I have just returned from a “battery charging” trip to Halifax related to nursing. This was an action packed week with lots accomplished and learned. Your CGNA executive had a very productive strategic planning session that resulted in a new vision statement, core values; we affirmed our mission and drafted a new strategic plan to take us into the future. We are looking forward to fulfilling another direction from membership related to online learning opportunities starting with a study group for CNA certification exams. We invite your input and you will be hearing more about this in the near future. We also met with our colleagues from Ontario and have been negotiating with their executive related to Ontario becoming conjoint members. Work continues towards this goal and Denise Levesque has committed to continue to assist with these negotiations even though her term as treasurer has been completed. Cheryl Knight was elected as our new treasurer in Banff in May 2009, but for personal reasons found it necessary to resign her position as treasurer. The good news is we were able to recruit Kathy Thomson into this position during our AGM in Halifax. Thanks to Cheryl for her contributions and welcome to Kathy who is coming to with experience, as she fulfilled this role previously for the CGNA. Denise has agreed to help with Kathy’s orientation, as processes have changed with our new business model and Malachite support. We had a very thought provoking education day with Dr. Belinda Parke talking about “Who is the Canadian Gerontological Nurse?” and showcasing our new Gerontological Standards. I am happy to report I am a Canadian Gerontological Nurse! The new Standards will be available in the very near future on a members’ only section of our web site. The AGM was very successful in that we were able to complete the needed changes to our by-laws. We were able to achieve quorum with the attendance of our east coast members and others calling in on the phone. The by-law changes will be sent to the government for
approval, and once that step is completed we will have fulfilled the mandate from membership at last years’ meeting in Banff to open up our full membership to all nurses including Registered Psychiatric Nurses and Registered Practical Nurses/Licensed Practical Nurses. We have also created a new Retired Nurse category that will give our very experienced Retired Nurses a reduced membership rate with the right to vote. In an effort to recruit new members we will now have a free membership category to the CGNA for nursing students in their undergraduate programs. The Ann C. Beckingham fund sponsored our awards lunch and three very deserving members were awarded $5,000.00 scholarships towards their education as recommended by the awards committee, chaired by Dr. Diane Buchanan. We also award a $2,500.00 research award as recommended by our Research Chair Dr. Kathleen Hunter and her committee. The recipients will be contacted and the information shared with you as to their names once they have accepted the awards. The CNA hosted an all day meeting with the Presidents or delegates of all of the Affiliate and Emerging groups in the country. This was a very positive experience and gave us a chance to network, share and learn from each other. I also learned about the Nurse One Portal and I strongly recommend that you all go to the CNA website and play around with the different search engines. You really need to see for yourself the amazing resources that are available to all nurses anywhere and anytime that have internet access. For example, there is one search engine where you can enter more than one medication and it will tell you right away if there is an unfavorable drug interaction. I came away from that meeting feeling very positive and strong about our strong organization and our enthusiastic and dedicated members. As president, the CNA also sponsored my attendance at the CNA conference. There was much discussion about the current situation in British Columbia and how nurses will continue to work together to have a united voice. There were also several sessions on the use of technology and communities of interest, both formal and informal. I wish to thank the executive for all of their hard work, Sharon Leung for keeping us organized and the Nova Scotia, New Brunswick, and Prince Edward Island members for their participation and attendance. I met many amazing nurses from across the country and it was a pleasure and honour to represent our organization and I thank you for the opportunity.

Respectfully Submitted,
Beverley Laurila, RN, BN, MSA, GNC(C) - President CGNA

SECRETARY'S REPORT

I am happy to say that the 2009 AGM minutes have been approved at the 2010 AGM. The approved minutes will be posted on the CGNA website, at www.cgna.net.

Respectfully Submitted,
Bonnie Hall - Secretary CGNA
On this beautiful 1st day of summer, I wish to thank all of you who have submitted a publication to your journal. I do hope that each of you will submit a short report of a recent conference or seminar that you have attended, or a program that you have developed or read about, or your suggestions about how we can move toward a creative aging approach to enhance both health related quality of life, and quality of life in the more general sense—where opportunities are opened up for older people to enjoy activities or related happenings that they consider important. I hope also that you will encourage students to let their voices be heard, and have them submit an article to this publication. Please send your submission for the issue that will go out in mid-September 2010 to me by September FIRST at the latest (remember you can submit it anytime you wish). Just send it to me at my email address below. A happy, healthy summer full of new hopes and joys, and all that is meaningful.

Carole-Lynne Le Navenec, Editor
The Canadian Gerontological Nurse.
cllenave@ucalgary.ca

Alberta AGNA

As incoming President of AGNA I want to thank Bonnie Launhardt for her all her hard work over the last year. It was a huge endeavor to update the operations manual, and welcome all level of professional nurses into our fold. I am a new face to many of you and look forward to your ideas, innovations and strategies for promoting excellence in Gerontological nursing in Alberta.

I want to thank Mollie Cole for accepting the position of President Elect, and look forward to continue working with dedicated executive board who are passionate about seniors health and care.

There are upcoming opportunities for AGNA members to participate in the Executive in 2011.

Positions will be available as follows; Secretary, Treasurer.

The AGM and Annual conference in Red Deer AB was an exciting event focusing on leadership in Gerontological nursing, ‘Gerontological Nurses Leading the Way’ despite uncooperative weather we had a substantial turnout. I would like to thank the captivating speakers and very supportive Sponsors, the conference committee and all the volunteers who made this a highly
Successfully and enjoyable event. In 2011 we are celebrating our 30th year, details will be coming soon. I hope to see all of you there!

Soon members will be able to register on-line to be members of AGNA/CGNA. It is an exciting opportunity to offer our members an interactive website to support ease of access to membership and educational resources, networking and knowledge sharing. Look for our revised website in JULY!  www.agna.ca

Information for members will follow and if you have no access to a computer you will be able to send in your registration as per usual.

Please contact me @ lleblanc@shepherdscare.org with your questions or suggestions.

By Lisa LeBlanc RN MN, President

"Success is achieved by development of our strengths, not by elimination of our weakness"

M Vos Savant

British Columbia GNABC

It has been a long and busy year and I can’t believe that it was only a year since we all converged on Banff for that wonderful conference. I would really like to have come to the AGM and CNA conference in Halifax but alas I am working and it just is too far to travel for a couple of days.

GNABC has been busy these last two years that I have been President. We successfully made the transition to an independent association and although our membership has not increased we are holding our own. We still have 7 active chapters in the province while Kamloops is struggling to get back on its feet. Like all the rest of Canada we have great distances to travel and there are people in the far corners of the province that don’t get to attend chapter meetings. We hope to be able to connect electronically with these folks in the near future. Further development of our website www.gnabc.com will assist with that aspect. Look for our September 2009 Nanaimo conference soon to available on the website. There was some excellent education presented at that conference.

All of the chapters throughout the province have had excellent educational presentations throughout the year and our Annual Conference will be held in Prince George which is in the northern part of the province. The theme of that conference is: Aging: Honouring the Journey. We are looking at chartering a bus to take people interested in attending the conference September 16th to 18th. Again the website will have more information. There may be some people in Alberta that would find it easy to slip across the border and we would welcome the chance to meet them.

As my newsletter is overdue I will end with this my last comment to say that the experience of being President of GNABC has been very rewarding made so by the fact that I have gotten to meet people from all over the country that are passionate about making a difference in the lives of the older person. Looking forward to where ever my journeys take to meet more of you.
Special thanks to the CGNA and GNABC executive and members for your support.

Sincerely,
Heather Hutchinson, GNABC President

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**TREASURER’S REPORT**

Dear Colleagues,

In the last month, your treasurer-elect has changed; Cheryl Knight resigned and then Kathy Thomson stepped forward. Thank you to both for volunteering. I will remain as Treasurer until Kathy has a proper orientation.

At the AGM, I presented highlights from the 2009/2010 audit. I wish to have this information available for all members (but only members). I will discuss this further with the executive but feel that the members-only section of the website is an appropriate forum.

I presented a budget for member consideration at the AGM. Thank you to members who voiced their support.

Members at the AGM approved bylaw changes that will open up our membership and, once approved by government, you will see the changes on our website. Expect a bit of chaos as provincial group membership categories may be different. In time, we hope, they will be the same.

As well, during our time in Halifax, the CGNA executive met with representatives from the Gerontological Nursing Association of Ontario. Major barriers to conjoint status have been overcome and I will continue to work with the Ontario treasurer to further the financial negotiations.

If you would like more information, have questions, or would like to see the audited report or budget now, please contact me directly deniselev2@hotmail.com

Respectfully submitted,
Denise Levesque, CGNA Treasurer/Membership

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**TREASURER-ELECT**

Kathy Thomson has been a registered nurse for 30 years and for the past 15 years has worked in the field of gerontological nursing, obtaining her certification in 2001. Kathy has a background in community health, palliative care, ambulatory care and long term care. Kathy is also a certified foot care specialist and does this work part time so that she can continue...
to provide hands on care to community dwelling older adults.

Kathy is currently the Director for Care of the Elderly for the South Shore District Health Authority in Nova Scotia. In this role, she oversees a Seniors Community Health Team and Veterans, Restorative Care and Alternate Level of Care units and Transition planning. She works closely with community based partners to improve the flow of older patients and residents across the continuum of care.

Kathy has held the position of Secretary/Treasurer for CGNA in the past during two separate terms. Kathy has been involved with her provincial Gerontological Nurses Association for many years and is currently the co-editor of their newsletter.

Parse’s Theory of Human Becoming: Strengths, Limitations and Tensions in Guiding Care of Patients in an Acute Palliative Care Setting
by Sarah Romero

Dr. Arthur Frank, speaking of his personal experience of illness, has noted the unique opportunity and privilege that nurses have to enter the world of another. By virtue of our close proximity to hurting people at vulnerable and uncertain times in their lives, we as nurses have a special chance to “play a role in helping people bury their old self and start collecting the fragments to build a new self” (class lecture, Nursing 207, February 25, 2010). Regrettably, in his own experience of cancer, he shared that while nurses were efficient in their provision of technically based procedures, very few were willing to drop away the austere veil of “professionalism”, to step into his world and meet him person to person on the grounds of equality, respect and courageous caring (class lecture, Nursing 207, February 25, 2010).

The nursing research overwhelmingly affirms Frank’s sentiments that patients desire to be cared for as unique individuals, not passive recipients of tasks. However, as nursing’s scope of practice includes many highly specialized technical skills and procedures, it can be easy to reduce practice to a series of applied, concrete and quantifiable tasks and neglect the therapeutic significance and centrality to nursing of building caring, personal relationships. Furthermore, the usefulness of nursing theories in guiding the development of such caring relationships can also be difficult to grasp. However, while the relevance of theories to concrete nursing practice can be elusive due to the abstract and complex nature of the ideas explored, my experience as a first year nursing student in the clinical setting has helped to clarify for me that theory does indeed matter and has a profound influence on both the nurse’s perspective and subsequent practice. As stated by Gail Mitchell: “The knowledge housed in a guiding theory shapes the way the professional thinks and acts with clients. This is important because thoughts guide actions, and actions weave relationships, and relationships form the fabric of nursing practice” (Parker, 1993, p. 63).

My primary purpose in writing, however, is not to speak of the relevance of theory to practice in an abstract sense. Instead, in this essay, I intend to reflect on my personal experience caring for Mr. H, an 81 year old patient receiving treatment on an acute medical-palliative hospital unit, as guided by the values and ideals embodied in Parse’s theory of human becoming (1981, 1987). A nursing theory radically different from many others and unapologetic in the boldness of its claims, the theory of human becoming is not a set of guidelines to rigidly
apply to practice or a standardized how-to manual for caring. Instead, it advocates for a way of being, promoting a set of values foundational to building ethical and person-centered relationships between nurse and patient. Strengths, tensions and limitations of this theory in a practice setting will be discussed, paying particular attention to the manner in which the theory of human becoming both supported and served as a barrier to me in building a caring nurse-patient relationship with Mr. H and providing care that he found personally meaningful.

**Overview of the Model**

The theory of human becoming emerged from Rosemarie Rizzo Parse’s own value system and her inherent belief in the dignity and uniqueness of each individual’s personal experience (Sitzman & Eichelberger, 2010, p.195). She also acknowledges that the concepts and assertions of fellow nurse theorist Martha Rogers’ Theory of Unitary Beings (1970), as well as the existentialist philosophies of Heidegger, Sartre and Merleau-Ponty, were foundational in the development of her theory (Bunting, 1993, p. 3).

Parse contends that her theory is a radical departure from the majority of nursing theories in its philosophical underpinnings and treatment of the major concepts of nursing, or the metaparadigm. For this reason, Parse does not adhere to the traditional nursing metaparadigm, asserting that it reflects a philosophical perspective that it is not representative of the human becoming school of thought (Malinski, 1996, p.100). Instead, she speaks of the human-universe-health interrelationship viewing “the concepts human, universe and health as inseparable and irreducible...although each can be described, they are intimately linked in mutual process” (Mitchell in Tomey & Alligood, 2006, p.531; Bunting, 1993, p.21).  However, for the purposes of this paper, Parse’s perspective on person, health, universe, and nursing will be discussed separately, as in the traditional metaparadigm, in order to provide a brief overview of key elements of her theory.

**Person**

Central to Parse’s assertions about the nature of person and the process of becoming is the assumption that individuals are unique and possess freedom to make choices. From this perspective, “a person is an open being, more than and different than the sum of parts, who changes and is changed with the universe” (Mitchell, 1988, p.26). Through life’s rhythms, its patterns of relating with others, individuals change, grow in insight and develop into who they authentically are. Simultaneously enabled and limited by the choices they make, individuals shape their lives through their decisions. As stated by Bunting (1993) “the events of a person’s life and the meanings of those events are created as the individual, through the choices made, creates the possibilities that he or she can become” (p.10).

**Environment**

Parse’s understanding of person is inextricably connected to her assertions about the environment. Parse views environment as a dynamic and far reaching phenomenon, which encompasses not only external phenomena, but also the feelings, hopes and internal ways of being that one experiences and chooses to embrace. While persons “change and are changed with the universe”, (Mitchell cited in Tomey & Alligood, 2006, p.531) for Parse this is not to be interpreted as part of a linear cause and effect relationship, but rather as a “mutual process with the universe”. Through this process, individuals freely choose the meaning they assign to situations, and thereby serve as authors of their experience, transforming and being transformed with the environment.

**Health**
While many nurse theorists have expanded the understanding of health to include more than the absence of disease, Parse argues that the definition overwhelmingly remains centred on health as a state of well-being, or a quest to attain this state. For Parse, however, “Health is what one lives.” (Mitchell, 1988, p.26). She describes health as:

...man’s unfolding. It is Man’s lived experiences, a nonlinear entity that cannot be quantified by terms such as good, bad, more or less. It is not Man adapting or coping...it is not the opposite of disease or a state that man has, but rather is a continuously changing process that Man cocreates (Bunting, 1993, p. 22).

For Parse, health is human becoming. This process of growth and movement beyond the present situation occurs as individuals discover meaning through relationship with others and the universe (Mitchell, 1988, p.26). The logic that flows from this assumption is that if health is the individual’s lived experience, than no one may define whether another person is healthy or not. The person is the only expert about their experience, and thus, the only expert about their own health. For this reason, health cannot be defined by societal values or norms and it cannot be viewed separately from the person and environment (Bunting, 1993, p.22) that cocreate and define it.

**Nursing**

From the perspective of the theory of human becoming, the nurse’s wishes or beliefs about what might be best for the individual are not relevant. The individual is seen as the expert about their own experience and their freedom to choose must be respected. While nurse-person activities and medical interventions are seen by Parse as important, they do not define nursing, as “others can and do perform these tasks in a variety of settings” (Mitchell, 1988, p.27). For Parse, “Nursing is offering a true presence to individuals as they struggle to move beyond where they are in the transforming process of life” (Rasmussen, Jonas & Mitchell, 1991, p.140). The goal of nursing is to enhance the quality of life from the individual’s perspective (Mitchell, 1988, p.26; Bunting, 1993, p.23). This goal is accomplished through a unique practice methodology involving three specific practice dimensions and processes: illuminating meaning through explicating, synchronizing rhythms through dwelling with and mobilizing transcendence through moving beyond (see Appendix A) which are practiced using “true presence”. The concept of true presence will be discussed in greater detail in the Nursing Care Process section of this essay.

**Case Study**

Mr. H, 81 years old, was admitted to hospital with a primary diagnosis of osteomyelitis. A chronic and serious bone infection, it involves acute inflammation of the bone and bone marrow (Day et. al, 2010, p.2292). Not only is the infection challenging to eradicate, it can also cause excruciating and debilitating chronic pain. Mr. H’s condition was complicated by his age and a litany of other poorly managed conditions he was living with: peripheral vascular disease, congestive heart failure, cognitive impairments related to chronic alcohol abuse, and a cerebrovascular accident that rendered his right side markedly weakened and right arm immobile. As a result of the cumulative effects of his illnesses and the severity of his constant pain, he was extremely weak and immobile, requiring total care. Medical care in hospital was palliative in nature, focused on promoting comfort and providing support to him as he approached the end of his life.

Mr. H could be aggressive; he spent many hours each day screaming, swearing, uttering racial obscenities and occasionally, throwing objects at staff. These behaviours were upsetting to other patients and unfortunately caused many staff members to be frustrated, resentful and angry with him as well, which served to increase his loneliness and sense of isolation. His
physician, labelling these aggressive displays as “attention seeking behaviours”, felt that Mr. H’s angry outbursts could be reduced by spending time with visitors and engaging in meaningful activities.

Mr. H had lived a transient lifestyle for many years, working as a labourer in many towns across western Canada for short periods of time. His wife had died of a stroke twelve years earlier and he continued to grieve her loss. Although Mr. H had eight children, he was estranged from all of them. On the day that I cared for Mr. H, he was informed by his primary nurse that a bed had been secured for him at a long term care facility in a town several hours away. He reported feeling very angry and apprehensive about this, as he had never even visited this town and had no connections to it.

**Nursing Care Process: Parse’s Theory of Human Becoming and the Nursing Process**

Parse has been very vocal in her opposition to the nursing process, asserting that its philosophical underpinnings are an extension of the traditional medical model and thus are irreconcilable with the values and assumptions of the theory of human becoming. She believes that this process inherently dehumanizes unique human experience and that “the labelling inherent in the nursing process is too restrictive for describing human beings” (Mitchell, 1988, p.25). Parse also rejects the nursing process on the grounds that it is a problem solving method that is not derived from the unique body of nursing knowledge. A focus on problem solving is not compatible with Parse’s theory, as nursing from her perspective is not concerned with defining problems, but on uncovering meanings and patterns in an individual’s unique experience. Mitchell (1988) reiterates this in stating:

> The traditional nursing process did not emerge from nursing knowledge, but is a problem solving process common to a wide variety of trades and professions...the caregiver identifies problems, assigns labels to them and initiates interventions to correct or manipulate the problem. This system narrows the nurse’s view of humans and their complex relationship with the world to problems and limitations (p.26).

While for the purposes of this essay the headings of the traditional nursing process will be used, in seeking to remain as true to the tenets of Parse’s theory as possible, the manner in which I provided care to Mr. H will be described according to her theory.

**Assessment**

Through the lens of the theory of human becoming, assessment is purely focused on monitoring physical symptoms and the individual’s response to medically related activities. Psychosocial states and individual response

**Nursing Diagnosis**

The concept of nursing diagnoses is not used in Parse’s theory because she makes no assumptions about linear cause and effect (Rasmussen, Jonas & Mitchell, 1991, p.140). Furthermore, the notion of standardized diagnoses is seen to be at odds with the theory’s assumptions about the uniqueness of people, allegedly creating dangerous potential for objectification. As Mitchell (1988) elaborates: “these standardized descriptions of ‘the same problem’ lead to standardized ways of treating the problem, even when the condition exists in the widely differing life situations of unique individuals.” (p.26).
The alternative to nursing diagnoses proposed by Parse is a mutual process in which the nurse listens to the person and based on what he or she shares with the nurse in discussion, “a personal health description is constructed from which emerging patterns of health are extracted” (Mitchell & Pilkington, 1990, p.82). The nurse is then able to “guide the individual to express their personal meanings and offer information and freedom to make choices” (Bunting, 1993, p. 28).

Mr. H's Personal Health Description

Mr. H shared that he felt useless now that he was ill and could never have anticipated how terrible his life would become. He said that prior to his stroke, “life was great”. He expressed a desire to commit suicide because he could no longer take care of himself and was in constant pain. He shared that he was afraid of losing his mind, as he noticed that he was becoming more confused and had a hard time remembering things. Mr. H described feeling lonely and wanting other people to listen and just be with him. While he said that he hated being in the hospital, he also confided that he was afraid of being transferred to long term care as “it’s tough to start over again in a new place”.

Emerging Patterns of Health
1. Mr. H said that he wanted to commit suicide, yet at the same time he said that he still enjoyed the company of others.
2. Mr. H said that he hated being in the hospital, yet at the same time he didn’t want to move to long term care as it would be hard to start over again.
3. Mr. H said that he was useless now that his mind was beginning to deteriorate and he was unable to care for himself. Yet, at the same time, he said that he was still sharp and had wisdom to share from his life experiences.

The emerging patterns of health that were extracted from Mr. H’s personal health description, compiled throughout our discussions, reveal that while he was preparing for death and wished to die quickly, he also still found meaning through relationships. He had a desire to give to others through sharing the wisdom he had gleaned in life. He also expressed hopes of finding comfort through relationships in his last days. These emerging patterns of health, while seemingly paradoxical, are not in conflict with one another, but demonstrate the rhythmic patterns of life that Parse speaks of: a struggle involving connecting and separating, and great wrestling in order to choose meanings and make choices. Furthermore, these patterns of health are useful to the nurse guided by Parse’s theory in assisting the patient to identify, and then reach toward, their goals.

Conclusion
Parse’s theory of human becoming offers both an innovative approach to nursing care of patients, and a thoughtful critique of the traditional nursing care process. A nursing theory focused on honoring the expertise of patients, it presents a creative alternative to standardized nursing diagnoses, providing a more collaborative and person-centred means for planning care of patients.

The second part of this case study, including discussion on goal setting, interventions, and evaluation of effectiveness of Parse’s theory of human becoming in providing care for this patient, will be presented in the September issue of Canadian Gerontological Nurse.

References
The Theory of Human Becoming: Practice Dimensions and Processes

The theory of human becoming is practiced through application of three specific and unique practice dimensions and corresponding processes created by Parse. Although these processes may be described separately, they occur all at once within the context of the nurse-patient relationship.

The first dimension is illuminating meaning, accomplished through the process of explicating. This process involves bringing clarity to what is being expressed, verbally and nonverbally. As the person discusses and shares their feelings and thoughts about their situation with the truly present nurse, they may discover new ways to understand their situation and glean deeper insights, as well as identify possibilities for different choices.

The second dimension is synchronizing rhythms, which occurs through the process of dwelling with. This requires the nurse to be with and support the individual, wherever they are at, without trying to change the ups and downs (rhythms) of the individual’s changing experience as they seek to choose and find meaning.
The third dimension is mobilizing transcendence, which happens through the process of moving beyond. Perhaps Bunting (1993) describes this process most simply: “As the nurse dwells in true presence with clients/families as they struggle with ever changing situations, they move beyond (transcend) the present meaning of the events in their lives” (p. 26) to discover new dreams and to seek to realize them. The nurse’s role is to guide and assist the individual to plan for and realize the goals they have identified through the ebb and flow of this rhythmical process.

JOURNALS/BEST PRACTICES REPORTS

A new issue of Canadian Medical Association Journal has been made available:

18 May 2010; Vol. 182, No. 8  URL:

http://www.cmaj.ca/content/vol182/issue8/index.dtl?etoc
Pfizer is committed to you. Because it all starts with nurses.

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SPEAK TO YOUR PFIZER REPRESENTATIVE TODAY TO GET STARTED.
Using Orem’s Self-Care Model of Nursing to Guide the Provision of Care for Persons with Alzheimer’s Disease

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Conflict of Interest: None to declare.

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Number of Appendix: 2

Abstract

The purpose of this paper is to provide an overview of how the authors applied Dorothea Orem’s Self-care conceptual framework to the nursing care process of a hypothetical client (whose pseudonym is Ally) who was diagnosed as having Alzheimer’s disease. The authors found that Orem’s conceptual model was an effective and relatively easy to use framework for providing quality nursing care and for enhancing the quality of life for this client.

Keywords: Persons with Alzheimer’s disease; Nursing care, Orem’s self-care deficit theory

Using Orem’s Self-Care Model of Nursing to Guide the Provision of Care for Persons with Alzheimer’s Disease: Part 1 Overview of the Model and Assessment Parameters

The purpose of this paper is to discuss how the authors used aspects of Orem’s Theory of Self-Care with a hypothetical client whose pseudonym is Mrs. Calhoun. Her primary diagnosis was Alzheimer’s disease. Because of the length of the paper, we will present only Part 1: Overview of Orem’s Self-Care model and the major assessment parameters. Part 2, which covers the subsequent phases of the nursing process will be presented in the September issue.

The paper will be divided into the following sections: Firstly, an overview of the nursing model is described followed by an in-depth case study of the pseudonym client. Next, the assessment section will focus on the types of self-care requisites, especially the ones of major concern: health deviation and self-care requisites. In Part 2, the nursing diagnosis, planning and goal setting, interventions and evaluations sections will be presented based on the initial assessment phase of the nursing process for our client. Interspersed throughout the paper are brief descriptions of current research pertaining to assessment techniques and intervention strategies for caring for persons with Alzheimer’s disease and their families.
Overview of Orem's Self Care Nursing Model

Although this self-care model was originally developed in the late 1950s, the latest revisions occurred in 2005 (“Dorothy Orem’s Self Care Theory,” 2010). This model, which is used in rehabilitation and primary care settings, is focused primarily on how to help clients be as independent as possible in terms of the ability to care for themselves, both in terms of personal activities of daily living, and instrumental activities of daily living (IADL such as shopping, cooking, banking, etc) (Jeffery, n.d.). Orem developed her self-care model by asking three questions: What do nurses do and what should nurses do as practitioners of nursing?, Why do nurses do what they do?, and What are the results of nursing interventions (Fawcett, 2001)?

Orem’s model is composed of three related theories: the theory of self-care, the theory of self-care deficit (see Appendix A for definition of italicized words), and the theory of nursing systems encompass the SCDNT (“Dorothy Orem’s Self-Care Theory,” 2010). The theory of self-care assumes that a person has the ability to perform activities to meet personal needs, as well as maintaining health and wellness of mind, body, and spirit. Self-care is a learned behaviour, which is influenced by the metaparadigm of person, environment, health, and nursing. The theory of self-care deficit occurs when a person is unable to meet their self-care needs (i.e., self-care requisites (Tomey & Alligood, 2006). Thus, when their health situation reduces their ability to perform self-care, nursing interventions are needed. The theory of nursing systems focuses on the person and includes the ability of the nurse to aid the person in meeting present and potential self-care demands. It is composed of three systems: wholly compensatory nursing system, partly compensatory nursing system, and supportive-educative nursing system (Bruce, Gagnon, Gendron, Puteris, & Tamblyn, n.d.).

Orem’s model takes into consideration the four concepts of the nursing metaparadigm: person, environment, health, and nursing (Kozier et al., 2010). Orem defines the person as the patient (the one who is being cared for) and who has the potential to learn and develop. The environment aspect within this model consists of factors, conditions and the development. The environment can either positively or negatively affect the person’s ability to provide self-care. The concept of health is defined by Orem as, “a state characterized by soundness or wholeness of bodily structure and function; illness [being] it’s opposite” (Fawcett, 2001). The final concept, nursing, is observed as a service to help one’s self and others. Ultimately, nursing is used to promote self-care agency and is needed when self-care demands exceed its parameters (Tomey & Alligood, 2006). (See Appendix C)

Case Study

Ally is an 83-year-old female married to Noah who is 8 years younger than her. They have been married for 55 years with two sons (Eli and Ben). Both sons are married but only Eli (the oldest of the two) has a daughter, who also has a child of her own. The family and extended family all currently live in Calgary and are all very close with one another. Ally started her career as a librarian but when Noah opened up his business, she began working as his secretary. Ally can be described as a very meticulous and very well organized independent female, as well as having a very patient, caring, and generous personality.

Ally was diagnosed with atrial fibrillation at the age of 72, prompting her doctors to place her on medication (Aspirin) to control her arrhythmias. Unfortunately, the desired outcome was not attained resulting in her first stroke, a cerebral vascular accident (CVA) in 2002. Ally has had troubles controlling hypertension, which was an added risk factor for her first CVA, and could have been a potential reason for her suffering a second stroke at age 77 (2004). In addition, the
symptoms of Ally’s Alzheimer’s disease began to appear three years after her last stroke at the age of 80. However, this was not diagnosed until a year later.

In summary, her primary medical diagnoses are Alzheimer’s disease and atrial fibrillation while her secondary medical diagnoses are hypertension, confusion (i.e., she does not know the date, where she lives, the names of many of her old friends, and she has forgotten how to bath herself, dress herself, or how to go shopping), and agitation. Her past medical history includes two CVAs in 2002 and 2004, as well as being at risk for another CVA accompanied with worsening conditions of her confusion and agitation as her Alzheimer’s disease progresses. There is one medical report that indicates that she may be suffering more from a vascular dementia than from Alzheimer’s disease (AD). However, because her two siblings, who are now deceased, were confirmed at autopsy to have had AD, it is suspected that Ally also has that condition, with a superimposed cardiac problem.

Initial findings were identified when Noah noticed Ally’s memory loss when she did not remember that she had a dentist appointment, which seemed very out of character for her. When Ally missed picking up a present for her great-granddaughter’s birthday, Noah began to speculate that something was wrong. He also noticed that his wife was becoming more and more irritable, especially with people who helped them on a weekly basis. She had always been very appreciative of their caregivers, so Noah found this recent behaviour to be abnormal. The trigger for admitting Ally into the hospital came before church one Sunday morning. Ally was preparing to take her bath when she left the water running and went outside with nothing on but her panties and slippers in order to get the mail. Noah, who was in the kitchen overlooking the front yard, saw Ally and was shocked. He quickly ran outside, clothed her with a bathrobe and brought her back into the house. He was baffled and asked her why she had gone outside and she nonchalantly replied that she was getting the mail. Noah explained to Ally that they have never received mail on a Sunday when she then quickly realized that he was right. At this point, he heard the water running and ran upstairs to find the bathtub overflowing. He turned off the taps and began to think about what he should do about Ally. He knew that something was wrong as her recent behaviour was very out of character.

Later that night, Noah called his two sons for advice on what he should do. Both sons suggested that Ally should be examined by a physician as they both agreed with Noah that this behaviour was out of the ordinary. The next day Noah took her to the local clinic where a doctor referred Ally to see a specialist. After a mini-mental state assessment, a behavioural assessment and cognitive tests were completed, a brain scan was performed. From these findings and gathered subjective data about Ally’s symptoms, doctors concluded that Ally was suffering from Senile Dementia of Alzheimer’s Type (SDAT).

After consulting with the doctor, Noah and his sons decided that it would be better if Ally was placed in a long-term care facility due to the nature of her disease. Due to placement issues, Ally was placed in a hospital awaiting long-term care. (See Appendix B)

Assessment

When using Orem’s framework, the focus of the assessment is on types of universal self-care requisites (Tomey & Alligood, 2006, p 270). Universal self-care requisites refer to the requisites that are common to all individuals. The patient has altered universal self-care requisites due to her medical situation. Her food intake has declined and she refuses to take part in activities without her family. She is restless and rejects the company of strangers and she is considered a hazard to herself and other people. Developmental self-care requisites are the developmental processes that result from a condition or event. Ally’s environment changed, due to her
worsening condition and she has been admitted to the hospital awaiting a bed at a long-term care facility. Health deviations are the requisites that result from conditions of illness, injury or disease. Because of Ally’s illness, her family asked for medical assistance about her change in behaviour and altered cognition.

In the process of identifying areas of self-care deficits related to Ally’s condition, a comprehensive interview was conducted with her, her husband and her care providers. The nurse assessed her responses on diagnostic examination, using the Mini-Mental State Examination. Her appearance at admittance was adequate for her age, her dress, hygiene and hair was kept well. Her behaviour was confused, anxious and agitated. Ally had obvious long and short-term memory impairments. She was oriented to person but not to time or place (although she knew that this place was unfamiliar). Her ability to respond to instruction through verbal and written communication was incoherent and illogical, however her willingness to respond was evident. After the interview with just Ally, her husband was asked similar questions. Such questions included: when did the onset of these symptoms occur, how long have they lasted and if there were any specific events or situations that triggered any changes in her behavior or memory. Noah was also asked if he had noticed any progression of Alzheimer’s disease, and what his perceptions were of this diagnosis. The nurse assessed Ally’s SDAT, atrial fibrillation coexisting with hypertension, confusion and agitation. The nurse also assessed Ally’s past medical history of two CVAs in 2002 and 2004. The nurse noted that she is also at risk for deteriorating conditions of her confusion and agitation due to her SDAT. Ally is currently at the Foothills Medical Center on Unit 81, awaiting a position for a bed to open up in a long-term care facility. Her designation of care is R3 suggesting that Ally is expected to benefit from interventions that can be provided including ICU care but excluding intubation and chest compressions.

Before Ally’s admittance to the hospital she was able to partake in activities of daily living (ADLs) with assistance from her husband, a family member, nursing attendant or a respite worker with verbal reminders in a step-by-step fashion. Due to the nature of Ally’s SDAT, her memory and critical thinking skills have deteriorated since her condition has progressed and she is unable to carry out ADLs independently. Now Ally has difficulty making her own meals, dressing and bathing herself and performing other necessary tasks of self-care without continuous reminders and assistance with these activities. Thus, there are several self-care deficits identified from an analysis of Ally’s history:

1. Ally is unwilling to participate in activities such as exercising or walking
2. She has little or no appetite
3. She is restless when her family is not present.
4. She has decreased ability to dress herself properly and cannot safely bathe herself.
5. Ally declines conversation and interaction with other people and at times she can be aggressive.
6. In addition, Ally is forgetful in regard to the date, where she lives, and her age, and she is unable to make effective decisions in regards to money management or planning a schedule (and related “executive functions”).

These self-care deficits illustrate the inability of the client to meet her self-care requisites. Self-care requisites are the actions or measures used to provide self-care encompassing three categories: universal, developmental and health deviation as mentioned previously (Wesley, 1995). Thus, because of the patient’s current situation, her care needs (universal, developmental and health deviation) are altered.

Nursing Diagnoses
Orem’s SCDNT specifies when nursing is needed and how people can be helped through nursing (Wesley, 1995). According to her theory, nursing is needed when an individual is incapable or limited in providing continuous and effective self-care needs. In order to identify Ally’s specific needs, the nurses must reflect on how effectively she is able to perform self-care requisites and relate that to her self-care deficits. In doing so, the nurses are able to use the information gathered from the assessment phase to create their nursing diagnoses (1995).

Formulated Nursing Diagnoses

CGNA Launches Online Membership Application

The Canadian Gerontological Nursing Association (CGNA) is pleased to announce the launch of its online membership application. New and renewing members with participating conjoint and non-conjoint provincial associations will now have the opportunity to submit membership information online at www.cgna.net!

Participating provinces include:

- British Columbia
- Manitoba
- New Brunswick
- Northwest Territories
- Nova Scotia
- Nunavut
- Ontario
- Prince Edward Island
- Quebec
- Saskatchewan
- Yukon
- USA

Please visit the CGNA website at www.cgna.net, click on the provincial association you belong to for additional information and to renew your membership.

MEMBER BENEFITS

As a member of CGNA, you will be entitled to receive the following member benefits:

- Access to members-only directory of CGNA members (NEW!)
- Opportunity to apply for scholarships and research grants
- Reduced rates at CGNA Biennial Meeting
- Reduced rates for educational resources and materials
- Subscription to the CGNA Google Listserv, an ad hoc update of news in the field of gerontological nursing
- Subscription to the CGNA quarterly newsletter, The Canadian Gerontological Nurse
- Option to participate in CGNA Committees
- Support and influence the development of the field

IN THE WORKS FOR 2010

- Publication of the 2010 Gerontological Nursing Standards and Competencies Document
- Planning the 2011 Biennial Meeting that will be held in Delta Meadowvale Resort and Conference Centre, Mississauga, Ontario, June 8 – 11, 2011
- Providing support to conjoint provincial members to assist with planning of provincial education sessions

NEW CGNA PHONE LINE

CGNA is pleased to announce that a dedicated telephone line has been set up at the Head Office.

CGNA Phone Line: 604.484.5698
Email: cgna@malachite-mgmt.com

The CGNA Board of Directors is committed to listen to the needs of the membership in order to continue developing the Society for the future. Please feel free to contact Sharon Leung, CGNA Project Manager at cgna@malachite-mgmt.com or 604.484.5698 with any questions or comments.

CGNA 2011 BIENNIAL MEETING ANNOUNCEMENT

The CGNA 2011 Conference Planning Committee is excited to announce the date and location of the next biennial conference:

CGNA 2011 Conference
“To Live is to Age…Raising the Bar for Excellence”
Delta Meadowvale Resort and Conference Center, Mississauga, ON June 8 – 11, 2011

Watch the CGNA website, www.cgna.net, for more information about the call for abstracts and information related to the conference!
FACULTY RETIREMENT

Some years ago Prof. Jeanne Bader (CSU-Long Beach), herself now retired, called attention to the issue of faculty retirement as a topic demanding more attention from academic gerontology. Her point is even more true today. Partly as a result of the elimination of mandatory retirement for college faculty, it is estimated that eight percent of faculty today are over age 70, and that proportion could grow in years to come.

Those of us who believe in the productivity of older workers (I myself am 65) don’t go along with proposals to put elders out to pasture. Nonetheless, there are questions about whether work life extension serves to diminish opportunities for younger scholars. The issue should not be avoided but should be discussed more openly. Faculty in gerontology could contribute to the conversation in valuable ways.

A recent article by Christopher Phelps, in THE CHRONICLE REVIEW, is titled “We Need to See Retirement as a Hiring Issue.” Phelps is by no means insensitive to the challenge facing faculty considering retirement. He favors phased retirement, continuing benefits for retirees, and, above all, creating “A Culture of Appreciation.”

“Discussions of retirement are often blind to intangibles of meaning, dignity, status, and community that underlie so many anxieties and hopes of individuals facing this important life decision... If retirement is not isolating, if it need not mean cutting oneself off from academic life, it will be perceived not as the end of the line but as a path of continuity... Given the right mix of financial incentives, positive moral reinforcement, and a welcoming atmosphere, an even higher proportion should be willing to make way for the next generation of scholars.”

Academic gerontology needs to be part of this discussion. For full text of the article in the CHRONICLE REVIEW, visit: http://chronicle.com/article/We-Need-to-See-Retirement-as-a/65187/?sid=at&utm_source=at&utm_medium=en

RESOURCES FOR LONG-TERM CARE POLICY

The SCAN Foundation has a very valuable "Resource & Policy Library" providing up-to-date information and sources on research and policy articles generated by think tanks, foundations and policy groups. Visit them at: http://www.thescanfoundation.org/sections/research-policy-library

In addition the SCAN Foundation has released a “Long-Term Care Policy Simulator Tool,” a web-based modeling approach enabling policymakers and the public to test budgetary implications for different federally run long-term care insurance programs. This model produces more than 25,000 unique outputs, each illustrating how public long-term care insurance program designs and benefits could translate into estimated coverage, participation rates, and costs to participants and taxpayers. To learn more, visit: http://www.ltcpolicysimulator.org/
LIVING THE LIFE YOU IMAGINED

Henry David Thoreau urged each person to "Live the life you have imagined." Too often we are constrained from accomplishment and living as we would wish by our own reluctance to pursue our dreams and aspirations. At the AGHE Annual Meeting, this sentiment will be translated into visions of AGHE's future as an educational leader in enabling people to live an old age they have imagined. It will center on three interlocking themes: imagining an old age worth living; preparing for the old age we imagine; and removing barriers to living the old age we imagine. For those interested in submitting an abstract on one of these themes, the deadline is June 22, 2010. For details, visit: http://www.aghe.org

For a young person's image of aging and the future, look at "Lost Generation," winner of the video winner of the "U@50" contest on YouTube (now viewed more than 13 million times). Available at: http://www.youtube.com/watch?v=42E2fAWM6rA

BIOETHICS AND AGING

For a no-cost e-newsletter on issues of bioethics and aging, "The Soul of Bioethics," send a request for a sample copy to: soulofbioethics@yahoo.com

VIDEO ENTITLED FROM RULES TO CARING PRACTICES

"From Rules To Caring Practices: Ethics and Community-Based Care For Elders" (Produced by The Park Ridge Center). This video presents four brief scenarios that will trigger thought and discussion around the human and emotional issues that are an integral part of home caregiving. Each scenario sheds light on a different aspect of home caregiving: self-determination, family responsibilities, elder abuse, and end-of-life decisions. Winner of the Silver Hugo Award for Best Video in the Adult Education Category. Available from Terra Nova Films at: http://www.terranova.org/

BOOKS OF INTEREST

AGING AWAKENINGS: Assisted Living Residents Teach University Students to Overcome Ageism, by Richard C. Adelman (CreateSpace, 2009).


WEB SITES TO SEE


IMAGES OF AGE. For an overview of "Changing our Perceptions of Aging" visit: http://blog.bioethics.net/2007/10/changing-our-perceptions-of-aging/

SEGMENTS FROM June 15, 2010 Issue of TEACHING GERONTOLOGY

THE END OF RETIREMENT?

80% of adults aged 65-74 years and 60% of adults aged 75+ are involved in four key activities: work, volunteering, caregiving, and education or "lifelong learning." In addition, 30% of older
adults devote some time to formal volunteer activity. The longevity revolution and the current economic climate are leading to new views of older adults and the retirement years. Older adulthood, it turns out, transcends infirmity, leisure, and disengagement from work and society. For more details, visit: http://www.bc.edu/research/agingandwork/all_feeds/IB24.html

For other publications of interest on this topic see:


CURRICULUM RESOURCES

The Association for Gerontology in Higher Education (AGHE) has available a collection of syllabi for courses in aging in two volumes: Volume 1 contains 52 syllabi covering core courses in aging (biology, health, psychology, adult development, research, program evaluation, social policy, sociology), and Volume II contains 39 syllabi covering elective courses in aging (the family, human services, humanities, cultural diversity, minorities, ethics, gender, long-term care, nutrition, professional issues in aging). For details, visit: http://www.aghe.org/templates/System/details.asp?id=40634&PID=691283

PROLONGEVITY: Dr Aubrey De Grey (Computer Scientist/ Self-made Gerontologist involved with a Strategy for Engineered Negligible Senescence (SENS))

There’s only been one gerontologist who’s been featured on "60 Minutes" and his name is Aubrey de Grey. De Grey argues that aging is a disease, a challenge to be overcome if we approach it as an engineering problem: what he calls a "Strategy for Engineered Negligible Senescence (SENS)."

De Grey expounds this vision in ENDING AGING: The Rejuvenation Breakthroughs That Could Reverse Human Aging in Our Lifetime (with Michael Rae, from St. Martin’s Press, 2008).

For a video, "Aubrey de Grey Says We Can Avoid Aging" visit: http://www.ted.com/talks/aubrey_de_grey_says_we_can_avoid_aging.html

For more on his call to arms to cure aging, visit: http://www.ted.com/speakers/aubrey_de_grey.html

See also the SENS Foundation at: http://www.sens.org/index.php?pagename=mj_index

Visit the Methuselah Foundation to learn more about life extension: http://www.methuselahfoundation.org/

For a balanced critical perspective on these issues, see: THE FOUNTAIN OF YOUTH: Cultural, Scientific, and Ethical Perspectives on a Biomedical Goal, by Stephen G. Post and Robert H.
Slightly more than a year ago, I submitted an article that was published in the April edition of the CGNA newsletter about a book project I was working on regarding “care for the caregiver.” In the article, I promised to update CGNA members on the book’s progress. I am pleased to say that it is currently in the publication process. Titled The Caregiver’s Companion, the book addresses caregiving from a holistic perspective with an emphasis on the spiritual aspect of the caregiving experience and is written for family, professional and volunteer caregivers. The book is accompanied by a journal for both caregivers and care receivers, titled My Journal, and contains inspirational quotes from all three of my books. Both the book and the journal can now be found on the General Store Publishing House website www.gsph.com under “What’s New.” Or you may call 1-800-465-6072 to pre-order your copies of the companion set. It is my intention to also produce a relaxation CD for caregivers and care receivers, titled A Time for Self-Care.

Here are some of the comments from readers who provided feedback for me at the pre-publication stage of the project:
“Reading the introduction made me feel like I was being wrapped in a very large hug by someone who understands.” Joan Fulford, Family caregiver

“You have captured all of the feelings, emotions, guilt and fatigue that seem to be part of the caregiver psyche, whether in the workplace or in the home. I could relate to so much of it as I reflected on my years in ER and more recently in our home with Mom. I know that those who read it - whether they are caregivers or not - will have a more caring and loving feeling of ‘self.’” Heather Arnold, RN

Former ER nurse, Nursing Instructor and family caregiver

“Wonderful book! So needed! It was a divine gift, arriving at just the right time for me. The concentrating on and being thankful for those little ‘in the moment’ things, like the feel of the bed sheets, the sun on my face, have been so helpful.” Heather McGrath, RN, BNSc Nursing Supervisor Care for Health and Community Services

CGNA Research Committee

Three members were recruited to form the CGNA research committee (2010-2012). These members are:

- Jennifer Baumbusch RN PhD
  Assistant Professor, School of Nursing,
  University of British Columbia
- Leslie Dryburgh RN MN CVAA(C)
  GNC(C), Clinical Nurse Specialist,
  Geriatrics
  Grace Hospital, Winnipeg, Manitoba
- Lisa Keeping-Burke RN PhD
  Assistant Professor of Nursing, Queen’s University

I am pleased to announce that the successful applicants for the $2500 research grant were Dr. Alison Phinney and Sherry Dahlke, PhD Candidate, both from the University of British Columbia, School of Nursing. The project, entitled Nursing older adults: Making meaning of complex practice, is Ms. Dahlke’s dissertation project. We are very pleased to support a new researcher who will make an important contribution to the growth of gerontological nursing research.

In the next year, the committee will concentrate on the following:

- Reviewing the discussion notes from the research breakfast, and formulating recommendations to the Executive on strategies to promote gerontological nursing research and knowledge transfer in Canada
- Reviewing the Research Committee terms of reference
- Revising the CGNA Research Grant criteria, grant application and review process
- Holding a competition for the 2011 Research grant

Submitted by
Kathleen F. Hunter PhD RN NP GNC(C) - Chair, CGNA Research Committee
Research Reports / Papers on Alzheimers / Dementia have been released in the past 8 weeks.

These are the most recent research papers / studies released in USA / Canada / UK and Australia.

The eight reports include:

Keeping dementia front of mind: incidence and prevalence 2009-2050: A report on the estimates and projections of the prevalence and incidence of Dementia in Australia/recommendations at strategic level for change in Australian health and hospital system/priorities of Dementia sufferers - 9 pages.

Continuing to care for people with Dementia: The Alzheimer Society of Ireland, St Luke’s Home in Cork, a 120-bed residential care facility with a dedicated Dementia unit, along with the ASI and Bradford University, commissioned this research - 53 pages.

Economic cost of Dementia in UK: According to the report, which was prepared with experts from Oxford University, Dementia’s overall annual cost dwarfs the £12 billion cost for cancer care and the £8 billion for heart disease. The £23 billion is made up of £9 billion in social care costs, £12 billion in unpaid care and £1.2 billion in health care costs, says the Dementia 2010 report - 36 pages.

Understanding Dementia / Study by University of Western Sydney: This paper discusses one aspect from the findings of an Australian study aimed at understanding the needs of people with advanced dementia.

Specifically, this paper focuses on the communication issues that might potentially inhibit the implementation of a palliative care approach for a person with advanced dementia in a residential aged care facility (RACF) - 30 pages.

Improving Dementia services in England: This report assesses the Department’s response to the Committee’s recommendations and the robustness of its Strategy and Implementation Plan, and evaluates the machinery in place to implement the Strategy, including the levers for change - 45 pages.

Dementia and the take-up of residential respite care: This bulletin presents take-up rates and factors that affect the take-up of residential respite care and investigates whether dementia, carer availability and English speaking background affect the take-up of residential respite care - 24 pages.

Predicting the progression of Alzheimer’s Disease: This study provided powerful evidence that prediction is possible. Additionally, inclusion of the pre-progression rate in clinical trials for proposed AD therapies should enhance the power of such studies to find real treatment differences, and could reduce the duration of trials designed to assess disease-modifying therapies, claims this report - 9 pages.

2010 Alzheimer’s Disease Facts & Figures: This USA study is a statistical resource on Alzheimer’s disease. The report includes definitions of types of Dementia; summary of current knowledge; analysis of prevalence, mortality, caregiving; use and costs of care and services; race and ethnicity and Alzheimer’s disease - 70 pages.

Info and to Order contact:
UPCOMING EVENTS

Saturday 18 Sept/10: 2nd Annual Creative Aging Calgary Symposium
9am to 12 noon: Professional Development Workshop: $119
1pm to 4:30pm: Creative Express Yourself Workshops: FREE
Location: Ross Glen Hall/Roderick Mah Centre for Continuous Learning
Mount Royal College, Calgary, AB
INFO and REGISTRATION: www.creativeagingcalgary.ca

September 16-18, 2010: GERONTOLOGICAL NURSES ASSOCIATION OF BC, 2010 CONFERENCE:
Aging: Honoring the Journey, Coast Inn of the North, Prince George, B.C
Info: Carol Mooring: mooring@unbc.ca (Tel: 250-964-6365)

October 3-5, 2010: THE 16TH QUALITATIVE HEALTH RESEARCH (QHR) CONFERENCE. Coast Plaza
Hotel, Vancouver, B.C. Info: see the QHR webpage at: http://www.uofaweb.ualberta.ca/iqm/QHR2010.cfm
QHR Keynotes:
Dr. Janice Morse - Sunday, October 3, 2010
Dr. Judith Wuest - Monday, October 4, 2010
Dr. Clive Seale - Tuesday, October 5, 2010

October 6, 2010 – WORKSHOPS and October 7-8, 2010 THE 11TH ADVANCES IN QUALITATIVE
METHODS (AQM) CONFERENCE, Coast Plaza Hotel, Vancouver, B.C. Info: visit the AQM
webpage for more information at: http://www.uofaweb.ualberta.ca/iqm/AQM2010.cfm
The AQM conference is the premier international and interdisciplinary conference for the
dissemination and discussion of developments in qualitative research methods.
AQM Keynotes
Dr. David Morgan - Thursday, October 7, 2010
Dr. Victor Minichiello - Friday, October 8, 2010

October 14-17, 2010, (U.S) NATIONAL GERONTOLOGICAL NURSES ASSOCIATION (NGNA) 25th
Annual Convention, Palm Springs, California. Info: https://www.ngna.org/

November 26- 27, 2010: 2ND CONFERENCE ON POSITIVE AGING: AN INTERDISCIPLINARY TEAM
APPROACH FOR HEALTH PROFESSIONALS (Friday & Saturday). Coast Plaza Hotel, Vancouver,
B.C. Info: ipad@interchange.ubc.ca or www.interprofessional.ubc.ca

December 2-4, 2010 CANADIAN ASSOCIATION OF GERONTOLOGY (CAG) ANNUAL SCIENTIFIC
AND EDUCATIONAL MEETING AND CONFERENCE, Montreal, Quebec. Submit your abstract by
June 21: http://www.cagacg.ca/conferences/callforabstracts/index_e.php

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