. The Silent Auction held in conjunction with the banquet is the main source of funding for these awards.

…… Cont'd. on p. 9..
Please consider donating item(s) valued at $50 or more to be auctioned for this very worthy cause.

Please reply to: shirley.cox@calgaryhealthregion.ca with the following:

Item(s) to be donated:
Description of item:
Approximate value:

☐ Attending and will bring
☐ Will send with Delegate

I came for the job.
I stayed for the team.

"The energy, the caring, the sharing, humor and wit enable our members to have fun, food, arm chair travel, artwork, painting, gardening, and pet visit extraordinaire."

Becky Lynn B., VCH Nurse Coordinator

New Challenges. New Horizons.

To find out more and to apply, visit:
www.vch.ca/careers

Phone: 604.875.5132
Toll-Free in North America: 1.800.565.1727
CGNA SCHOLARSHIP APPLICATION FORM

Name: ____________________________________________________________

Address: __________________________________________________________

Phone Number:___________  E-Mail Address: ______________  Social Insurance Number:________

Member of CGNA: Yes___ No___ How many years? ______

CNA certification: Yes___ Year_____ Recertification: Yes___ Year _____

Are you a Canadian citizen or landed immigrant? Yes___ No___

Indicate present level of academic preparation:

Diploma___ BScN/BN___ MScN/MN___ PhD. ____ Other: Please explain _________

Enclosures required:

1. Copy of your certificate to practice nursing in a Canadian province/territory;
2. Copy of current national/provincial/territorial gerontological nursing association membership card (or copy of your completed CGNA/provincial/territorial association application form);
3. Evidence from an academic institution of part-time or full-time student status or acceptance into a program of study;
4. Academic transcript of most recently completed nursing program.
5. Your curriculum vitae; and

Please complete the application by answering the following three questions (no more than one page for each).

1. Please describe the program that you are entering or are in the process of completing.
2. Describe your past contributions to gerontological nursing in Canada.
3. Describe why you are interested in furthering your education in gerontological nursing and indicate how this additional education will assist your career plans.

DEADLINE: APRIL 30TH 2009

Completed application is to be sent to:

CGNA OFFICE C/O ALICE DA SILVA
FACULTY OF NURSING
CLINICAL SCIENCES BUILDING
UNIVERSITY OF ALBERTA
EDMONTON, AB  T6G 2G3

It is your responsibility to ensure that your application is complete upon submission. Incomplete applications will not be considered.

*Members of the Executive and/or their families are not eligible for these scholarships

Revised March 16th 2009
UPCOMING EVENTS

NATIONAL INITIATIVE FOR THE CARE OF THE ELDERLY (NICE)
Annual NICE Knowledge Exchange 2009
May 20 & 21, 2009
Victoria University at the University of Toronto
Toronto, Ontario
Website: http://www.nicenet.ca

2009 SHANGHAI INTERNATIONAL NURSING CONFERENCE, TO BE HELD IN SHANGHAI, CHINA
Info www.shinc.cn <http://www.shinc.cn/>

3RD N-NURSE SYMPOSIUM: REAFFIRMING CULTURAL KNOWLEDGE FOR TRANSFORMATION
IN HEALTH CARE
April 15-17, 2009 Albuquerque, NM More details at http://www.n-nurse.org/

IN SICKNESS & IN HEALTH CONFERENCE 2009: GOVERNMENTALITY IN THE CLINIC AND THE
COMMUNITY

11TH COMMUNITY-CAMPUS PARTNERSHIPS FOR HEALTH CONFERENCE: TRANSFORMING
COMMUNITIES AND HIGHER EDUCATION
April 29-May 2, 2009 Milwaukee, WI Details at http://www.ccph.info

NURSING RESEARCH: THE PATH TO EXCELLENCE: SHOWCASING LINKS TO PRACTICE
SETTINGS
May 1, 2009 London, ON For more information, email alaw1@uwo.ca

SOLID FOUNDATIONS… SHIFTING HORIZONS  2009 NATIONAL EDUCATION CONFERENCE
INFECTION PREVENTION AND CONTROL
May 9-14, 2009 St. Johns NL More details at http://www.chica.org

ENGAGING REFLECTION IN HEALTH PROFESSIONAL EDUCATION AND PRACTICE

RECIPROCAL PARTNERSHIPS: TRANSFORMING HIGHER EDUCATION AND COMMUNITY FOR
THE FUTURE
May 18 & 19, 2009 Portland, Oregon Call for proposals and registration at
http://www.pdx.edu/cae/partnership.html

STRENGTHENING THE BOND: CULTURE, COLLABORATION, AND CHANGE

HEALTH PROFESSIONS EDUCATION 2009 CONFERENCE : GLOBAL BEST PRACTICES IN
SIMULATION
May 21-23, 2009 Toronto, ON More information at
http://bloomberg.nursing.utoronto.ca/CIENE/conference2009.htm

CANADIAN SOCIETY FOR EPIDEMIOLOGY & BIOSTATISTICS - NATIONAL STUDENT
CONFERENCE

FAMILY CENTRED CARE IN CONTEXT 2009 CONFERENCE
May 24-26, 2009 Edmonton AB Details at http://www.fcc-conference.ca/index.htm
THE UNIVERSITY OF THE WEST INDIES FACULTY OF MEDICAL SCIENCES ANNUAL NURSING MIDWIFERY RESEARCH CONFERENCE AND MARY SEIWRIGHT DAY
May 28 & 29, 2009 More details at http://myspot.mona.uwi.edu/nursing/conference

THE CANADIAN PUBLIC HEALTH ASSOCIATION ANNUAL CONFERENCE

THE IAGG WORLD CONGRESS, PARIS, FRANCE
July 5-9, 2009
Info: www.gerontologyparis2009.com

THE GREYING NATION: KEEPING AHEAD OF THE WAVE
June 10-12, Edmonton, AB More details at http://www.capitalhealth.ca/GreyingNation2009

THE DAPHNE COCKWELL SCHOOL OF NURSING (RYERSON UNIVERSITY) 2ND ANNUAL NURSING RESEARCH DAY: LEADING RESEARCH FOR HEALTH IN OUR COMMUNITIES
June 24th, 2009 Toronto, ON Details at http://www.ryerson.ca/nursing/news/nursingresearchday.html

INTERNATIONAL COUNCIL OF NURSES 24TH QUADRENNIAL CONGRESS: LEADING CHANGE: BUILDING HEALTHIER NATIONS

INTERNATIONAL NURSING RESEARCH CONGRESS FOCUSING ON EVIDENCE-BASED PRACTICE (SIGMA THETA TAU)
July 13-17, 2009 Cancun, Mexico Details at http://www.nursingsociety.org/STTIEvents/ResearchCongress/Pages/congress.aspx

HISPANIC NURSES: CREATING PATHWAYS TO REDUCE HEALTH DISPARITIES

THE 4TH INTERNATIONAL CONFERENCE ON COMMUNITY HEALTH NURSING RESEARCH: HEALTH IN TRANSITION: RESEARCHING FOR THE FUTURE

DEMENTIA SERVICES DEVELOPMENT CENTRE'S 3RD INTERNATIONAL CONFERENCE: FACING THE FUTURE

CANADIAN ASSOCIATION ON GERONTOLOGY (CAG) 2009 CONFERENCE
October 22-24, 2009
Fairmont Hotel, Winnipeg, Manitoba
Info: http://www.cagacg.ca

16TH ANNUAL CANADIAN CONFERENCE ON INTERNATIONAL HEALTH: HEALTH EQUITY: OUR GLOBAL RESPONSIBILITY
October 25-28, 2009 Ottawa, ON More details at http://www.csih.org
Summary of Western and Northern Regional Roundtable, held September 15, 2008
Regina Saskatchewan on:

Valuing Health Care Team Members: Working with Unregulated Health Workers (UHW)

We opened the day by hearing Caroline Kealey, Principal of Ingenium Communications welcoming everyone and reviewing the guiding principles for the day which included an overview of the purpose, structure and objectives of the session. We set the stage with Norma Freeman, Nurse Consultant of the Canadian Nurses Association identifying the eight key findings of the Discussion Paper. We heard from Noreen Linton, Executive Director and Associate Chief Nursing Officer, Calgary Health Region who provided us with an employer’s perspective on the key issues of Unregulated Health Workers (UHWs) particularly focusing on the integration of UHWs across the continuum of care.

At our tables, we broke into discussions about the identified issues and attempted to validate and or refine those issues. At this Western and Northern Regional Roundtable, the priorities were identified as:

1. Health Human Resource planning/Health System Capacity Planning
   - Lack of information (statistical) about and from UHW’s
   - Portability
   - Cost and Funding
   - Employment structure and collective bargaining
   - Recruitment and retention; health worker shortages and rural versus urban practices
2. Education and Training/Competencies/Standards of Practice
   - Provincial autonomy
   - Position titles
   - Identification of competencies
3. Delegation, Liability and Accountability
   - Greater specificity and clarity from government and employer
   - Assistive role to the professional not to the patient/client
   - Need to examine this issue in relation to clarity of roles and position titles
   - Understand the mindset of UHW-acclimated to being assigned tasks and directed
   - Open and transparent

It was noted that for this group a large focus was on patient outcomes that was not necessarily prioritized in the other roundtable discussions.

During the afternoon, we again broke into small groups to evaluate avenues to address issues and identify stakeholders and potential strategies for success. Participants examined the role of the UHW in a collaborative inter-professional team setting identifying the key dangers (risks), opportunities and strengths. In addition, participants described the key factors which would demonstrate progress and success in a relatively short timeframe (over the next one to two years).

The Western and Northern Regional Roundtable is the final in a series of three sessions. The collaboration of information from all the roundtable discussions will go forward to the National Symposium in March 2009. The National Symposium is of critical importance to build on the exploratory discussions and develop an actionable plan.

Dawn Winterhalt, RN, BScN, GNC(C), MS in Health Services (Dawn.Winterhalt@Saskatoonhealthregion.ca)
SGNA President

As a nursing teacher I think this book is very important and useful in nursing education and nursing practice. It gives new ideas for nurses’ work by encouraging nurses to collaborate with other specialists, and it sheds new light on the work of creative arts therapists. The content of the book is diverse and it has been written by professionals in their respective field of practice. In my review I will concentrate on the topic of my research area: the use of dance in the care of people with dementia.

In Chapter 18, Laurel Bridges writes about the application of dance/movement therapy principles to the nursing care of people with dementia. The focus of the article is on non-verbal communication and its importance in the care of this population. Bridges bases her chapter on a broad and comprehensive range of literary sources.

In the introduction, Bridges describes the meaning of communication to the human being and the changes in their ability to communicate verbally when the person has dementia. She also presents different research results of the use of dance therapy and social dance in the care of elderly people. That information provides the reader with a concise and precise overview of the subsequent parts of the article, and thereby enhances his or her understanding of how and why dance/movement therapy is helpful for people with dementia.

Bridges clarifies the concepts of movement and dance as communication. She describes them in such a way that the reader’s earlier views might change a lot. In my opinion, it is important that we understand dance and movement widely in the nursing context. Dance/movement therapy is also described and introduced in the context of the care of elderly people. Bridges makes use of the theory of dance/movement therapy to introduce movement communication to the nurses working in dementia care. She does not, of course, introduce dance/movement therapy as a therapy method.

What I found very interesting in this chapter were the parts where Bridges introduces recent research on dementia and non-verbal communication, nonverbal nursing approaches and the use of body language in providing reassurance and preventing aggressive behaviour. That gives justification for the importance of the topic.

In summary, this chapter provides principle knowledge and concrete examples of movement observation and connection through movement. I think the consciousness of kinaesthetic empathy and validation through movement is fundamentally important. Movement and nonverbal communication offer nurses new possibilities to really influence different situations with the people with dementia. Bridges justifies that in a credible way. Case studies clarify the theoretical parts.

If you have no already done so, ask your local library to order a copy. ISBN #0-398-07556-5
Orders can be made directly with the publisher: Charles C Thomas: books@ccthomas.com or visit the Creative Arts/Integrative Therapies in Health Care Research Group website: www.cait.fr.nf

Review done by:
Teija Ravelin, RN, PhD, Lecturer E-mail address: teija.ravelin@kajak.fi
University of Applied Sciences
P.O.Box 52, Ketunpolku 4
FI-87101 Kajaani, Finland

******************************************************************

BOOK REVIEWS / NEW BOOKS

This clearly written paperback by two University of Calgary faculty members contains a description of 85 religions/spiritual practices. This book is very timely and will be welcomed by many people worldwide, given the multicultural context in which we all live and work. Another excellent feature is that it extremely well referenced, including direct weblinks to the religious/spiritual communities involved. Further information will soon be available on the University of Calgary Faculty of Nursing website [www.ucalgary.ca/NU](http://www.ucalgary.ca/NU) and/or by contacting the first author directly at: ngrant@ucalgary.ca

Please ask your librarian to order a copy. ISBN 978-0-5955-0527-2

Review done by: Carole-Lynne Le Navenec, RN, PhD

********************************************************************************

Care for the Caregiver

*A Handbook on Spirituality for Professional and Family Caregivers* by

Judith Campbell
Holistic Wellness Facilitator & Author
[www.energywellness.ca](http://www.energywellness.ca)

What began as a response to an article¹ in *The Canadian Nurse*, titled, “Why is it so hard to talk about Spirituality?” has evolved into a project to help raise funds for a hospice in rural Ottawa!

My first thought after reading the article in which the authors speak of the inadequacy experienced by nurses in talking with their patients about the subject of spirituality, was that maybe I could help by creating a handbook on spirituality for nurses, based on my two books that deal with this subject.

In my work as a retreat facilitator for family caregivers associated with *Friends of Hospice Ottawa*, it was apparent that family caregivers could also benefit from such a publication, and further, that a portion of the revenues could be used as a fundraiser for the full-time hospice planned for 2011.

It is with this vision that I am now approaching the text, so that both professional and family caregivers can utilize the handbook equally.

My objective in this project is three-fold. First I would like caregivers – whether professional or family caregivers – to understand what it means to experience their own spirit, and how connecting with this part of themselves regularly is essential for balanced and healthy living. In other words, spiritual health is integral to a healthy body and mind.

Second, I would like caregivers - through their developing spiritual awareness – to creatively integrate spiritual care as part of their care-giving routines. This means attending to details in their care *such as*: ensuring that patients / clients / family members are able to comfortably see out their window before

---

¹ Why is it so hard to talk about Spirituality? Jan 01, 2008; Molzahn, Anita E; Shields, Laurene, *The Canadian Nurse*. Vol. 25(4) www.cgna.net
leaving the room so the client can watch the cloud formations, or the sunset or the moonrise, for example; offering to take them outdoors to breathe in the fresh air of a Spring or Autumn morning, or to sit in the beauty of nature; letting them put their hands in the soil and nurture a growing plant; arranging for them to have access to inspirational readings, and to be able to listen to meditative music during quiet times of the day, and for soft lighting when evening approaches; encouraging them to do something they love to do - that brings them joy, etc. When used in conjunction with quality standards of addressing physical and mental / emotional needs, the result is a balanced approach to short- or long-term health care.

And third, in the simplest of care-giving tasks, I would like caregivers to learn to offer their “complete presence” — i.e. body, mind and spirit - during care. It is in such an approach, that a sense of oneness with the person they are caring for may be experienced. When this happens, both care giving and care receiving occur, and mutual respect for the other is experienced in both – a deeper realization of the common humanity we all share. This brings new meaning and fulfillment to caregiving, where concerns about having to talk about spirituality vanish.

Anyone reading this who is not clear on the meaning of spirituality might confuse the term spirituality with religion. And this is the first lesson in the handbook. Spirituality can exist alongside religion, however they are not the same thing. In fact many people who are followers of a religious belief and faith are not familiar with spirituality in the context in which I am using it.

Since the writing is not yet completed, I invite any suggestions from readers of this article about what you would like to see in such a handbook. I welcome your comments at judithmcampbell@hotmail.com.

I am grateful to the Canadian Gerontological Nurses Association for this opportunity to tell you a little of this exciting project and hopefully I will be able to give you an update as it comes closer to finalization. Educated in public health nursing (now retired), Judith has had 30 years experience in community and occupational health nursing working both at the grass roots level and in middle and senior management positions in the Ottawa area. Her first book, titled energywellness.ca was published in 2004, by General Store Publishing House, Renfrew, Ontario, followed in 2006, by I Brake for Butterflies / Finding Divinity in All That Is. In her teaching role, Judith offers workshops, retreats and courses on the subject of body, mind and spirit wellness.

For a splendid, concisely organized and wonderfully indexed, non heavy book (that can fit in your purse) on providing quality nursing care of the elderly see: Carlson, D.S., and Pfadt, E. (2009). *Davis’s Clinical Coach Series: Nursing Care for Older Adults.* Philadelphia: FA Davis

For info re cost and ordering in Canada contact: orders@lb.ca or contact Customer Service at 800-665-1148

This handy reference transitions from theory to clinical to practice to provide the information nurses need to ensure quality care for older adults in any practice setting. You’ll have access to all of the signs, symptoms, and collaborative management of common conditions experienced by older adults as well as community resources. A spiral binding and nine thumb tabs make it easy to quickly find the information you need.
Institute on Aging Newslink  http://www.nia.nih.gov

Alberta Centre on Aging – NewsLink
Website:  http://www.aging.ualberta.ca/News_Link%20Archive.html

Recent issues of the Canadian Medical Association Journal are available from 17 March 2009; Vol. 180, No. 6 URL:  http://www.cmaj.ca/content/vol180/issue6

Newsletters about Developments in Technology:


NURSES

The Quotable Nurse
“You can please some of the patients all of the time, and all of the patients some of the time, but you will never please the family”

Heard on the Radio
Local public radio reporter: Nurse Smith is responsible for the health of over 2,000 students in the school district, but she seems to know many of them individually and calls them by name as she passé them in the hallway.

School nurse, to kids: Hey, guys

Chapel Hill, North Carolina
www.overheardintheoffice.com
A Pattern of Care Transitions for Older Adults: A Gerontological Nursing Perspective

Dr. Belinda Parke RN GNC(C)
Dr. Kathleen F Hunter RN NP GNC(C)

Movement from one practice setting to another is complex in a population who have continuing and persistent care needs that are endured across treatment and practice settings. The persistent nature of these care needs are overlooked in the discharge planning perspective that dominates health care systems today. Further, discharge planning is underpinned by an efficiency model that sheds responsibility for the successfulness of outcomes in the next practice setting. For example, leaving hospital emphasizes vacating the bed. This is observed in language such as “moving the patient from our service”. In objectifying the older person with complex health needs in this way, we cut off responsibility for the individual’s successful transition to the next setting as responsibility ends when care ends. We argue that gerontological nurses’ responsibility continues as a shared responsibility with other health care providers in different care settings to ensure that the needs of the individual are met. Rather than responsibility ending, we should view this as a shift in responsibility that each care setting shares in ensuring successfulness.

Defining Transitional Care

Transitional care has been defined as “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location” (Coleman, Boult, American Geriatrics Society, 2003). While this definition addresses the system perspective on transferring between care settings, we assert that a transfer is only part of the transitional care experience that affects both quality and safety for the older individual, and psychological comfort for a family. The transition process varies between people (community dwelling older people, family members, professionals) and health care settings and systems (hospital, nursing homes, assisted living, private homes). Literature on transitions addresses both systems and experiential perspectives.

The Systems Perspective

From a systems perspective, organizational processes and programs have been used to assess the quality, often described as continuity of care, of transfer between settings and discharge planning. For example, Boockvar and Burack (2007) examined whether a management level relationship between nursing homes and hospitals was associated with better hospital-to-nursing home transfer process of care, but concluded that it was not. Instead, specialized geriatric care and hospital characteristics were more likely to be associated with a better hospital-to-nursing home transfer processes. Coleman, Parry, Chalmers, and Min (2006) described using a “transition coach” to assist community based older adult patients and their caregivers to play a more active role during care transitions and Naylor, Brooten, Campbell, Maislin, McCauley, and Schwartz (2004) examined the effectiveness of a transitional care intervention delivered by advanced practice nurses (APNs) to older adults hospitalized.

From a safety perspective, work has focused on adverse events related to medication reconciliation at points of transfer (Boockvar, Carlson, LaCorte, Giambanco, Fridman, & Siu 2006). In addition, effectiveness of communication between nursing homes and hospitals has been examined and insufficient or inadequate documentation has been described (Jones, et al 1997). Cognitive impairment has been singled out as a primary factor in communication. In a retrospective study of nursing home to hospital transfers, Boockvar, Fridman, and Marturano (2005) found documentation did not identify all patients with dementia and was often incomplete in terms of characterizing patients' cognitive status thereby negatively impacting the quality and safety of transitional care.
Experiential Perspective

An experiential perspective is represented in the literature in the context of relocation to a nursing home and, to lesser extent the disempowering effect of hospital discharge on the individual. For example, Hagen (2001) identified emotional aspects for caregivers related to transitional care into a nursing home that included fear of loneliness, and a sense of guilt. He suggested that transitions of care are complex and that Gerontological nurses must explore deeper meaning issues for residents and their families. Similarly, Wells (1997) showed that discharge from acute care is often driven system need, which in turn evokes distress for older people and burden for family members.

In addition, literature has addressed the individual’s experience with transitional care in relation to chronic disease management. When considering chronic disease care needs, gerontological nurses’ concern extends to preserving functional capacity/ability. Hence, transitional care is complicated by geriatric syndromes such as dementia, falls, incontinence, deconditioning, and chronic pain to name a few. The application of Gerontological nursing expertise in transitional care is poorly articulated.

The Gap for Gerontological Nursing Response

A gerontological nursing perspective on transitional care begins when there is a change in the older adult’s condition that triggers a decision to transfer to a different care setting (See Figure 1). This figure represents points in a pattern of care transitions for older adults where gerontological nurses can make a difference.

In this model, the decision to transfer is determined after assessment. Influencing variables on the decision to transfer are the older adult’s personal choice, family requests and expectations, formal advanced directives, the context of the practice setting, access to specialized interdisciplinary resources, and the staff knowledge and tolerance for the burden of care created by the change in condition. The burden created by the change is variable across practice settings. For example, if an older adult in the community becomes acutely ill and delirious, the Home Care Nurse may make a decision to transfer to the Emergency Department (ED) if the care needs cannot be met in the home setting. Once the individual is seen as stable, discharge home may occur as the burden is perceived as a non ill person deemed inappropriate for the ED service. The same can be said for other practice settings such as the nursing home, assisted living facility, and acute care hospital or outpatient clinic.

The special features of Gerontological nurses’ role are to support optimum transitions of care where opportunities to affect quality and safety in both the system and the lived experience of older people and families occur. In our example, the Homecare nurse working with a Gerontological lens would be sensitive to ensuring communication about client cognitive and physical function as a part of coordination of care on a system level, while taking account of the personal impact a transition from home to an emergency department creates. This nurse in all her communication, care planning and interactions would be distinguishing the normal age-related changes with disease and illness in order to ensure appropriate system response.

The complexity of geriatric syndromes, as expressed in cognitive and physical function changes, are a primary factor challenging the safety, effectiveness and quality of care during transitions. Geriatric syndromes such as those mentioned above, act upon each other in a synergistic manner to produce cascading effects culminating in tenuous coping and disability. These syndromes affect quality of life, functional status, ability to live independently and sometimes survival, which are often not recognized or overlooked in a hospital setting. Together, this gap highlights the essential role of Gerontological nurses in transitions of care.
We are interested in connecting with other gerontological nurses in the country to begin to dialogue on transitions of care. Our hope is to establish a network of contact who might be interested in investigating the special feature of transitions experienced by older people. If you are interested contact:

Dr. Belinda Parke    Dr. Kathleen Hunter
Belinda.parke@ualberta.ca    kathleen.hunter@ualberta.ca

Figure 1. A PATTERN OF CARE TRANSITIONS FOR OLDER ADULTS

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>Process Points Along The Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Home, Community Centre, Hospital, Long Term Care)</td>
<td></td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td>S T A R T</td>
</tr>
<tr>
<td>Trigger: A Change In Older Adults Conditions</td>
<td>Assessment</td>
</tr>
<tr>
<td>Decision On Disposition</td>
<td>Internal Process</td>
</tr>
<tr>
<td>• ED Admission</td>
<td>• Assessment</td>
</tr>
<tr>
<td>• Assessment</td>
<td>• Diagnosis</td>
</tr>
<tr>
<td>• Treatment</td>
<td></td>
</tr>
<tr>
<td>Arrival at next care site</td>
<td>Travel to next care setting</td>
</tr>
<tr>
<td>Decision To Transfer</td>
<td>Getting Ready</td>
</tr>
<tr>
<td>Influencing Variables</td>
<td></td>
</tr>
<tr>
<td>• Older Person’s Choice</td>
<td></td>
</tr>
<tr>
<td>• Formal Advance Directive</td>
<td></td>
</tr>
<tr>
<td>• Family Request And Expectation</td>
<td></td>
</tr>
<tr>
<td>• Interdisciplinary Resources</td>
<td></td>
</tr>
<tr>
<td>• Staff Knowledge &amp; Tolerance</td>
<td></td>
</tr>
<tr>
<td>Hand off</td>
<td>shift in responsibility</td>
</tr>
</tbody>
</table>

| Hospital (Emergency Department- Direct Admission to Patient Unit) | |
| Decision On Disposition | |
| Options | |
| Rehabilitation | SubAcute |
| Home | Alternate Level of Care (ALC) |
| Long Term Care | Death |

Influencing Variables:
- Older Person’s Choice
- Formal Advance Directive
- Family Request And Expectation
- Interdisciplinary Resources
- Staff Knowledge & Tolerance

References


************************************************************************************

**Where Am I?**

**How the environment enhances care for persons with Alzheimer’s and related dementias**

by

Gwendolyn de Geest

*CruiseRespite Solutions*

gwendolyn@CruiseRespite.com

Tel: (778) 772-7776

IT IS BEDTIME AT TICK TOCK MANOR, things are done right on time at Tick Tock Manor. Contrary to a sleepy thought, one hears Sam down the long corridor, shouting “Help, help, help.....” When the caregiver approaches Sam, “What’s wrong Sam?”

“I want to go home,” cries Sam. He is sitting in his wheelchair, staring at the “EXIT” sign. Here comes Elsie, doing her wheelchair shuffle, up and down the long hallway. When asked if she is ready for bedtime, Elsie replies, “I am looking for my pet doggie, have you seen him?” She adds, “My doggie is lost on this long road.”

Mary goes by, picking up extra towels and briefs from the care cart as she passes by each of the others. Mary never wants to run out of supplies. One of the nurses attempts to convince Mary that she won’t be needing these things. Mary takes a good swing at her.

Gerry is being wheeled along in his wheelchair by his companion. “Are you ready for sleep time Gerry?” asks the caregiver.
"I am waiting for a taxi," says Gerry.

Ingrid has a pair of scissors in her hand, and she is standing beside a picture of a bouquet of sweet-peas, poised to snip a stem. "Would you like to get ready for bed Ingrid?" She shakes her head, not understanding.

The caregiver gives up.

Florence is not wanting to change her clothes for bedtime. "No, no, no," cries Florence. Her caregiver struggles to remove the clothes anyway, and discovers later that Florence only wants to save these same clothes for wearing tomorrow.

Sam, Elsie, Mary, Gerry, Ingrid, and Florence live at Tick Tock Manor because they have been diagnosed with Alzheimer's disease and related dementias.

This is one bedtime at Tick Tock Manor when things will not be done quite on time.

**Abstract**

The fact that there is no known cause and no known cure for Alzheimer's disease is not uplifting for the care partners, both family and professional, nor for the person receiving the diagnosis. However, one of the best goals in treatment lies in the persons' environment. The above case study illustrates some of the many challenges in caring for this special population. This paper will identify some simple environmental modifications in a dementia care setting, such as Tick Tock Manor, intended to dramatically improve the quality of life, both for the person with dementia and their care partner.

Utilizing the Professional Environmental Assessment Protocol (PEAP, 1994), organized with respect to eight therapeutic goals judged to be significant in the provision of dementia care, this paper will illustrate selected environmental features commonly found in Special Care Units (SCUs). This timely approach to care has been selected, allowing persons with Alzheimer's disease and related dementias to live out their dementia in any manner they will live it out.

**Before**

As a result of working in dementia care for over two decades, both as an educator and at the bedside, I have made many observations regarding the environment for persons with dementia. The purpose of this paper is to illustrate how some simple environmental modifications can enhance the quality of life and impact on behaviors of persons with dementia.

The clinician in charge invited me to visit Tick Tock Manor, a Special Care Unit (SCU) to make some observations. Naturally, in these times of tightening purse strings on our health care system, this clinician is looking for low-cost solutions for improvement in the environment. It is well known that there is no known cause and no known cure for Alzheimer's disease. Before any of us get too depressed about this fact, we do know that one of the very best goals in treatment for Alzheimer's disease lies in the environment.

In fact, when we lift the disease and embrace the person, one of our very best treatments is the environment. In particular, this clinician is looking for ways to modify the environment in the SCU. The very first feature I noted when entering the dementia care unit was the long, dark hospital corridor. (PEAP - therapeutic goal is to maximize safety and security). In the case study, Elsie is searching for her lost doggie on 'this long road.'

Secondly, as we walked along, I noted there were many, many pictures hanging on either wall, narrowing the corridor even more. The environment for persons with dementia should be neither over stimulating nor under stimulating (PEAP- therapeutic goal is to regulate and provide quality of stimulation). The clinician agreed that many of these pictures, such as a medieval castle or a Christmas flower, were disorienting even for the mentally alert individual.
There was common agreement that it might be a good plan to remove the pictures. And she added that they already have some cans of paint that can be used to paint the walls in more pastel shades, eliminating the sense of darkness. This simple modification will be cost effective as well as enhancing the environment for persons with dementia.

As a plan to eliminate the perception of the long hallway, I suggested making three clusters along the way, utilizing benches at each cluster. The first bench will be a place where individuals can sit and look at the fish pond. The next stop along the way, there will be a bread maker. Who doesn’t love to smell fresh bread? And at the third cluster, there will be some nice soft classical music playing, where persons can sit and relax. This concept really draws the person to come and sit and relax while eliminating that feeling of the long, dark corridor (PEAP- therapeutic goal is to facilitate social contact). Gerry, who believes he is waiting for a taxi, can sit on one of the benches and talk to the fish as a form of distraction.

One thing I have learned very early in working with this population is that there seems to be nothing wrong with the person’s reading ability. In fact, many persons with dementia read very well. Everywhere in this SCU was signage, for example:

- FIRE EXTINGUISHER - what do you and I do when we see the word fire? We run.
- EXIT - what do persons with dementia want to do? Go home. ‘Hooray! I can get outta here!’
- PLEASE DO NOT TOUCH - as with our children, when we say please do not touch, what do they want to do? They want to touch (PEAP- therapeutic goal is to maximize awareness and orientation). Sam, shouting for help, wants to go home; seeing the ‘Exit’ sign may encourage this thought process.

Persons with dementia are constantly searching for meaning in their environment; they are drawn towards persons or things that will assist them to understand their reality. The goal is to keep the person connected with their reality; so why not have a real bouquet of flowers on the table rather than a picture (PEAP- therapeutic goal is to regulate and provide quality of stimulation)? As with Ingrid, she is trying to make sense of the world around her while snipping the sweet peas in her garden, persistence of a long-term memory.

Another major factor in our environment involves the people in it. As we were strolling through the SCU, I heard one of the professional care partners say in a loud, impatient voice, "Hurry up Florence, I already told you it’s your bath day" (PEAP- therapeutic goal is to support functional abilities). As depicted in the case study, Florence refuses to change her clothes; she has lived in an era where one simply did not change their clothes on a daily basis. Perhaps her care partner needs to communicate with Florence in a more respectful manner.

I later asked the clinician, "Is that care partner dementia friendly?"

As persons with dementia are constantly searching for meaning in their environment, it is absolutely critical that their care partners are communicating with them in a manner that is both orienting and friendly.

As in the case study, Mary is collecting briefs and towels from the cart (PEAP- therapeutic goal is to provide opportunity for personal control). This menial task allows Mary to exercise personal preference, choice and independent initiative to determine what she will do and when she will do it.

**After**

Naturally, transformation does not happen overnight. However, I toured this SCU setting a short thirty days later, and some major changes were evident every step along the way in Tick Tock Manor. I could actually feel the sense of calm.
The first thing I noted in the SCU was that the walls were now bare of pictures. And the old dark paint had been replaced with a very delicate eggshell colour. These simple modifications gave the illusion of making the hallway brighter and wider.

Secondly, I could see individuals sitting at one of the benches down the long corridor, gazing at the fish pond. As I came closer and introduced myself to Gerry, I witnessed a huge smile on his face as he was admiring the fish. “I like this,” smiled Gerry.

The bread maker was not in operation this day; however, the report from the previous day was that the aroma of freshly baked bread was highly successful in comforting the person with dementia.

The clinician at Tick Tock Manor agrees that signage, such as ‘EXIT’ may possibly pose a problem for Sam and others who are wanting to go home. However, this environmental feature is critical in meeting the Fire and Safety regulations. Persons with dementia are always searching for home. But are they really searching for the place or are they searching for the feeling of comfort (de Geest, 2006)?

Following is an example of a highly successful communication, when Claudia, a care partner of Dorothy, engages with Dorothy in a dementia-friendly manner:

“Where is she, where is she? Did she go that way? I have to find her.” Dorothy is becoming agitated, searching for her sister (who presumably has been dead for over thirty years). Claudia responds in a friendly manner, “I saw her in the dining room. Let me help you Dorothy. My, that is a lovely neckline on you. All the girls are wearing that. It looks so sharp.” This strategy has charmed and distracted Dorothy for the moment. In fact, Dorothy replies, “Oh, do you really think so? Thank you.” She takes Claudia’s arm, and off they go to the dining room (PEAP- therapeutic goal focuses on attempts to preserve continuity between present and past environments and the self of past and present).

A puppy dog now lives at Tick Tock Manor; he merrily is romping up and down the hallways, stopping only briefly to sniff and visit with friends along the way. Elsie looks on, smiling.

Finally, it was evident that the atmosphere in general, was calm and relaxed. I engaged with one of the care partners working that day in SCU, and she reported,

“I am amazed how much calmer the people are since these few changes were put in place.”

**Professional Environmental Assessment Protocol Criteria (PEAP)**

**Maximize Safety And Security**

Definition: The extent to which the environment both minimizes threats to residents’ safety and maximizes sense of security of residents, staff, and family members

**Maximize Awareness And Orientation**

Definition: The extent to which users (often staff and visitors as well as residents) can effectively orient themselves to physical, social, and temporal dimensions of the environment.

**Support Functional Abilities**

Definition: The extent to which the environment and the rules regarding the use of the environment support the practice or continued use of everyday skills. These skills can be divided into both activities of daily living (ambulation, grooming, bathing & toileting, eating) and independent activities of daily living, which will vary with stage of the disease.
Facilitation Of Social Contact

Definition: The extent to which the physical environment and rules governing its use support social contact and interaction among residents.

Provision Of Privacy

Definition: The extent to which input from (e.g., noise) and output to (e.g., confidential conversations) the larger environment are regulated.

Opportunities For Personal Control

Definition: The extent to which the physical environment and the rules governing the use of the environment provide residents with opportunities, consistent with level of acuity, for exercise of personal preference, choice, and independent initiative to determine what they will do and when it is done.

Regulation And Quality Of Stimulation

Definition: People with dementia have decreased ability to deal with potentially conflicting stimuli, and have greater difficulty distinguishing between foreground and background stimulation. Therefore the environment must be sensitive to both the “qualify” of stimulation, and its effective regulation. The goal, in Mace’s term, is “stimulation but not stress.”

Continuity Of The Self

Definition: This scale focuses on attempts to preserve continuity between present and past environments and the self of past and present. This can be expressed in two different ways: through presence of personal items belonging to the individual, and creation of a non-institutional ambiance.

References:

Gwendolyn deGeest RN, BSN, MA is the author of “Where am I?” She has been working in dementia care for over two decades and has witnessed the joys and sorrows of families struggling to maintain a quality of life for themselves and their loved ones. Gwendolyn’s thesis, “The Relation Between the Perceived Role of Family and the Behavior of the Person with Dementia” is published in the American Journal of Alzheimer’s Disease, May/June, 2003. This work was presented at The International Congress of Gerontology, Vancouver, Canada. Gwendolyn resides in Vancouver, with her family where she is a professor.

Gwendolyn welcomes your questions/comments at gmdegeest@cruiserespite.com. You may also wish to meet with her during the May 27-30 CGNA Conference in Banff. Just send an email note to request a meeting date and time.
My interest in a nursing speciality of Gerontology

Judy Kelly

Over the past several years, I have worked in a long-term care nursing home setting as a nursing attendant, and most recently as an undergraduate student nurse, and personally, I have watched my aged mother struggle with the confusion of an unrelenting and increased short-term memory loss, and become increasingly frail and home-bound.

By means of these professional and personal experiences, I have gained a growing interest in understanding the social process of aging. As I consider how to best work and thrive as a Registered nurse specializing in gerontology, I believe it is essential that I learn more about the normal process of aging, and gain specific knowledge and skills in working with and relating to older adults in all areas of my professional and personal life.

As a future gerontology nurse, I am excited about learning about the complex characteristics of aging that are unique to each person; from promoting health to prevention or management of the physical changes that decrease the effectiveness of main organs; to chronic illness that accompany aging; to the individual’s changing roles and relationships with family and friends; to the changes that occur in memory, motivation and interests. I value older people and I look forward to seeking ways of improving the health and wellness, or quality of life for older individuals.

Because our population is aging, I believe that there will be a growing need for RN’s who are specialized in concerns affecting the elderly. For me, I see a bright future that might include becoming a gerontology Nurse Practitioner, teaching at universities, assisting with government policy and definitely conducting research. I hope to meet with other nursing students or new graduates at CGNA May/09 Banff conference.

Judy Kelly University of Calgary
kellyenquiries@hotmail.com

Bachelor of Nursing – Accelerated Track Student
(will graduate in June 2009)

Footnote: Judy Kelly will be attending the Canadian Geronotological Nurses Association (CGNA) National Conference in Banff and would be most intested in networking with other graduate students/new graduates who are wanting to specialize in Gerontological Nursing.

*****************************************************************************
A GOOD INVESTMENT PRODUCT

Sensors Help Keep the Elderly Safe, and at Home
February 13, 2009
By JOHN LELAND

Increasingly, many older people who live alone are not truly alone. They are being watched by a flurry of new technologies designed to enable them to live independently and avoid expensive trips to the emergency room or nursing homes.

Bertha Branch, 78, discovered the power of a system called eNeighbor when she fell to the floor of her Philadelphia apartment late one night without her emergency alert pendant and could not phone for help.

A wireless sensor under Ms. Branch’s bed detected that she had gotten up. Motion detectors in her bedroom and bathroom registered that she had not left the area in her usual pattern and relayed that information to a central monitoring system, prompting a call to her telephone to ask if she was all right. When she did not answer, that incited more calls — to a neighbor, to the building manager and finally to 911, which dispatched firefighters to break through her door. She had been on the floor less than an hour when they arrived.

Technologies like eNeighbor come with great promise of improved care at lower cost and the backing of large companies like Intel and General Electric.

But the devices, which can be expensive, remain largely unproven and are not usually covered by the government or private insurance plans. Doctors are not trained to treat patients using remote data and have no mechanism to be paid for doing so. And like all technologies, the devices — including motion sensors, pill compliance detectors and wireless devices that transmit data on blood pressure, weight, oxygen and glucose levels — may have unintended consequences, substituting electronic measurements for face-to-face contact with doctors, nurses and family members.

Ms. Branch, who has severe diabetes and heart disease, said she could not live on her own without the system, built by a Minnesota company called Healthsense. “I lost a very close friend recently,” she said. “She was also diabetic and she fell during the night. She didn’t have the sensors. She went into a coma.”

Without the sensors, Ms. Branch said, “I would probably be dead.”

Stories like Ms. Branch’s show the potential of relatively simple devices to provide comfort and independence to an aging population that is quickly outgrowing the resources of doctors, nurses, hospitals and health care dollars available to it. The cost for Ms. Branch’s basic system, supplied by a health care provider called New Courtland as part of a publicly financed program, is about $100 a month, far less than a nursing home, where the costs to taxpayers can exceed $200 a day. In the two years Mrs. Branch has had the system, she has fallen three times and been stuck once in the bathtub, each time unable to call for help without it.

“On an individual basis, we’ve demonstrated that they can be very effective,” said Brent Ridge, an assistant professor of geriatrics at Mount Sinai School of Medicine in New York. “But until they’re launched on a wide-scale basis, you just don’t know. Physicians might say, ‘I’m already overstretched, I don’t have time for all this data.’”

****************************************************************************
DEVELOPING “EVIDENCE BASED” APPROACHES FOR DEALING WITH BANK BUREACRACY: AN ACTUAL LETTER THAT WAS SENT TO A BANK BY AN 86-YEAR-OLD WOMAN.

[Yes, that's right, she was 86!! The bank manager thought it amusing enough to have it published in the New York Times]

Dear Sir:

I am writing to thank you for bouncing my check with which I endeavored to pay my plumber last month. By my calculations, three nanoseconds must have elapsed between his presenting the check and the arrival in my account of the funds needed to honor it.

I refer, of course, to the automatic monthly deposit of my entire pension, an arrangement which, I admit, has been in place for only eight years. You are to be commended for seizing that brief window of opportunity, and also for debiting my account $30 by way of penalty for the inconvenience caused to your bank. My thankfulness springs from the manner in which this incident has caused me to rethink my errant financial ways.

I noticed that whereas I personally answer your telephone calls and letters, --- when I try to contact you, I am confronted by the impersonal, overcharging, pre-recorded, faceless entity which your bank has become. From now on, I, like you, choose only to deal with a flesh-and-blood person.

My mortgage and loan repayments will therefore and hereafter, no longer be automatic, but will arrive at your bank, by check, addressed personally and confidentially to an employee at your bank whom you must nominate.

Be aware that it is an offence under the Postal Act for any other person to open such an envelope. Please find attached an Application Contract which I require your chosen employee to complete. I am sorry it runs to eight pages, but in order that I know as much about him or her as your bank knows about me, there is no alternative. Please note that all copies of his or her medical history must be countersigned by a Notary Public, and the mandatory details of his/her financial situation (income, debts, assets and liabilities) must be accompanied by documented proof.

In due course, at MY convenience, I will issue your employee with a PIN number which he/she must quote in dealings with me.

I regret that it cannot be shorter than 28 digits but, again, I have modeled it on the number of button presses required of me, to access my account balance on your phone bank service. As they say, imitation is the sincerest form of flattery.

Let me level the playing field even further. When you call me, press buttons as follows:

IMMEDIATELY AFTER DIALING, PRESS THE STAR (*) BUTTON FOR ENGLISH

1. To make an appointment to see me.
2. To query a missing payment.
3. To transfer the call to my living room in case I am there.
4. To transfer the call to my bedroom in case I am sleeping.
5. To transfer the call to my toilet in case I am attending to nature.
6. To transfer the call to my mobile phone if I am not at home.
7. To leave a message on my computer, a password to access my computer is required. Password will be
communicated to you at a later date, and only to that Authorized Contact mentioned earlier.

8. To return to the main menu and again listen to options 1 through 7.

9. To make a general complaint or inquiry. The contact will then be put on hold, pending the attention of my automated answering service.

10. This is a second reminder to press * for English. While this may, on occasion, involved a lengthy wait, uplifting music will play for the duration of the call.

Regrettably, but again following your example, I must also levy an establishment fee to cover the setting up of this new arrangement.

May I wish you a happy, if ever so slightly less prosperous New Year?

Your Humble Client,


Editor's Note: Thank you to Dr Sandi Hirst, Director, Brenda Strafford Centre of Excellence, and Associate Professor, University of Calgary Faculty of Nursing. She received it from a previous CGNA President, Dr. Joyce Springate

FEDERAL INCOME BENEFIT PROGRAMS FOR SENIORS Maureen Osis

With the current economic situation, seniors and their families are looking for ways to make the most of their income and their assets. Low-income seniors face even greater challenges. We encourage everyone to become aware of seniors’ benefits available to them.

First, a reminder about a previous ElderWise Info discussing "Tax Matters for Seniors." We noted the value of filing a tax return:

"Filing a tax return can make a real economic difference, especially to low income seniors. Many government programs that help low income seniors require that you file a tax return. In some cases, the application for the program can be submitted with your return."

The Old Age Security Program is the foundation piece for seniors’ benefits in Canada. The following information is adapted from the Government of Canada's webpage Services for Seniors Guide:
http://www.seniors.gc.ca/content.jsp?contentid=100&font=0

What is the Old Age Security (OAS) Program?

This program provides a modest pension at age 65 if you have lived in Canada for at least 10 years after turning 18. If you are a low-income senior, you may be eligible for other benefits as early as age 60.

The OAS program offers four types of benefits:

The Old Age Security Pension
If you are 65 or older and are a Canadian citizen or a legal resident of Canada, you should apply for the Old Age Security pension. You may be entitled to receive this pension even if you are still working or have never worked.
You should apply for the Old Age Security pension six months before you turn 65. Normally, you must apply on your own behalf. If you are applying for someone else, please contact the Income Security Program for more information (see telephone numbers below).

The Guaranteed Income Supplement (GIS)

The GIS provides additional money, on top of the Old Age Security pension, to low-income seniors living in Canada. To be eligible for the GIS benefit, you must be receiving the Old Age Security pension.

Because this supplement is based on marital status and income, you may qualify now, even if you did not qualify in a previous year.

The Allowance

If you are 60 to 64 and your spouse or common-law partner receives the Old Age Security pension and is eligible for the Guaranteed Income Supplement, you should apply for the Allowance.

The Allowance for the Survivor

If you are 60 to 64, have little or no income, and your spouse or common-law partner has died, you may qualify for the Allowance for the Survivor.

How can you receive OAS benefits?

Old Age Security benefits do not start automatically. You must apply for them. For more information:

- Call toll-free 1-800-277-9914 in Canada and the United States.
- If you have a hearing or speech impairment and use a teletypewriter (TTY), call 1-800-255-4786.
- If you live outside Canada and the United States, contact Service Canada at: 1-613-957-1954 (collect calls accepted)

Have your Canadian Social Insurance Number at hand.

This website has more contact options and details: http://www.hrsdc.gc.ca/eng/isp/contact/contact_us.shtml

Related Reading:

Tax Matters for Seniors

Talking About Finances

Information on health, housing and relationship issues in the ElderWise newsletter archive

What every Canadian with aging parents needs to know: Read our full length book: Your Aging Parents

Maureen Osis
Last month (Vol. 4, No. 15) we wrote about how you can approach sensitive topics during holiday visits with aging parents. During the visit you may have noticed new areas of concern, or old problems that are calling for action. Now, you may feel anxiety or uncertainty about what to do next. Taking that first step, no matter how small, can create momentum towards positive change. Here are some first steps for common concerns:

1. Health

Changes in physical or mental health are the most likely root cause of all other challenges facing your aging loved ones. Many factors combine to keep seniors healthy. Among the most important are good medical care, proper exercise and nutrition, and a sense of purpose and belonging.

A good first step is to become more informed about your parent's health. Educate yourself about normal aging, and learn more about their chronic health conditions. With your parents' permission, talk with their family doctor about your concerns.

2. Hygiene

Personal care may slip if a senior's eyesight, physical energy, or state of mind are negatively affected. First, gently point out some physical evidence (e.g., stained clothing) and share your concern. Encourage your parent to get a physical check-up and/or an eye exam.

3. Housekeeping

Loss of strength or mobility can make household chores more difficult. Start a conversation about getting more help - either from other family members, or by hiring someone.

Some seniors are reluctant to ask for help or to invite "strangers" into their homes. Suggest that help with household duties may mean that your parents stay in their own home a little longer.

4. Hazards

Many seniors can benefit from a few home modifications. There are many simple adaptations that make life safer: rearrange cupboards to easily reach things, install grab bars in the bathroom, remove loose scatter rugs, and add brighter lighting, particularly over stairways.

You can also look into emergency response systems. These devices, worn on the wrist or as a pendant, enable your parent to call for emergency help when they cannot reach a telephone.

Initiating some of these changes may require a "community" effort. That can mean recruiting help from other family members, friends, neighbors and/or getting outside help - private or public. In larger towns and cities, families can call on their local seniors' resource centre for more information on support programs. In rural areas, churches and other members of the community traditionally step up to help neighbors. Concerned families can also ask for an assessment of the senior by their local health authority, to see whether their family member qualifies for public assistance.
INTERDISCIPLINARY ENTIRELY WEB-BASED CREDIT COURSE FOR SPRING TERM, 2009 entitled:

INTRODUCTION TO MUSIC AND SOUND FOR THE HELPING PROFESSIONS

May 14–June 26, 2009

Info: Laura Hampson E-mail: hampson@ucalgary.ca Fax (403) 284-4803

This course involves an exploration of traditional and newly developed applications of music and sound to health care modalities and theories. Both theoretical and experiential aspects of the field will be surveyed. This course is considered to be a senior level nursing option.

Course Professors: Dr Carole Le Navenec, Associate Professor, Faculty of Nursing, University of Calgary and Dr Marcia Epstein, Musicologist and Assistant Professor, Faculty of Communication and Culture, University of Calgary

Pre-requisites: Permission of the Faculty. Both students and certified health care practitioners are welcome
The Nominations Committee of CGNA is seeking individuals who are committed to the Mission and Mandate of CGNA.

Positions to be elected at the AGM in May 2009 include:

- President-Elect: Term 2009 to 2011
- Secretary: Term 2009 to 2011
- Treasurer/Membership: Term 2010 – 2013
- The actual position does not begin until the Annual Meeting in 2010 that is held in conjunction with CNA. This provides the new Treasurer with a year of mentoring and learning.

Position descriptions are available on the web site http://www.cgna.net/

Suggested Target Date for submitting Nominations: anytime between September 2008 to March 31, 2009 so that we can feature the people being nominated in upcoming newsletters

For more information please contact:
- Sandi Hirst, Chair, Nominations Committee Email: shirst@ucalgary.ca
  Faculty of Nursing, PF 2260,
  University of Calgary,
  2500 University Drive NW,
  Calgary, AB T2N 1 N4

Nominations Process:

- A nurse interested in an executive position must be a member of CGNA, in good standing, for at least TWO years. This person is to be nominated by two other CGNA members, who each complete a nomination form.
- Nominees will be members who are committed to CGNA and who possess skills related to the potential office.
- Nominations are forwarded to the Nomination Committee Chair.
- Once a member has been nominated, the process continues. The nominee acknowledges and accepts their nomination in writing and forwards this acceptance to the Nomination Committee Chair.
- The nominee forwards a black and white passport photograph to the newsletter editor to be included in the spring newsletter, along with a 250-word written summary with background information and the nominee’s reason for running for the position.
- At the AGM each candidate has three (3) minutes for a speech to the assembly.
- As well nominations are accepted from the floor at the AGM.
- Campaigning takes place during the conference.
- The slate of candidates is introduced in the spring newsletter.

If you are interested in an executive position or are thinking of someone to nominate please contact the Chair of the Nominations Committee. Use the Executive Nomination form below or download the nomination form from the web page at http://www.cgna.net/ Deadline for submission of this form is:
CGNA EXECUTIVE NOMINATION FORM

Date of Nomination: _____________________________________________________________

Nominee’s Name: _______________________________________________________________________

Position: ____________________________________________________________________________

CGNA MEMBER since (specify year): _______________________________________________________

I, (specify your first name, last name): _____________________________________________________

hereby nominate (specify person’s first name, last name): _____________________________________

to the Executive Position of (specify name of the position): _________________________________
of the Canadian Gerontological Nursing Association

NOMINEE Signature: _____________________________________________________________________

Address (include all details including postal code): _____________________________________________

Work/Home Telephone Number: __________________________ Fax Number: _______________________

E-mail Address: ______________________________

NOMINATOR Signature: ___________________________________________________________________

Address ______________________________________________________________________________

Work/Home Telephone Number ___________________________________________________________________

Fax Number __________________________ E-mail Address ________________________________

Send completed form by the target date specified above by email to: shirst@ucalgary.ca

or by Fax: 403-284-4803, or by mail:

Dr Sandra Hirst, Faculty of Nursing, PF 2260,
University of Calgary,
2500 University Drive NW,
Calgary, AB T2N 1 N4

For Office Use Only:
Received by Nominating Committee Member: (specify Name):
Date:
CANADIAN GERONTOLOGICAL NURSES ASSOCIATION (CGNA)
EXECUTIVE

President: Belinda Parke, RN, MN, PhD, GNC(C) belinda.parke@ualberta.ca
President Elect: Beverley Laurila, RN, BScN, MSA, GNC(C) blaurila@sogh.mb.ca
Treasurer/Membership: Denise Levesque, RN, BScN, GNC(C) denselev2@hotmail.com
Secretary: Diane Buchanan, RN, MSN, PhD buchan@queensu.ca
Past President: Sandi Hirst, RN, PhD, GNC(C) shirst@ucalgary.ca
Research Chair: Kathleen Hunter, RN, PhD, NP, GNC(C) kathleen.hunter@ualberta.ca
Newsletter Editor: Carole-Lynne Le Navenec, RN, PhD cllenave@ucalgary.ca

PROVINCIAL REPRESENTATIVES

British Columbia, GNABC President: Heather Hutchinson, RN hhutchinson@vcc.ca
Alberta, AGNA President: Ruth Graham, RN, BScN, MES mrgraham@telusplanet.net
Saskatchewan, SGNA President: Dawn Winterhalt, RN, BScN, M.S (Health Sciences), GNC (C) Dawn.Winterhalt@saskatoonhealthregion.ca
Manitoba, MNGA President: Anne Williams, BA, RN, BN awilly@mts.net
New Brunswick, NBGNA President: Lois Carson, RN, GNC(C) lois.carson@rvh.ab.ca
Nova Scotia, NSGNA President: Gloria Connolly, RN, BScN, GNC(C) gloria.connolly@cdha.nshealth.ca
Prince Edward Island, PEIGNA President: Mary P. Mac Swain, RN BN GNC(C) mpmacswain@his.org
Newfoundland / Labrador, NLGNA President: Annette Morgan, BN,MN, GNC(C) annette.morgan@easternhealth.ca

OTHER

▪ CGNA Website: www.cgna.net Send inquiries to CGNA Email address: cgna@nurs.ualberta.ca.
▪ CGNA Mailing Address: CGNA, c/o Dr. Belinda Parke, CGNA President, Faculty of Nursing,
  3rd Floor Clinical Sciences Building. University of Alberta, Edmonton, Alberta TG6 2G3

ADVERTISING DETAILS

<table>
<thead>
<tr>
<th>Rates</th>
<th>Submission Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/4 page: 1.875” x 2.5 ” (5 cm x 6.5 cm) $100 +</td>
<td>All ads must be camera ready in digital format, i.e. Postscript, TIFF, High Resolution PDF</td>
</tr>
<tr>
<td>1/2 page: 7.5” x 5” (18.75 cm x 12.5 cm) OR 3.75” x 10” (9.37 cm x 25cm) $200 +</td>
<td>Invoicing information must accompany all orders and be sent to: CGNA Newsletter Editor—see above</td>
</tr>
<tr>
<td>3/4 page 7.5” x 7.5” (18.75 cm x 18.75 cm) $300 +</td>
<td>Inquiries can be sent to either the CGNA Mailing Address or to the Editor—see addresses above.</td>
</tr>
<tr>
<td>Full Page: 7” x 10” (18.75 cm x 25 cm) $400 +</td>
<td>All postings to the listserv, emails, and web postings must include the following disclaimer: “Senders(s) or poster(s) opinions are their own and do not necessarily reflect the views of the CGNA”</td>
</tr>
<tr>
<td>Email List Serv: for each mailing $100 +</td>
<td></td>
</tr>
<tr>
<td>Website Advertisements: To be announced</td>
<td>Contact Newsletter Editor: <a href="mailto:cllenave@ucalgary.ca">cllenave@ucalgary.ca</a></td>
</tr>
</tbody>
</table>

ISSN 0825-9291

The Canadian Gerontological Nurse is a publication of the Canadian Gerontological Nursing Association. Author’s opinions are their own and do not reflect the point of view of the Canadian Gerontological Nursing Association. Contributions are welcome and should be addressed to the Editor. CGNA reserves the right to edit information submitted for publication. The use by any means of an article or part thereof published in The Canadian Gerontological Nurse is an infringement of copyright law. Request for written consent of CGNA prior to the reprinting of any article or part should be directed to the editor.

Vol. 25(4)
www.cgna.net