Who are we? Why do we exist as an organization? What is CGNA’s strategic direction for the future? These are some of the tough questions your executive wrestled with during our strategic planning session in Halifax, in June of this year.

In the strategic planning process we looked at what are the core values of the CGNA that are most important to our association. The identified core values are:

- **Value collaborative partnerships**
- **Respectful and accountable stewardship**
- **Uniqueness of older individuals**
- **Collective wisdom**
- **Voices of nurses in all roles**
- **Conduct activities with integrity and ethical actions**

We reviewed and modified our Mission Statement which now states:

The Mission of the Canadian Gerontological Nursing Association (CGNA) is to address the health of older Canadians and the nurses who participate with them in health care. The Canadian Gerontological Nursing Association is an organization that represents gerontological nurses and promotes Gerontological nursing practice across national and international boundaries.

In working our way through the process we realized that we did not have a Vision Statement for our organization. A Vision Statement is a statement that captures the long-term picture of what the organization wants to become. A vision statement must be inspirational, memorable and reflect the desires of those with vested interests. Our new Vision Statement is:

The vision of the CGNA is to promote excellence in gerontological nursing through leadership, knowledge and scholarship.

Using our Vision Statement, Mission Statement and Core Values the strategic direction was developed for the next 3-5 year period. The 2005
Strategic Plan was used as starting point for moving forward.

The Strategic Directions fall under five main headings that all of the initiatives and activities of the organization will fall under. These five directions are:

1. Membership, Recruitment and Retention

Under this direction, the new on-line process for joining, or renewing membership is in place for participating provinces. A system has been developed, for those provinces that have chosen not to participate at this time. We thank everyone for their help, patience and feedback during the development and implementation of this service. There has been much work and collaboration with the Gerontological Nursing Association of Ontario, related to our Ontario colleagues becoming conjoint members in the near future. Our revised by-laws approved in Halifax will become official with Industry Canada’s approval in the next few weeks. We now have a “members-only” section on our website.

2. Organizational Functioning

The executive have agreed to revise the operations manual to reflect our current operational reality.

3. Dissemination of Knowledge and Expertise

The executive is committed to revamping all communication tools. Work is proceeding on the development of web based education to assist with studying for the CNA certification exam in Gerontology. The new Standards document that was launched in Halifax is now available to members, free in the “members only” section and available to purchase for others. Planning is proceeding for the 2011 conference in Mississauga, Ontario, June 8 - 11, 2011.

4. Promoting the Association

In the past year it was reported that we have collaborated and partnered with the Canadian Geriatric Society, NICE, Health Canada (via grant) to develop educational resources. We participated in the International Congress of Geriatrics and Gerontology in Paris, France by hosting an international focus group. Relationships have been developed with the Korean and American Gerontological Nursing Associations in the development of our standards. Bev and Denise participated at the American Gerontological Nursing Association annual conference in Palm Springs in October and we were able to promote our conference with the American membership.

5. Political Action and Advocacy

The Executive agreed that a working group will be established to develop a mechanism that will allow us to monitor, review and address advocacy, public relations and regulatory issues. We have recently joined the Congress of National Seniors Organizations (CNSO) that is a very politically active group. We were invited to participate with this group on Parliament Hill to discuss the lack of action by government to address the issues identified in Senator Carstairs Report on the challenges of aging in Canada.

This does not reflect all of the current work and activities.

Our Executive would like to formally thank the previous Executives for all of their hard work and leadership. We agreed as an Executive that we cannot move forward without acknowledging and honouring the past and those great nurse leaders that have gone before us, leading the way.

Respectfully Submitted,

Bev Laurila, CGNA President
The definition of leadership that John Quincy Adams developed seems to apply to many Gerontological Nurses: “If your actions inspire others to dream more, learn more, do more and become more, you are a Leader.” This gerontological nursing leadership was very evident in the reports in the Summer issue of The Canadian Gerontological Nurse, and it continues to shine in recent developments such as the publication of the newly developed document that included in this issue, namely the *Gerontological Nursing Competencies and Standards of Practice*. Furthermore, plans have been developed for our 16th National Conference on Gerontological Nursing to be held from Wednesday June 8, 2011 to Saturday June 11, 2011 at the Delta Meadowvale Resort and Conference Cent, which is located in the Toronto suburb of Mississauga. As is noted on our CGNA website, “the CGNA conference is your opportunity to learn, discuss and network with other nurses who work with older adults across the country and beyond” (see www.cgna.net). Please remember to check our CGNA website for the Call for Abstracts for the June 2011 conference, whose theme is: “To Live is To Age: Raising the Bar for Excellence”.

I do hope some of you can send feedback to the two students who submitted their articles in the Summer issue. Unfortunately the contact information for the article written by SARAH ROMERO was not included. Hence, I have inserted this information in the section called: Articles by students. In this issue, you will find Part 2 of the article by Sykes.

In this issue, you will notice news from our gerontological colleagues in other disciplines and in other areas of the world, as well as some funding opportunities. I hope that this information will stimulate ideas on your part for an article or news item that you could submit for the next issue of The Canadian Gerontological Nurse. Your submission is needed by December 1st to my email address below. The issue will go out prior to the Christmas break.

**A HAPPY AUTUMN SEASON TO ALL OF YOU.**

Carole-Lynne Le Navenec (RN, PhD),
Editor
The Canadian Gerontological Nurse. (EMAIL: cllenave@ucalgary.ca)
CGNA is pleased to announce the launch of its new Gerontological Nursing Competencies and Standards of Practice document!

The revision of the standards and competencies was requested by members in 2007 when they identified a need to refine the existing standards to reflect the current and future gerontological nursing practice in Canada.

The face of gerontological nursing in Canada is evolving and changing in accordance with demographic imperatives and the growth of evidence-informed nursing knowledge. These standards are meant to reflect current knowledge and understanding of our discipline, and are, as a consequence, conditional, dynamic and subject to change because of the influence of social, cultural, economic and political environments of health care.

Practice standards are organized into six categories, including:

- physiological health
- optimizing functional health
- responsive care
- relationship care
- health system
- safety and security

The practice standards describe the appropriate therapeutic interventions or activities of the Canadian nurse which facilitate client health behavior directed towards promotion, prevention, maintenance, rehabilitation or palliation. This document is available in both English and French.

Members can now download an electronic copy of the Gerontological Nursing Competencies and Standards of Practice document in the member-only section of the website. A printed version of the document is also available for purchase. Contact the Head Office at cgna@malachite-mgmt.com if you would like to purchase a copy.

Acknowledgement

Many people must be acknowledged for their contributions. We begin with the Gerontological Nursing Standards working group (GNS-WkG). This group was established in March 2009. Membership for the GNS-WkG consisted of CGNA members and representatives from National Initiative for Care of the Elderly (NICE).

Working group members were:

**CGNA Provincial Presidents/Designates/Members**
Gloria Connolly and Sohani Welcher – Nova Scotia
Heather Hutchinson – British Columbia
Ruth Graham and Helle Tees – Alberta
Dawn Winterhalt – Saskatchewan
Dawn Fenton – New Brunswick
Mary Mac Swain and Anna Enman – Prince Edward Island
Annette Morgan – Newfoundland and Labrador
Bonnie Hall – Ontario

**National Initiative for Care of the Elderly (NICE) Representatives**
Dr. Kathy McGilton and Dr. Lorna Guse

We must also acknowledge the contributions of:

**Canadian Nurses Association (CNA)**
Lucie Vachon – Nurse Consultant, CNA Certification Program

**International Collaborators**
Dr. Judith Hertz and Susan Carlson – President NGNA (United States)
Dr. Gwi-Ryung Son Hong – KGNS (Korean Gerontological Nursing Society)

To ensure the relevance of the new standards and competencies an external review was conducted by inviting experts across the country to provide a critical analysis of the document content. We are grateful to the following external review panel:

**External Review Panel**
Deborah Vandewater – Nova Scotia
Julie Langlois - Ontario
Julie Doyon – British Columbia
Carla Wells – Newfoundland and Labrador
Lori Schindel-Martin - Ontario
Anne Stephens - Ontario
Mollie Cole - Alberta
Kathleen Hunter - Alberta
Lynn McCleary - Ontario

We would also like to recognize the contributions made by our research assistants, administrative support, and the guidance we received from current and previous CGNA executive members:

Mr. Richard Littleton: Graduate Student, University of Alberta
Ms. Cheryl Silveira: Graduate Student, University of Toronto
Ms. Sharon Leung: CGNA Administrative Manager – Malachite Management Services
Ms. Beverley Laurila: CGNA President and other 2009-2010 executive members: Denise Levesque, Sandi Hirst, Cheryl Knight

Many people from across Canada have provided wisdom and insight to ensure that gerontological nursing is represented by a specialized body of knowledge. Thank you everyone.

Respectfully submitted,

Belinda Parke, RN, MScN, PhD, GNC(C)  
CGNA Past President

Diane Buchanan, RN, MScN, PhD,  
CGNA President Elect
CALL FOR ABSTRACTS

You are invited to submit an abstract for consideration as an oral, poster, symposium, or roundtable presentation addressing the conference theme, “To Live is to Age...Raising the Bar for Excellence”.

NEW THIS YEAR!

A new online abstract submission system will be set up to allow members to submit abstracts quickly and conveniently via the website. Instructions for online submission will be available on the abstract submission site. Abstracts that have been published elsewhere are not acceptable for presentation. Notification of acceptance will be e-mailed to the primary contact person, and those abstracts accepted will be published in the CGNA conference abstract book. Guidelines for development of the abstract are outlined below.

We look forward to seeing you in the city of Mississauga, Ontario, which is in close proximity to downtown Toronto and all its attractions. Please schedule in the conference dates and share this abstract call and details of this exciting conference with your colleagues.

The guidelines for submission are available online at the CGNA 2011 conference website at www.cgnaconference.ca. The online abstract submission site will open soon.

CONFERENCE PROPERTY

Located 15 minutes west of Lester B. Pearson International Airport and only 25 minutes from downtown Toronto, the Delta Meadowvale Resort and Conference Center is easily accessed from all sides, via the QEW and Highways 401, 407, 403 and 427.

CGNA has negotiated special rates at the Delta Meadowvale Resort for attendees of the 2011 Biennial Conference - $149/night including complimentary parking, complimentary access to the Health Club, and complimentary internet access in the guestrooms!

Visit www.cgnaconference.ca for more information and to make your reservations today!

REGISTRATION WILL OPEN SOON!
CALL FOR CGNA 2013 CONFERENCE PROPOSALS

CGNA is soliciting proposals from provincial groups who are interested in hosting the CGNA 2013 Conference. Proposals should be sent to CGNA President, Bev Laurila, at blaurila@exchange.hsc.mb.ca no later than Friday, December 3, 2010. Please email the President if your group is currently working on a proposal.

The proposal should include:

1. General objectives
2. Suggested theme
3. Strengths of the planning group
4. Available resources
5. Location – Conference and accommodation facilities
6. Proposed dates for Conference
7. Name, address, telephone number, email of liaison

CRITERIA FOR SELECTION OF CONFERENCE SITE

Although there are no clear cut rules about the geographic location, CGNA Executive will consider Canada’s geography so that sequential conferences are held in different regions of the country. The following principles guide its decision:

1. Geographical location is accessible to members.
2. Proposed convention centre can hold a minimum of 600 delegates in plenary session and has space for small group discussions.
3. Hotels are close to the conference site, e.g. within walking distance or 5 minutes taxi ride.
4. Adequate hotel facilities are available, e.g. able to accommodate minimum of 350 delegates.
5. Conference planning committee (CPC) members belong to CGNA.
6. Conference planning committee members have conference organizational experience at the provincial or national level.
7. Conference planning committee provides assurance that they are not planning to host a provincial Conference in the year immediately preceding the CGNA Conference.
8. An organized interest group or association is supporting the proposal.
9. Site represents an area of choice reflecting distribution across the country.
Alberta Gerontological Nurses Association (AGNA)

Greetings

Moving forward into the fall and winter season AGNA executive will be meeting and reviewing priorities. One goal for our association is to continue to promote our interactive website and promote accessibility for our rural members. AGNA continues to promote excellence in Gerontological nursing by offering chapter members education support opportunities for CNA Gerontological certification. We will be acknowledging Gerontological nurses and their contributions over the next year in our newsletter, on our website and at our annual conference in Red Deer. Please access the various mediums and see how Alberta Gerontological nurses made and continue to make a difference in seniors’ health.

Lisa LeBlanc RN MN

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

M Vos Savant

Gerontological Nursing Association of B.C. (GNABC)

Greetings from BC

I thought my previous newsletter report was the last as I step down in September and Darlene Rogers Neary in Kelowna will become President of GNABC, however, here I am again for one last time.

It has been a very busy two years for GNABC with transitioning from a Professional Practice Group to a stand alone association (GNGBC). This has taken a lot of effort on the part of the dedicated people that made it possible. I would like to thank Catherine Marsden from Surrey as past president for getting us going, Judy Delaney of Victoria a long time member of GNGBC who really knows how to word smith, Heather Frame in Victoria for keeping us straight as secretary of minutes of meetings, Rea Braithwaite from Burnaby for preventing us from becoming too bogged down, Patti Parkyn from Victoria who had been involved in other association formations and typed up the first draft of the constitution and bylaws (which I lost) and Sandy Oxenbury for remembering most of what we did that day which was way back in 2007 and put it all back on the computer so we could start again. The government took some time to tell us we were a legal association but in 2008 it all came to pass. We have since made some revisions to the bylaws and have learned a lot about associations.

Along the way we updated the GNABC website, joined CGNA and Malachite with online registration and had our AGM and Provincial conferences in Coquitlam and Nanaimo with one to come in Prince George in September. This conference is nearly sold out. What a great job has been done by the chapter and the leadership of Carol Mooring. My motto is that if you provide good education and good food people will attend.

There have been study groups throughout the province for GNC© certification as well as monthly/bimonthly chapter education presentations by the 8 chapters. At these chapter meetings we give people a certificate of attendance because in BC we can be audited at anytime by the College of Registered Nurses to show that we are maintaining competency.

Because we feel passionate about the care of older adults where ever they live, we opened our membership to all disciplines and for two years have had RPNs and LPNs as full GNABC members. Catherine Marsden lobbied CGNA to do the same and that happened this year at the AGM in Halifax.
I am very proud to be a member of an association that has quality health care for the older adult at the forefront of its mandate.

Once again I thank GNABC executive and the executive of CGNA for their work and support.

Respectfully submitted,

Heather Hutchinson, BSN, GNC(C)
President, GNA

**UPCOMING EVENTS & CALL FOR:**
PAPERS OR ABSTRACTS OR PROPOSALS

**December 10-15, 2010** Qatar Health 2010 International Health Care Congress and Exhibition,
Info: http://www.qatarhealth.info/abstract_form.html

Info: tara.consunji2@qwqhc.ca Tel: 1.800.814.7769 X362o
NOTE: Call for submissions deadline is September 30, 2010

[Theme: Advancing Patient-Centered Arts]
Info regarding Abstract submissions (for papers, panels, workshops, & posters)
http://www.thesah.org/template/page.cfm?page_id=21

**18 – 20 May 2011**: 5th International Congress on Innovations in Nursing 2011 Innovation and Leadership in Clinical Practice Research and Education
Perth Convention Exhibition Centre
Info: http://icin2011.com

**June 5-8, 2011**: CALL FOR ABSTRACTS (until December 31, 2010) for Festival of [6] International Conferences on Care giving, Disability, Aging, and Technology (FCCDAT): Living longer and living better
Sheraton Centre Toronto Hotel, Toronto
Info: http://cts.vresp.com/c/?FestivalofInternatio/442c63652d/9f9ad993b5/1630f2f2e5

**June 8-11, 2011**: CGNA 2011 Biennial Conference 16th National Conference on Gerontological Nursing Delta Meadowvale Resort and Conference Center, Mississauga, Ontario
Info: www.cgna.net

**THE SECTION BELOW CONTAINS THE CALL FOR PAPERS, ABSTRACTS OR PROPOSALS**

***CALL FOR ABSTRACTS for the 16th NATIONAL CONFERENCE ON GERONTOLOGICAL NURSING to be held from Wednesday June 8, 2011 to Saturday June 11, 2011 at the Delta Meadowvale Resort and Conference Centre, in the Toronto suburb of Mississauga. Abstracts can be submitted online via the CGNA Website: www.cgna.net. To avoid disappointment, check the website for the deadline for submissions.***
***CALL FOR ABSTRACTS for THE 5TH INTERNATIONAL CONGRESS ON INNOVATIONS IN NURSING 2011 (ICIN), Innovation and Leadership in Clinical Practice, Research and Education, 18-20 May 2011, Perth, Australia

NOTE: The deadline for abstract submissions is Friday 15 October 2010. However, check with the organizers because very, very often the deadline is extended.

Info: lexie@eecw.com.au or Website: http://icin2011.com/index.php

This congress will be of interest to nursing professionals who are interested in furthering their professional practice and competency or want to share original nursing concepts and practices from around the world.

The Congress will provide numerous professional networking opportunities, with a view to generating new and original projects and will feature a wide range of nursing innovations and initiatives that have resulted in improvements in patient outcomes and the health system in general. Keynote presenters have been confirmed from Australia, Europe, Canada and America and include world renowned experts within the nursing profession.

****CALL FOR PROPOSALS: PROMOTING AWARENESS OF ELDER ABUSE IN LONG-TERM CARE HOMES, 2010-2012: A PAN-CANADIAN INITIATIVE

ENDING DATE: CHECK THEIR WEBSITE TO SEE IF THE SEPTEMBER DEADLINE HAS BEEN EXTENDS.

Info: contact project manager Pamela VanBelle at pamelav@rnao.org or nurse consultant Norma Freeman at nfreeman@cna-aiic.ca.

Nurses are concerned about the incidence of elder abuse in Canada. Abuse of older adults is a patient safety issue. As Canada's aging population is growing, there is an increase in the number of seniors at risk.

The Canadian Nurses Association (CNA) and the Registered Nurses’ Association of Ontario (RNAO) are partnering to develop educational resources for staff at long-term care homes. The goal of this project, Promoting the awareness of elder abuse in long-term care homes, is to increase direct service providers’ awareness and understanding of elder abuse in order to reduce its incidence.

CNA and RNAO are committed to ensuring that seniors benefit from and contribute to the quality of life in their communities. This elder abuse awareness project helps to reduce the incidence of abuse of older adults. As a result of this project, new resources will be available to improve the quality of life and safety for seniors.

This initiative will focus on the development of an elder abuse prevention curriculum that will build on existing elder abuse resources supplied by federal, provincial and territorial governments and other related sources. The curriculum will be offered as an education series to staff at long-term care homes across Canada. An online elder abuse awareness guide will be published and accompany the education series.

The Promoting Awareness of Elder Abuse in Long-Term Care Homes project will continue until March 2012. It is guided by a pan-Canadian Advisory Committee comprised of representatives from key stakeholders, including representatives from consumer, provider, employer, patient safety, older adult organizations. Milestones include:

1) Identification and compilation of elder abuse awareness resources
2) Selection of long-term care (LTC) Prevention of Elder Abuse Centres of Excellence (PEACE) sites across Canada
3) Collaboration with RN LTC elder abuse awareness coordinators from each PEACE site
4) Development of evidence-based curriculum, resources and on-line community of practice on elder abuse prevention
5) Pan-Canadian dissemination of resources across sectors
6) Promotion of LTC champions in long-term care homes
Long-term care homes, for the purpose of this initiative, are facilities in Canada which provide living accommodation for people who require on-site delivery of 24 hour, 7 days a week supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping (Health Canada, 2004).

**Description of Pan-Canadian Initiative**

Abuse of older adults is an issue of growing importance and concern in Canada. Elder abuse is defined as any action by someone in a relationship of trust that results in harm or distress to an older person. Commonly recognized types of elder abuse include physical, psychological, financial, neglect and denial of entitlements protected by law (Seniors Canada, 2009). It is expected that due to the growing age of the population there will be an increase in the number of seniors at risk. The goal of this initiative is to help address this issue.

The Canadian Nurses Association (CNA) has engaged the Registered Nurses’ Association of Ontario (RNAO), with funding provided by Human Resources and Skills Development Canada – New Horizons for Seniors Program, to increase front-line service providers’ awareness and understanding of elder abuse in long-term care homes.

The activities of the Promoting Awareness of Elder Abuse in Long-Term Care Homes project include:

- Develop and deliver education sessions on elder abuse prevention customized to long-term care sites (five long-term care homes and outreach areas) across Canada.
- Develop promotional material on elder abuse prevention; and
- Develop an online elder abuse awareness toolkit.

The Promoting Awareness of Elder Abuse in Long-Term Care Homes project will utilize the following multi-prong interventions:

1) Identification and compilation of elder abuse awareness resources
2) Five long-term care (LTC) Prevention of Elder Abuse Centres of Excellence (PEACE) sites, representing a range of jurisdictions
3) Five RN LTC elder abuse awareness coordinators
4) LTC champions in a range of long-term care homes
5) Evidence based education on prevention of elder abuse
6) Pan-Canadian dissemination of resources across sectors

**Call for PEACE Sites**

RNAO, in partnership with CNA, is requesting applications to be submitted from interested long-term care homes, to become Prevention of Elder Abuse Centres of Excellence (PEACE) for the 2010-2012 Promoting Awareness of Elder Abuse in Long-Term Care Homes Initiative. This call is directed to all long-term care homes across Canada interested in becoming a centre of excellence related to the prevention of elder abuse. The project timeframe is January 3, 2011 to March 31, 2012.

Five PEACE sites will be established across Canada in long-term care homes. These sites have the potential for outreach to other long-term homes within their provincial/territorial jurisdiction. PEACE sites will be selected based on:

- Demonstrated commitment to evidence-based practice.
- Ability to disseminate and spread information to outreach areas, through the use of existing resources (e.g., established networks, teleconference or videoconference capacity, etc.).
- Ability to meet project requirements.
- Identification of a registered nurse (RN) to act as a LTC elder abuse awareness coordinator.
- Jurisdictional representation.
Successful applicants will be provided with key resources including educational materials and workshops for their staff focused on preventing elder abuse. In addition, selected sites will be spotlighted as leaders in this critical area of care for older persons. Funding for this initiative has been provided by Human Resources Skills and Development Canada.

Benefits of Becoming a PEACE Site
The PEACE site will be:
- Seen as a prototype home in developing strategies to prevent elder abuse that can be shared with others in its jurisdiction/network.
- Highlighted as a Canadian PEACE site and will receive a certificate recognizing its commitment on the completion of the initiative.
- Be among the first to become champions in elder abuse prevention, with enhanced knowledge and skills in this area.
- Recognized as a Canadian leader in elder abuse prevention in its region, and will be highlighted in all initiative dissemination strategies.
- Spotlighted as a Canadian centre of excellence in elder abuse prevention.

The RN LTC coordinator at the PEACE site will:
- Receive four days of leading edge, evidence-based education on prevention of elder abuse and facilitation skills in order to train others.
- Take on leadership role in facilitating the elder abuse awareness education series.
- Be recognized as a leader in educating champions in their organization and outreach areas.

Roles and Responsibilities
The role of the PEACE site is to:
- Identify an RN from its staff to act as an LTC elder abuse awareness coordinator.
- Communicate with and facilitate education in its own and other long-term care homes in its region, and disseminate resources related to elder abuse prevention.
- Support the initiative and the role of the LTC coordinator through provision of release time to:
  - Attend a four day orientation session at the RNAO offices in Toronto (travel expenses covered by project).
  - Provide education in its facility and to other long-term care homes in its region (through existing networking channels); and attend regular knowledge exchange teleconferences and participate in the online Community of Practice.
- Provide internet and computer access to the LTC coordinator to participate in the community of practice with the other LTC coordinators.
- Work with RNAO to collect and share data related to the initiative and its impact through data reports provided by RNAO.
- Promote the dissemination of elder abuse prevention materials (across disciplines, healthcare sectors and to the public) in order to raise awareness of elder abuse.
- Become a champion organization in relation to elder abuse prevention.

The role of the RN LTC coordinator is to:
- Participate in the orientation session at RNAO.
- Facilitate the elder abuse awareness education series with staff in their PEACE site, and other homes across the region.
- Seek, create and coordinate opportunities to promote the elder abuse awareness resources.
- Create linkages with other PEACE sites through regular knowledge exchange (to build a network of resources and contacts), including the integration of elder abuse prevention resources (i.e., RNAO clinical and healthy work environment best practice guidelines) into practice, the sustained improvement in knowledge, attitudes, behaviours or skills of staff at three and six months post-education sessions).
- Monitor and facilitate knowledge uptake in their site.
- Monitor and track necessary data, through reports provided to the RNAO project team.
- Maintain ongoing communication with the RNAO project team.

The role of the RNAO, in partnership with CNA, is to:

- Provide access to published and electronic elder abuse resources and implementation tools.
- Provide a four-day orientation session for the LTC coordinators at the RNAO offices in Toronto (travel expenses covered by project).
- Provide mentorship and support to LTC coordinators by responding to questions and providing guidance in delivering the education series.
- Facilitate the knowledge exchange teleconferences and moderate the online Community of Practice to support the PEACE sites, through sharing progress and lessons learned.
- Provide evaluation measures related to the initiative and appropriate evaluation tools to track and monitor progress.
- Provide each PEACE site with funding of up to $1000 to cover agreed-upon costs of delivering the education series.

Eligibility Criteria for PEACE Sites
In order for a long-term care home to be considered as a PEACE site, the home is able to demonstrate organizational support and a commitment to evidence-based practice and quality improvement.

A. Organizational Support
- Description of your long-term care home (including type, size, resident population, structure and region).
- Description of your long-term care home’s interest in the issue of the prevention of elder abuse.
- A letter of support from the governing body (i.e. Board) and/or senior management for this initiative.
- Identification of an RN to be the LTC coordinator - name, credentials, current role and a brief description of how this individual meets the requirements of the initiative (200 words).
  - Demonstrated skill in facilitating educational programs.
  - Knowledge and experience of adult education strategies and change management.
  - Project management experience an asset.
  - Excellent communication skills and ability to work with internal and external stakeholders.
  - Ability to work independently, set priorities, organize workload and meet deadlines.
    - Maximum 3 page resume to be included as an appendix.
    - Confirmation of support for the LTC coordinator to the role from January 3, 2011 to March 31, 2012.

B. Commitment to Evidence-Based Practice and Quality Improvement
- Outline any past activities related to evidence-based practice/quality improvement in which the LTC home has been involved.
- Description of the organization’s commitment and approach/strategies to facilitating and sustaining evidence-based clinical practice in long-term care.
- Description of current infrastructure for staff (regulated and unregulated staff) development.
- Description of how the organization will ensure staff participation and attendance at the education sessions.
- Description of how the education series will be spread to other long-term care homes in the region.
- Description of past experiences with data collection and evaluation.

Instructions to Applicants
All inquiries concerning the application can be submitted via email to Eliisa Fok, Project Assistant at efok@rnao.org. Please include the phrase Prevention of Elder Abuse Centre of Excellence Application in the subject line.
All proposals will undergo a screening process. Although not limited or restricted to, the following criteria may be used in evaluation of the proposals. Applicants will be able to demonstrate:

- Commitment to evidence-based practice.
- Ability to disseminate and spread information to outreach area.
- Availability of an RN to act as the LTC coordinator for the PEACE site from January 3, 2011 to March 31, 2012.
- Commitment to send LTC coordinators to Toronto for four-day training session.
- Commitment to providing in-kind support for the LTC coordinator to facilitate education and resource sharing about prevention of elder abuse in their LTC home and outreach area.
- Support for long-term care home staff (regulated and unregulated) to attend the elder abuse awareness education sessions, in order to build capacity in supporting the prevention of elder abuse, and ongoing knowledge exchange through teleconferences.
- A relationship with other long-term care facilities in the region that could be the basis of outreach activities.
- A commitment to ensure tracking and monitoring of initiative activities and provide evaluation data as required.
- Agreement to share learnings, outcomes and achievements with RNAO and CNA for dissemination to the broader provincial/territorial and pan-Canadian healthcare community.
- Willingness to identify successful strategies for linking with regional health care organizations for sector-wide knowledge transfer and health promotion activities.

Other Information
The RNAO, in consultation with the CNA, has the right to cancel this Request for Proposals at any time and to reissue it for any reason whatsoever without incurring any liability and no applicant will have any claim against the RNAO, the CNA, or any of their respective staff.

The RNAO and the CNA, are not liable for any costs of preparation or presentation of applications.

A Review Committee established by the RNAO, in consultation with CNA, will review each submission. The RNAO, in consultation with the CNA, reserves the exclusive right to determine the qualitative aspects of all applications.

The application and accompanying documentation submitted by the applicants shall become property of the RNAO and the CNA, and will not be returned. All information and data submitted by the applicant will be held in confidence by the RNAO and will not be disclosed to parties other than the project team without prior written consent of the applicant.

References


Relevant Websites
Canadian Nurses Association
NurseOne
Human Resources and Skills Development Canada - New Horizons for Seniors
Registered Nurses’ Association of Ontario
RNAO Best Practice Guidelines
RNAO Toolkit: Implementation of Clinical Practice Guidelines
AGING IS AN AFFAIR WITH LIFE: SO WHY OUR FASCINATION WITH 65 YEARS?

By Sandra. P. Hirst RN, PhD, GNC(C) [shirst@ucalgary.ca]
Director, Brenda Strafford Centre for Excellence in Gerontological Nursing, Faculty of Nursing, University of Calgary and
Annette M. Lane RN, PhD (alane@ucalgary.ca),
Assistant Professor, Faculty of Nursing, University of Calgary

Chronological age starts at birth and ends at death. In Canada, older adults (seniors) are acknowledged to be individuals over the age of 65 years – but why this age? How well does this definition serve seniors? Why is 65 years of age the arbitrary number assigned to older adults in Canada? How does this help us in our work as gerontological nurses?

Age-related entitlements for older adults date to the late 1800s in Germany, when German Chancellor Otto von Bismarck established 70 years as the age when benefits could begin for those in military service. Few were expected to receive this pension. Until the late 1960s, the age of eligibility for Old Age Security in Canada was set at 70. Canadians nearing retirement in the 1960s had experienced the Great Depression of the 1930s and the Second World War, and consequently most had limited opportunities to save for their retirement. Faced with high levels of poverty among seniors, the Canada Pension Plan (CPP) was established in 1966 to provide working Canadians and their families with income for retirement. The age of eligibility for CPP, was set initially at a 68 years, which was reduced to 65 years by 1970. However, today there is talk of increasing the age to 67. As noted in legislation in Australia, “From 1 July 2017, the qualifying age for Age Pension will increase from 65 to 65.5 years. The qualifying age for Age Pension will then rise by 6 months every 2 years, reaching 67 by 1 July 2023.” (Government of Australia, 2010).

The age of 65 years has significance for public policies relating to aging in Canada because it represents the current age of eligibility for national income security programs and, in those jurisdictions which permit mandatory retirement, it remains the age beyond which employees are no longer protected against discrimination based on age. The use of the chronological age of 65 years by governments, demographers, and administrators of public pensions reflects a societal choice made within an historical context. In Canada, as in most industrialized societies during the postwar period, the establishment of the welfare state included a diversity of social programs to improve the living conditions of its older citizens. The age 65 was also set as an age at which employment could be terminated based on age, through mandatory retirement policies. Gradually, these policies have been challenged, in several jurisdictions, and found to be discriminatory under human rights legislation.

Moving away from clearly defined age-based retirement criteria raises a number of questions, such as determining when one is old? Some of us, as members of CGNA, were around in 1960. We know that a 65-year-old at that time is not the same as a 65-year-old today, in 2010. They are different people. On average, today’s older adults are much healthier and have many more years of good health ahead of them. They are also more productive and do not necessarily want to retire; 70% of Australians do not want to retire completely, but want to downsize the amount they work, and enter more meaningful work. Hence, the term “encore” work (AgeWave Australia Newsletter, August 27, 2010).

Within this perspective, the concept of the life course merits attention. It describes the successive role statuses held by individuals across their lives that impact them as they age. By focusing on social roles (e.g. student, parent, employee, grandparent) and processes (e.g. education, living arrangements,
socioeconomic status), this concept targets the sociological dimensions of aging, viewing these life-long processes as a succession of interactions between the individual and work, family, education, and other institutions (Fuller-Iglesias, Smith & Antonucci 2009).

The concept of the *life course* can be distinguished from life cycle, which refers to distinct stages, maturation, and generational replacement and refers to specific time frames, rather than an accumulation of events over time that profoundly impact older adults (Jackson, Williams & Gomberg, 1998). It is more applicable to populations, organizations, or groups such as the family, which undergo a series of stages (O’Rand & Krecker, 1990). In addition, the concept of life span is applicable to individuals and refers to the duration of time from birth to death.

So what are the implications of this discussion for us, as gerontological nurses, if we accept the premise that aging begins at birth? It means that nurses need to challenge how they conceptualize aging and its associated issues. Nurses, even those who work in gerontological settings, may tend to see the health and social problems of older adults as being related to aging. But are they really? A life course perspective takes into consideration that older adults’ experiences of health and aging are really an accumulation of life events and circumstances. Hence, depression in an older adult may not be the result of current circumstances. Rather, the older adult may have struggled much of his life with depression; methods of treatment such as SSRIs and counseling may have been very effective in the past. Employing a life course perspective means that nurses assess the life span of the older adult and consider that health problems, such as depression, are not the result of becoming a specific age. They utilize the older adult’s past for answers to health problems in the present.

As we previously stated, nurses need to educate clients and the public about aging and its associated challenges. However, education about aging should not begin when clients are middle aged or approaching older age. Education should start with the young. We need to encourage education in the grade schools as to what is aging and emphasize health promotion strategies as a lifelong objective. For example, children and adolescents need education about the importance of exercise and diet in preventing obesity and the link between childhood obesity and cardiovascular disease in adulthood (Brown, 2006). Addressing obesity and other risks for cardiac disease at earlier ages may decrease the cardiac problems of adults as they age.

Not only should education on aging focus on aging as a life course affair, but research should also take this approach. There is a need for long term studies that examine health problems in younger adults and the resultant problems that come in older age. Further, research should assess the impact of social processes over a life time upon health on older adults. For instance, financial problems (poverty, problems accessing medical care and lack of food) increases mortality in older adults (Tucker-Seeley, Subramanian & Sorensen, 2009). These financial problems, including poverty, have often been a life long problem. Nurses may become involved in research studies with colleagues from varied disciplines to examine the effects of poverty on children, adults and older adults. Even if nurses are not directly involved in research, they should utilize research findings to strengthen their practices.

Aging is truly a life long affair! How we live in childhood and adulthood have major implications for how we experience older age. Today, older adults are living longer and often experiencing greater health and choices in their latter years. Nurses can advocate for older adults by recognizing their abilities, rather than fixating on numbers to represent older age.

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PART TWO: PARSE’S THEORY OF HUMAN BECOMING : STRENGTHS, LIMITATIONS AND TENSIONS IN GUIDING CARE OF PATIENTS IN AN ACUTE PALLIATIVE CARE SETTING  by Sarah Romero, Student Nurse (2nd year), Faculty of Nursing, University of Calgary (EMAIL: seromero@ucalgary.ca)

Part ONE of This article was in the Summer 2010 issue of The Canadian Gerontological Nurse (Volume 27 Number 1, June-July, 2010, pp. 6-12). Sarah Romero, Student Nurse, 2nd Year; EMAIL: seromero@ucalgary.ca

The first part of this essay, a case study exploring the value of Parse’s theory of human becoming (1981,1987) in guiding nursing care of Mr.H, an 81 year old patient receiving treatment on an acute medical-palliative hospital unit, appeared in the summer 2010 edition of the Canadian Gerontological Nurse. In this second segment of the essay, the manner in which the theory of human becoming both supported and served as a barrier to me, a first year nursing student, in guiding care of Mr. H will be further discussed.

Planning/Goal Setting

The nurse guided by Parse’s theory cannot plan care, as the goal of nursing is quality of life from the individual’s perspective. Therefore, any goals planned for are those identified by the patient. As expressed by Quiquero, Knights, and Meo (1991): “We cannot prepare for [the patient’s] nursing care, the focus of which is their hopes, dreams and wishes...we cannot know about the person until we are truly present with him or her, going to where the individual is.” (p.15). Through true presence, the nurse may come to understand and learn more about the individual’s emerging patterns of health and thereby guide and support them as they discover dreams and plan for them.

Mr. H’s emerging patterns of health were helpful to me as his caregiver, as they provided insights into some possible goals that he did not express explicitly. While Mr. H was eager to talk about his experience, he struggled with introspection and when asked direct questions concerning his goals or desires, he would change the subject. I suspect that this was because he was unsure of the answers. The reality is that often we do not understand how we feel or what we need and want- we need time to
sort through and make sense of it. This is one reason why the use of true presence is so essential—when someone listens, we are able to clarify what we think and discover what we most need. As stated by Jonas-Simpson (2001) “In giving an account of our experience to someone who listens, we are better able to listen to ourselves.” (p.227). Based on what Mr. H shared, one goal that was very apparent was to prepare for the end of his life. In disclosing his longing for relationships during this time, it seemed that a second goal that he was implicitly expressing was to be able to develop relationships and find comfort through others as he prepared for death.

Interventions

When using Parse’s theory, the term intervention is not used. Instead, nursing practice as guided by Parse’s theory is shaped through three practice dimensions and processes, which occur simultaneously as the nurse acts as a true presence (see Appendix A). Reflecting on my experience caring for Mr. H, these processes as part of our relationship are apparent. However, for the purposes of this essay, instead of speaking of my experience with these practice dimensions and processes, I will simply discuss two specific interventions and several related nurse-person activities that I focused on in caring for Mr. H.

Intervention: Presence

The concept of presence is fairly abstract and Nursing Interventions Classifications (2008) defines it as “being with another, both physically and psychologically, during times of need” (p. 584). However, this definition does not fully capture Parse’s intentions in using the term. As Parse explains:

Living true presence is unique to the art of human becoming. It is sometimes misinterpreted as simply asking persons what they want and respecting their desires. This alone is not true presence. True presence is a free flowing attentiveness that arises from the belief that the human in mutual process with the universe is unitary, freely chooses in situations, structures personal meaning, lives paradoxical rhythms and moves beyond (in Parker, 2006, p. 191)

For Parse, then, presence embodies the notion of ‘bearing witness’, of witnessing yet simultaneously entering into the other’s experience. Presence was certainly what I felt was the most important intervention I used when caring for Mr. H. Presence was my overarching ‘way of being’ in the relationship. Below are examples of nurse-person activities that we engaged in that demonstrate my way of being present with him, as guided by Parse’s theory.

Nurse-Person Activities

1. I sought to understand and validate his situation by listening to him empathically.

I spent a fair amount of time with Mr. H as he talked about his hopes and fears in moving to long term care. He was understandably upset by moving to an unfamiliar place. He spoke at length about his concerns that he would be all by himself, that the other patients would be demented and unable to befriend him, that the staff would be unkind and the food terrible. I did not seek to correct his thinking or to provide suggestions or advice. I solely listened and sought to validate the legitimacy of his fears in saying “It must be very hard for you to have to start over again in a new place”. When I said this, he shared even more openly about deeper fears and concerns about dying.

2. I used non verbal means of communication like touch, tone of voice and facial expression to convey my presence to Mr. H.

For instance, when Mr. H expressed his anger and grief about dying, I recognized that there were no words that could lessen his pain. I took his hand in mine and sat with him as he wept and shared all that was on his mind. Another example is that when I went into his room in the morning to wake him, I knelt
by his bed, touched his arm, looked him in the eye and smiled. This seemingly small act opened the door for a profound interaction and the building of trust between us. Mr. H was silent for a long time, and simply met my gaze and smiled back at me.

**Intervention: Comfort**

While comfort is not yet a specific intervention discussed in *Nursing Interventions Classifications*, it was a very important way that I cared for Mr. H. Too often end of life care neglects focus on quality of life.

**Nurse-Person Activities**

1. I explored with Mr. H aspects of life that he still enjoyed, and we participated in activities together that he enjoyed, but was unable to do independently.

For example, we went for a walk together off the hospital unit to give him a change of scenery. He was very appreciative of the opportunity to look out a window. As well, the corridors of the hospital were lined with artwork, which he enjoyed looking at. Interestingly, this served as helpful method in remembering the past and exploring the possibilities of the future, part of Parse’s practice dimension of mobilizing transcendence through moving beyond (see Appendix A). For instance, when we admired a photo of Lake Louise, Mr. H began to discuss his sorrow at never having visited the place and his pain at knowing his chances to do so had passed.

**Evaluation**

According to Parse, “evaluation is based on the person’s own description of a change in their health pattern” (Janisch, 1992 p. 19), rather than the nurse’s collection of data and determination of success through outcome indicators. For this reason, it is essential to consider Mr. H’s feelings and thoughts in evaluation of the impact of my behavior and the interventions used. While Mr. H had a history of aggression and verbal abuse toward staff, he displayed none of these behaviors toward me throughout the day that we spent together. At the end of my shift, he took my hand and thanked me for all my help, saying that it had meant so much to have someone be with him and listen. In light of the emphasis of Parse’s theory on the individual’s own subjective perceptions, Mr. H’s assertion that I had helped him by listening and being with him provided me with concrete feedback that suggested that my interventions were indeed therapeutic. (Had I been assigned to Mr. H’s care again, it would have been helpful to revisit this topic and obtain further, more specific information regarding how my care had benefitted him, from his perspective).

**Discussion**

Parse’s theory was certainly helpful to me in building a caring and trusting relationship with my patient that helped to promote his healing. The underlying ethical assumptions about the nature of the person as a unitary being with individual freedom guided me to focus intentionally on the uniqueness and wholeness of my patient and to approach the relationship with reverence and deep respect for his rights. These key tenets of the theory served as a safeguard of sorts in reminding me to keep the relationship person-centered and based on the needs and wishes he expressed. This, in turn, fostered trust. Interestingly, while Mr. H affirmed that my way of being present with him was meaningful, I also saw that it began a work of growth and movement within me. By being truly present with Mr. H, allowing myself to be open to listening and understanding, I bore witness to the wisdom that he gleaned from years of experience. It led me to begin to probe in deeper ways many of my own questions, assumptions, and fears, particularly concerning death. It challenged me to reflect on my own values, professionally and personally. Parse describes human becoming as a process cocreated between nurse and patient, and I personally experienced this reality.

Although the theory of human becoming was helpful in assisting me to build a caring relationship that my patient found therapeutic, it did have limitations in practice. Firstly, the language that the theory is
written in is very abstract and complex, utilizing an obscure and somewhat inaccessible vocabulary coined by Parse. This language served as a barrier to me, as I had to spend vast amounts of time trying to understand what she was saying before I could even think about applying it to a practice setting. Secondly, while Parse levels logical criticisms of the nursing process and the objectification present in its use, it can be very difficult to understand how one is to practice in an alternative way, particularly because of the complex and abstract language.

As well, some of Parse’s assumptions do not seem to reflect the reality of patient experience. For example, she asserts that health is not a state or a continuum involving good and bad, better or worse. Yet, this was exactly how Mr. H understood and defined his health— he shared that he had experienced times of better and worse health. From his perspective, his health was directly related to his medical condition. Parse’s definition of health as a process of growth is certainly an observable and logical phenomenon. However, it might be helpful in practice to compliment her understanding of health with use of a more traditional definition that accounts for objective disease states, viewing the process of personal growth and self-awareness integral to her theory as an important overarching theme when considering health and wellness.

While acting as a true presence in accordance with this theory was essential to building a caring relationship, my experience demonstrated that the receptive role that the nurse adopts, as well as the theoretical focus on subjective knowledge, may pose some extra challenges when caring for patients who struggle with introspection. Although no one could know and understand Mr. H as well as he knew himself, he experienced difficulties expressing and articulating his needs. When I asked him direct, open-ended questions, he did not respond, but changed the subject almost every time. Many of the nurse-person activities we engaged in together came not at his request, but at my suggestion, as he was not aware of his options. Parse’s assertion that the nurse is not to make assumptions about the patient’s experience is ethical and resonates with me. The focus on subjective knowledge helps to promote patient-centered care. However, in the theory’s emphasis on the patient’s subjective experience, focus on the nurse’s perceptions is easily neglected. Yet, it is very important to recognize that nurses may bring a different, specialized and valuable understanding and perspective to the nurse-patient relationship, based on unique nursing knowledge, and by virtue of being situated outside of a chaotic and confusing situation. For individuals who struggle with self awareness as Mr. H did, it may be helpful to adopt a more direct, active approach in helping them to explore possibilities.

For these reasons, integration of elements of other theories that place greater emphasis on objective ways of knowing may be helpful in application in an acute care setting. Paterson and Zderad’s (1976) humanistic nursing theory may blend nicely with Parse’s theory and address some of its limitations, while not compromising the values of freedom and uniqueness essential to the theory. Like Parse, Paterson and Zderad emphasize presence and authentic relationship, but these nurse theorists focus more on different ways of knowing and being with patients—objective, subjective and intersubjective, whereas Parse is primarily concerned with the patient’s subjective experience. Intersubjective knowing and relating is created through the interplay of both the nurse’s and patient’s subjective perspectives and the objective realities of a situation. For Paterson and Zderad, it is in this intersubjective reality that nursing care occurs (Doane & Varcoe, 2005, p.99). This articulation of nursing care might allow for a more active role on the nurse’s part, possibly addressing the potential problems related to the more receptive stance of the nurse guided by Parse’s theory.

Conclusion

Seeking to care for patients as guided by the values of Parse’s theory of human becoming involves a commitment not only to provide ethical care, but also to learn and change through living authentically alongside patients. If nursing is, as Parse defines it, “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), then it involves a true giving of the self. By choosing to care courageously, to be truly present rather than analyzing and dissecting experience from a distance, we as nurses may create a safe place for hurting people to find support and healing as they seek to make sense of their experiences and create new ways of being. As I am discovering, living this theory carries the potential to not only
support the patient to create new possibilities and work towards their goals, but also to change the nurse through this process of bearing witness to another person’s unique and profound journey. Mr. H was my patient for only one day of my very first clinical rotation. Yet caring for him, as guided by Parse’s theory, opened up possibilities for greater awareness, new insights and transformation not just within him, but also in me, clarifying my values and adding new depth and vision to how I view and wish to practice nursing.

References


Appendix A

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 simultaneously 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.

PART 2* of 2: USING OREM’S SELF-CARE MODEL OF NURSING TO GUIDE THE PROVISION OF CARE FOR PERSONS WITH ALZHEIMER’S DISEASE by Lindsay L. Sykes,1 Meghan Sweeney,7 Karen Sangalang,1 Kevin Tan,1 Carole-Lynne Le Navenec, RN, , PhD,2 Faculty of Nursing, University of Calgary, Calgary, AB T2N 1N4 Canada

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As discussed in Part 1 of this article (see The Canadian Gerontological Nurse, Vol 27, issue 2, June-July 2010), the purpose of this paper was to provide a review of the current research on formulated nursing diagnoses, planning and goal setting for patients and their families, and interventions; physiologically and behaviorally that can be considered for helping persons with Alzheimer’s disease. An evaluation section is also presented for this hypothetical case study. The authors discuss how they applied the nursing care process to Dorothea Orem’s Self-care Deficit Nursing Theory (SCDNT) conceptual framework during their involvement with hypothetical client whose pseudonym is Mrs. Ally Le Puil (hereafter referred to as Ally because that was how she asked us to address her). Part 2 begins with the Nursing Diagnosis phase.

Nursing Diagnoses

This step of the nursing process involves the judgements that the nurse makes in conjunction with the client (patient or family member) about the assessment data. As Carpenito-Moyer (2007) has noted, “this judgement can be a problem, risk for a problem, or a strength” (p. 5). Although Ally has several self-care deficits, she has several strengths. For example, although Ally was disorientated as to time and place, she was able to distinguish who her husband and family were, which indicates that her recognition memory was intact. Furthermore, although she initially refused to participate in her personal activities of daily living, (P-ADLs), she eventually reasserted, with some support and encouragement from her family, all of her morning and evening bathing and selecting clothing to wear. This aspect might be related to the finding that most people will do things asked of them if such requests come from persons they trust. It was also noted that Ally was still able to recognize symbols associated with her religious faith as indicated by the cross she wore on a necklace, and by the rosary in her pocket, both of which her family said were comforting aids for Ally. In summary, these are some examples of her major strengths, which we believe are indicators of her feelings of well-being. With the help from her husband and sons, (who visit daily), Ally’s ability to be a self-care agent in several areas of daily life have been maintained, despite her illness condition.

Having discussed several of Ally’s strengths, there are several actual and potential health problems. One nursing diagnosis was “Forgetfulness and Disorientation” (Kozier et al., 2010, p 1066), as indicated by her inability to remember her last name, her room number, and her birth date, or the name of the town where she was currently living. Her husband mentioned how Ally thought that it was a weekday so she went outside to get the mail, only to be told by her live-in homemaker that it was a Sunday.
Another diagnosis nurses indicated was “impaired decision making” (Kozier 2008, pp. 1066-1067), which referred to her difficulty with making reasonable decisions, particularly in regard to personal activities of daily living (dressing, washing self, and related activities). For example, on one occasion, she left the house without putting any clothes on. A further nursing diagnosis was “impaired memory” (Kozier et al., 2008, pp. 1066-1067) particularly in regard to people or things that Ally had just encountered. These problems related to her short-term memory were in sharp contrast to her previous abilities, such as during her work life as a secretary, when she was described as being extremely gifted with skills such as organization, keenness and punctuality. An additional nursing diagnosis was “risk for social isolation,” (Kozier et al., 2008, pp. 1066-1067) because Ally was sometimes aggressive toward others due to unfamiliarity and restlessness when her family was not present (Denyes, Orem, & Bekel, 2001; Geden, Sang-arun, & Taylor, 2001). A final nursing diagnosis was “Risk of being underweight” (Kozier et al., 2010, p 1551). This aspect was evident in the substantial loss of weight that Ally experienced following her second stroke. She does not much of an appetite, especially when family is not around. This behaviour may result in inadequate nutrition of the patient.

Planning and Goal Setting

The planning and goal setting aspect in relation to SCDNT involved designing a nursing system that would enable the patient to meet self-care requisites. Orem’s theory is composed of three systems – wholly compensatory, partly compensatory and support-educative of which the latter two systems are most appropriate for Ally. The partly compensatory nursing system (Wesley, 1995) is used when a patient is able to meet some of her care needs but needs the nurse with other self-care requisites (1995). One goal for the client under this system is to maximize the level of function; thus the healthcare team encouraged Ally to participate in healthcare decisions. Another goal was to prevent further deterioration; therefore the nurses needed to supervise the patient’s activities. The supportive-educative nursing system is used when a patient needs assistance with decision making, behaviour control and knowledge acquisition skills (1995). A major goal for this system is to build rapport with the patient and family, earning trust is needed in order to avoid Ally’s combative nature. Providing a safe and calm environment can also play a part in controlling the patient’s behaviour. Another plan includes involving the family with the patient care.

Interventions

For those of us who adhere to Orem’s Self-Care Theory, we, as nurses, focus on promoting self-care for Ally through education. Our goal is to encourage Ally to perform personal activities of daily living (P-ADL) independently in order to promote and maintain her personal well-being. Due to Ally’s primary diagnoses of Alzheimer’s disease and atrial fibrillation, we would implement several interventions for Ally. We believe that the most critical types of interventions that would be beneficial for Ally are physiological and behavioral interventions.

Physiological

Physiological interventions may include Exercise Therapy (Bulechek, Butcher, & Dochtermen, 2008, p 331); ensuring that the patient changes positions frequently if on bed-rest, and encouraging the patient to be up and walking around in the unit as much as possible. Applying these interventions to Ally, would ensure blood circulation and decrease her risk of blood clots. Self-Care Assistance (p 632); would also be an important intervention for the nurse to utilize in caring for Ally with assistance in dressing and bathing as well as other ADL’s. This intervention consists of monitoring the patient’s ability for independent self-care and educating her if possible, with constant reminders on the importance of self-care. In addition, the nurses would use Weight Gain Assistance (p 796-797); as another intervention by facilitating the weight gain and closely monitoring a day-by-day trend of the weight. Most commonly, patients who stay in the hospital lose weight (McWhirter & Pennington, 1994), therefore as nurse’s we want to ensure that Ally is gaining weight. Anxiety Reduction (p 138) is also a critical intervention; promoting deep breathing exercises to calm the patient and introducing possible types of therapy such as music. Lastly, memory training is a further intervention that we would employ through continuous
sessions of Memory Training (p 496) to stimulate the brain and monitoring the patient’s progress to ensure no substantial loss of memory.

Behavioural

Behavioural interventions may include being present both physically and psychologically for Ally during her times of need. Having company may reduce anxiety and stress felt by the patient, as well as calm her in the hospital setting. Active Listening (p 115) is also a possible behavioural intervention; being attentive and attaching significance to a patient’s verbal and nonverbal signals during communication. Such interventions are important in Ally’s case due to her Alzheimer’s disease. As her condition progresses, she may have more episodes where she may find herself to be confused. Thus being present and practising active listening is important in order to observe any sudden changes in behaviour.

Possible barriers that may occur due to Ally’s condition are definitely ones of non-compliance. Since Ally is easily agitated, giving her ideations to ambulate independently, educating her on caring for herself or training her memory may easily frustrate her in a combative nature. The best way to deal with such behaviour is patience. Not every patient will be cooperative, so as nurses, we need to be ready for the unexpected. Determination is also something to keep in mind if the aforementioned situation arises. Even though Ally may try to push the nurses away, they need to understand that it may be because of her Alzheimer’s disease and not because of something they did wrong so they should not give up or take it personal. Lastly, we think it is important during difficult situations to remind ourselves why we are doing what we do as nurses. We are there to provide care for individuals in times of need, to improve their potential at a better quality of life.

Due to the nature of the disease and its progression we believe that the only viable option for discharge is placing Ally into a long-term care facility. In terms of discharge planning, we suggest types of therapy such as art therapy or music therapy to reduce her anxiety. Also, we would suggest having family and/or social support for Ally. It is important to keep Ally stimulated, and being socially active, amongst friends and family would help in doing so.

Evaluation

Since we have not seen Ally since her admission, we developed several questions or and statements that we have passed on to the current treatment team in order to evaluate Ally’s condition and her readiness for discharge from hospital. This evaluation would include the nurse and Ally working together to identify some concrete physical and/or psycho-social indicators of well-being. Illustrative examples of such questions regarding aspects of Ally’s ADLs performance included: Has Ally been up and about on the unit?, Does she use an ambulatory aid?, Does she need assistance, and/or does she walk independently?. Other questions may included: how her memory training has been progressing and/or does having family around make Ally more or less anxious. Examples of statements we would look for in terms of evaluating Ally’s progress are: patient states she is finding it easier to memorize certain things, patient voices she finds it easier to sleep at night due to decreased anxiety, or day nurse reports that the disseminated information regarding the importance of self-care has been understood by the patient. If in this case, Ally persists to be characterized as having self-care deficits, this will correlate with the fact that nursing care process is no longer a model of circular continuance but one of circular discontinuance. In addition, precautions, cures and interventions will be improbable to ascertain for individuals with Alzheimer’s disease. Thus, this discontinuance leads us to reconsider our steps included in the nursing process.

Conclusion

In conclusion, our group felt comfortable with Orem’s Self-Care model because we found it very useful in assessing, diagnosing, implementing and planning care for our hypothetical patient (Ally), as well providing nursing care that we have experienced in our nursing practice: “The study of theory develops analytical skills and critical thinking ability…. The challenge today is to translate the knowledge base nurtured and grown in the world of scholarship into practice in the worlds of nurses’ direct experiences” (Tomey & Alligood, 2006). As student nurses, we have incorporated Orem’s Self-Care
model in our nursing practice, finding it functional and effective while being cognizant of the central philosophy which Orem’s model holds - “every patient wants to care for him or herself” (Bruce, Gagnon, Gendron, Puteris, & Tamblyn, n.d.). We believe that in order to help a patient manage their illness and maintain their health, the patient must play an active role in their health management for the nurse’s care process (interventions, diagnoses, and planning) to be successful. However, the extent of the patient’s active involvement and the nature of the nurse’s care process must also concurrently consider Orem’s Self-Care deficit theory in order to be effective. This balanced perspective will become more critical as the population ages and as the number of cases of Alzheimer’s disease inevitably increases.

As practitioners, we should also be mindful of the fact that the SCDNT is very important to provide us proper guidance in our practice. However, because the theory has the term ‘deficit’ in it, this has a negative connotation and shouldn’t be mentioned around the patient and/or their family as this may result in negative implications. Perhaps if Orem had used a term such as learning, in place of deficit, the model would not have such an off-putting nuance attached to it.

References and definitions of terms will be available upon request.
Appendix B (Orem’s Conceptual Model of Nursing: ECOMAP - The CALHOUN Family.

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<tr>
<th>HEALTH CARE</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live-in Nursing Aid 5 times weekly</td>
<td>Respite worker every weekend</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXTENDED FAMILY</th>
<th>23</th>
</tr>
</thead>
<tbody>
<tr>
<td>All extended family have passed away</td>
<td>Noah and the two sons including their families are Ally’s only residing family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noah is still able to drive</td>
<td>The respite/NA drive as well and are able to use the family car.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WORK</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ally is a retired secretary.</td>
<td>Noah is a retired entrepreneur of an his oil &amp; gas company</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NURSING AID</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family is very satisfied with the care she/he (respectively) provides and Ally enjoys their company</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESpite WORKER</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ally spends 2 hours per night knitting in her den, while listening to classical music</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOUSING</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large (2850 sq. ft.) bungalow</td>
<td>Master bedroom and en suite on main floor, walk out basement, 2 bedrooms in basement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FOLK MEDICINE</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noah and Ally have no belief in complementary and alternative medicine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEGAL RESOURCES</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noah is Ally’s legal guardian.</td>
<td>He is in charge of all financial and trustee information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOCIAL WELFARE</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah works as an Alzheimer community support worker, offering help to her family. She has been employed there since her Grandmother was diagnosed.</td>
<td>She also canvases for this cause.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLEANING GARDENING</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning comes in every 2 weeks</td>
<td>Paid for by family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FAMILY / HOUSEHOLD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Noah</td>
<td>Ally</td>
</tr>
<tr>
<td>Mary</td>
<td>Eli</td>
</tr>
<tr>
<td>Sar</td>
<td>Ki</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDEX PERSON</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The original ecomaps forms were developed by Hartman, 1978.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Orem’s Conceptual Framework for Nursing.

OREM’S CONCEPTUAL FRAMEWORK FOR NURSING

This illustration relates the major components of Orem’s Self-Care Deficit Theory. “R” shows a relationship between components; “<” shows a current or potential deficit where nursing would be required.

PATIENT

Self-care

R

Self-care capabilities (self-care agency)

R

R

Therapeutic self-care demand

NURSE

Nursing capabilities (nursing agency)

R

<

R

R

INSTITUTE OF AGING

CURRENT FUNDING OPPORTUNITIES Meetings, Planning and Dissemination Grant: Aging
This funding opportunity is intended to provide support for meetings, planning and/or dissemination activities that are consistent with the mandate of IA and stimulate research and knowledge translation and exchange beyond traditional recurring meetings or conferences.

Application deadline: October 15, 2010
For all CIHR funding opportunities, visit the CIHR Funding Database

PARTNERSHIPS: Alberta Centre on Aging hosts Institute of Aging (IA)_Summer Program in Aging (SPA) 2010

Presented each year by a regional partner, IA’s Summer Program in Aging (SPA) is a highly-regarded capacity-building initiative that continues to be enhanced by refinements and innovations introduced by our successive hosts. The Institute is indebted to the SPA 2010 program co-chairs Dr. Laurel Strain and Dr. Carole Estabrooks of the Alberta Centre on Aging at the University of Alberta for the exceptional four day program offered in June at Jasper Park Lodge. The fact that the participating trainees willingly ignored the striking surroundings of Jasper National Park in favour of attending sessions, is testament to the compelling program assembled by the Alberta Centre on Aging. We also thank most sincerely this summer’s talented mentors, who made a significant commitment to a program that demands almost a week of their time, and includes presentations, group discussions, one-on-one mentoring, and participating in the social aspects of the program. Their willingness to share with candor, their vast knowledge and insights on succeeding as an academic, was greatly appreciated by all involved. The 2010 mentors were:

- **Dr. Anne-Marie Bostrom**, University of Alberta
- **Dr. Alex Clark**, University of Alberta
- **Dr. Sultan Darvesh**, Dalhousie University
- **Dr. Guylaine Ferland**, University of Montreal
- **Dr. Anne Martin-Matthews**, University of British Columbia
- **Dr. Colleen Maxwell**, University of Calgary
- **Dr. Dot Pringle**, University of Toronto
- **Dr. Jane Rylett**, University of Western Ontario
- **Dr. Susan Slaughter**, University of Alberta
- **Dr. Adrian Wagg**, University of Alberta
- **Dr. Cheryl Wellington**, University of British Columbia

The other partners in the SPA are of course the trainees themselves. Selected from a record number of 124 applicants, this summer’s 45 participants took full advantage of the program to strengthen their skills and build their network of colleagues, towards accomplished careers in aging.

CONFERENCE REPORT: Overview of The International Society for Gerontechnology (ISG) 7th World Conference, Vancouver, May 27-30, 2010

The Vancouver venue of the 7th World Conference of the International Society for Gerontechnology, offered an unprecedented opportunity for the Institute to host a special symposium aimed at showcasing the ground-breaking work being done by international research teams funded under the Institute’s innovative Canada-UK New Dynamics of Aging research program. This event provided an opportunity for team members to meet face-to-face, many for the first time, with their research collaborators, as well as with members of the larger network. The IA-led symposium, “Canada-UK Collaborations in
Gerontechnology, chaired by IAB member Dr. Peter Lansley of KT-EQUAL (UK), covered such issues as assistive technologies for incontinence, nutrition assessment and prompting, and internet use to promote autonomy among older adults.

With the aim of advancing the international network of emerging scholars in gerontechnology, IA also invited a trainee-affiliate of each of the Canada-UK investigators to attend the conference and participate in the ISG Master Class on Technologies for Active Aging.

RESEARCH NEWS:

♦ THE CANADIAN LONGITUDINAL STUDY ON AGING AND CIHR: A GENERATIONAL PARTNERSHIP

At $23.5 million, it’s one of the largest single investments of this size that CIHR has made to date. And with 50,000 participants, it’s one of the largest studies of its kind undertaken in Canada. So it’s not surprising that CIHR’s involvement with the Canadian Longitudinal Study on Aging (CLSA) extends far beyond the role of funder.

“CIHR is working on the best way to demonstrate the progress and value of the CLSA,” says Dr. Linda Mealing, who, after many years with the CIHR Institute of Aging is now the Associate Director of the CLSA. “Being unique, the CLSA had required CIHR to develop new processes, committees and even policies.”

Over the past year, Dr. Mealing has been working to set up mechanisms to allow CIHR to oversee the study and – equally important – to guide efforts to protect the rights and interests of study participants.

Among these mechanisms is the establishment of two key committees, the CIHR Advisory Committee on Ethical, Legal and Social Issues for the CLSA, and the CIHR International Oversight Committee on the CLSA.

The ethics committee alone has met eight times since its creation in September 2009, considering issues such as privacy, consent and meeting the different legal requirements of jurisdictions across Canada.

The main task of the International Oversight Committee is to advise the CLSA as it progresses through its crucial implementation phase. This committee plays an important evaluation role with respect to the return on CIHR’s investment.

“We want to ensure that the CLSA remains an efficient operation, a good investment by the Canadian people that results in optimal quality of life for older citizens, both now and in the future,” says Dr. Mealing.

Another major component of CIHR’s involvement with the CLSA is to help raise awareness of the study amongst the larger research community, as well as those in government (federal, provincial and municipal), the non-profit sector and the private sector who will be able to use its data to support their own work.

“We want to ensure that everyone understands the great utility of the CLSA,” says Dr. Mealing. “We’re putting our tentacles out right now because you never know when opportunities will come up. Timing is everything!”
For more information about the CLSA and the people leading it, visit the CLSA website.

INTERNATIONAL COLLABORATIVE RESEARCH STRATEGY FOR ALZHEIMER’S DISEASE (ICRSA.D)

ICRSA.D is seeking input from stakeholders on the draft Alzheimer’s Research Strategy to take a leadership role in improving treatment and increasing prevention of Alzheimer’s Disease and related dementias internationally. Please take the time to review the proposed strategy Turning the Tide - A Canadian Strategy for International Leadership in the Prevention and Early Treatment of Alzheimer’s Disease and Related Dementias, and participate in the survey.

SOLE SENSOR™

IA was delighted to hear recently from Dr. Stephen Perry that the Sole Sensor™ device is now being manufactured and distributed by Hart Mobility. This insole, developed from research funded by CIHR-IA, improves balance and helps avoid the most common cause of injury among seniors – falls. It was co-invented by Dr. Perry, an associate professor of kinesiology at Wilfrid Laurier University, Dr. Brian Maki of Toronto’s Sunnybrook Health Sciences Centre, Dr. William McIlroy of the University of Waterloo and Dr. Geoff Fernie of the Toronto Rehabilitation Institute, and was featured in the March 2007 issue of Grey Matters.

LIPSTICK IS FOREVER

“I’d only give it up when I’m desperately ill in the hospital. And even then I’d like my lipstick to be nearby.”

A new study has found older women wear lipstick to boost their self-confidence and signal to others they are still in charge. Read the complete article by Dr. Laura Hurd-Clark and Andrea Bundon of the University of British Columbia, in the Journal on Women and Aging, Vol. 21(3): 198-212.

EXCERPTS from CENTRE ON AGING NEWSLETTER, University of Manitoba, Vol. 28, No. 2, Summer 2010 ISSN 0826-4694

EDUCATIONAL RESOURCES: WHAT EVERY OLDER CANADIAN SHOULD KNOW

The Federal/Provincial/Territorial Ministers Responsible for Seniors Forum is an intergovernmental body established to share information, discuss new and emerging issues related to seniors, and work collaboratively on key projects. They have produced a series of eight pamphlets outlining “what every older Canadian should know”. The pamphlets focus on the following topics.

- Financial Planning
- Income and Benefits from Government Programs
- Managing and Protecting Their Assets
- Planning for Possible Loss of Independence
- Planning for Their Future Housing Needs
- Having a Will and Making Funeral Plans
- Financial Abuse
- Frauds and Scams

Documents are available on demand in alternative formats including Large Print, Braille, Audio Cassette, e-Text, CD at 1-800-622-6232. In Manitoba, contact the Manitoba Seniors & Healthy Aging Secretariat at 945-2127.
DEMENTIA CARE EDUCATION INITIATIVE P.I.E.C.E.S.TM IN MANITOBA 2008-2009

P.I.E.C.E.S.TM The first three letters, (P), (I), (E), represent the individual’s physical, intellectual and emotional health. The letter (C) is the centre piece or focus in care. Lastly, the (E) and the (S) represents the environment in which the individual interacts as well as a person’s social self.

Manitoba Health announced financial support for the implementation of a comprehensive Dementia Care Education Program in November, 2007. Developed in Ontario, the P.I.E.C.E.S.TM curriculum was adopted by the Alzheimer Strategy Education Working Group. The overall goal of the Education Program is to enhance the care of individuals with dementia in Manitoba Personal Care Homes (PCH) and, ultimately, residents' quality of life. Training is provided to senior leaders in PCHs (e.g., PCH managers, Directors of Care) and frontline staff (e.g. nurses, social workers, etc.).

The Centre on Aging, University of Manitoba conducted an external evaluation of the first year of the P.I.E.C.E.S.TM implementation in Manitoba, at the request of the Alzheimer Strategy Committee. The evaluation results will be used to assist the Alzheimer Strategy Overview Committee in making recommendations surrounding the future of the Provincial dementia education initiative.

Suggestions for improved implementation of the P.I.E.C.E.S.TM Education Program included buy-in/support from management for the use of the P.I.E.C.E.S.TM framework in the facility; clearer direction to PCHs on how to roll-out P.I.E.C.E.S.TM; a more focused approach to training (e.g., train a number of individuals from a unit/facility at one time to provide support for one another after training); and, the inclusion of non-professional staff, especially Health Care Aides, in the P.I.E.C.E.S.TM training initiative.

For information, contact the Dementia Care Education Coordinator, Alzheimer Society Manitoba, Tel: 943-6622. E-mail: pieces@alzheimer.mb.ca

EXCERPTS FROM INTERNATIONAL FEDERATION ON AGING (IFA) eNews: Consider subscribing to the IFA newsletter by sending your email address to http://www.ifafiv.org/index.php?option=com_content&view=category&layout=blog&id=91&Itemid=192

OLDER PERSONS’ EXPERIENCES OF ENVIRONMENTAL CHANGE IN RESIDENTIAL CARE by Hanna Falk

Older persons’ experiences of environmental change in residential care are not from the viewpoint of an elderly person in a residential care setting. Hanna Falk, a nurse and ex-doctoral student (who defended her thesis in March 2010) discovered that the 'home-like' ideas of architects and designers have little positive impact on the elderly in residential homes. Her doctoral thesis at the University of Gothenberg, Sweden, revealed that renovations designed to make institutional settings more supportive and homely did not have much influence on the way elderly residents felt about their surroundings. Adaptation to living changes is ultimately most successful when the elderly can experience their own perceptions of home, not the perceptions of others, no matter how well-meaning they may be.

"A sense of belonging where you live is important for your sense of self and identity, which in turn strengthens a person's ability to deal with the changes that impaired function and institutionalization can bring,” says Falk.

The thesis examines how the elderly define the concept of “a sense of home”, and finds that it covers far more than just a pleasant physical environment. "There are other factors that come into play, for example that the elderly furnish their rooms exactly as they did when they lived at home, or that they make new friends who contribute to a greater sense of home," says Falk, stating that actual attachment to the institution is vital if it is to be viewed as home.

She also found that relocation and renovations designed to help create a more home-like and supportive environment in residential care can negatively affect the quality of life and wellbeing of the elderly. "The vulnerability of the elderly in connection with changes to their environment must be given greater consideration in the context of extensive renovations than is currently the case in the care of the elderly,"
says Falk. "There's still plenty of work to be done, for example the development of action plans to handle relocations and renovations so that the elderly and the staff are in the best possible position to cope with the situation."

EXCERPTS FROM GLOBAL AGING

♦ GLOBAL AGEING: DISASTER PREPAREDNESS AND RESPONSE

Recent world events, particularly the devastating earthquake in Haiti, have shaped the title and contents of the latest edition of Global Ageing: Volume 6 Number 1.

Articles include:

- Emergency Support Provided by JDC-ESHEL During the Second Lebanon War
- Impact on Older Persons of Pakistan's 2005 Earthquake
- Cuba's Disaster Planning Involves Elders, Saves Lives, Reduces Losses
- Enhancing Global Policy on Emergency Preparedness and Response: Canada's Role in Addressing the Needs and Contributions of Older People
- The SWiFT System: A Post-Disaster Approach to Vulnerable Elderly Disaster Victims
- Urban Aging, Social Isolation, and Emergency Preparedness

IFA members may download a free PDF version of this latest volume of Global Ageing.

♦ THE HUMAN RIGHTS OF THE ELDERLY: OVERVIEW OF AN EMERGING CHALLENGE

A recent publication by Fredric Megret, McGill University, attempts to provide an overview of the rights and challenges that face older people worldwide.

From the abstract: "...attention to the human rights of the elderly is a relatively recent phenomenon borne from a perception that older persons raise specific challenges in terms of human rights, that are not appropriately addressed by the prevailing medical or welfare paradigms. Some of the salient features of the elderly as a category of humanity are highlighted including the difficulty of defining "old age", the paradox that the old may be both powerful and vulnerable, and the dilemmas raised by inter-generational justice. Beyond existing domestic and international instruments, a concrete look is given at how human rights issues play out in subtly different and sometimes novel way for the elderly. Apart from examining discreet rights or clusters of rights, the paper suggests a number of emerging cross-cutting problems. For example, "ageist" discrimination is increasingly becoming a concern in societies that idealize youth. The difficulties encountered by some older persons also take some focus away from the state, to the family, care institutions and even the global legal order."

Part of the Working Paper Series of the Social Sciences Research Network. For further information, contact the author Frederic Megret, McGill University - Faculty of Law, Montreal, Quebec, Canada.

♦ TRADITIONAL WOMEN'S ROLE: ELDER CARE IN PRACTICE. CAN IT TRANSLATE TO ELDER CARE IN POLICY?

For more information, contact the authors: Charles Lockhart, Joanne Connor Green, Jean Giles-Sims

Studies continue to show that women worldwide accept the lion's share of support for older family members. Are supportive women hopelessly enmeshed in the tyranny of a traditional family social framework, or does their caring reflect a deeper wellspring of respect and concern for older people?
In April 2010, a paper presented to the Western Political Science Association examines the role of women in a radically different social framework: American State Legislatures. Does the increasing presence of women in state legislatures improve state elderly friendliness?

From the abstract: "A number of studies have found that the presence of women is associated with broadly kinder, gentler legislative initiatives toward various aspects of social and educational policies. As the baby-boom generation has begun to enter retirement, states face growing demands for social orientations and public policies responsive to the varying needs of older citizens in different circumstances. We draw on a cross-section of the American states around the year 2000 in conjunction with regression to see whether states with more extensive legislative representation of women meet the growing challenges of an aging population more effectively. We find that, controlling for the most prominent alternative factors generally shaping state orientations and policies, the duration of a significant presence (i.e., greater than 20 percent) of women legislators has by far the most powerful positive influence on the three relevant dimensions of state elderly friendliness that we include in this study.

PLAN TO BE A YOUNGER OLDSTER: BE A YOUNGER YOUNGSTER!

It's not just a cheerful saying: in some ways you really may well be "as young as you feel." But research suggests it may help to start practicing those young feelings when you're younger!

"How old you are matters, but beyond that it's your interpretation that has far-reaching implications for the process of aging," said Markus H. Schafer, a doctoral student in sociology and gerontology who led a study at Purdue University. "So, if you feel old beyond your own chronological years you are probably going to experience a lot of the downsides that we associate with aging. "But if you are older and maintain a sense of being younger, then that gives you an edge in maintaining a lot of the abilities you prize."

Schafer and co-author Tetyana P. Shippee, a Purdue graduate who is a research associate at Purdue's Center on Aging and the Life Course, compared people's chronological age and their subjective age to determine which one has a greater influence on cognitive abilities during older adulthood. Nearly 500 people ages 55-74 were surveyed about aging in 1995 and 2005 as part of the National Survey of Midlife Development in the United States.

In 1995, when people were asked what age do you feel most of the time, the majority identified with being 12 years younger than they actually were. "We found that these people who felt young for their age were more likely to have greater confidence about their cognitive abilities a decade later," Schafer said. "Yes, chronological age was important, but the subjective age had a stronger effect."
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<td>Website Advertisement</td>
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Following the Editor’s approval, you will be sent an invoice, which is payable upon receipt, with a cheque made out to CGNA

This publication usually goes out in the middle of the month of: April, June, September and December. Submissions are due to the Editor by the 1st of those months.

All postings to the listserve, 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”

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Page 34 The Canadian Gerontological Nurse, 27(2) [2010] www.cgna.net