Happy New Year to you and yours, from your CGNA Executive. The New Year is a time to reflect on what has been accomplished in the past year. Our new CGNA Vision Statement is one of those accomplishments. “The vision of the CGNA is to promote excellence in gerontological nursing through leadership, knowledge and scholarship.”

Another very significant accomplishment, I would like to elaborate on is to tell you about an historical meeting that recently took place in Ontario, that will help us achieve our vision. In November of 2010, I was able to attend the Conference and Annual General Meeting for the Gerontological Nursing Association of Ontario, with Denise Levesque. This event was held in Hamilton, Ontario and was a very special meeting because; the outcome of the meeting was the last step in a lengthy process to facilitate the Ontario gerontological nurses, now becoming conjoint members of the CGNA. I had goose bumps as this final hurdle was voted unanimously by those GNAO members. It was a privilege to be able to attend this AGM and conference. The magnitude of the impact upon the CGNA as an organization is enormous. One of our strategic goals is to increase membership. In 2011 our membership will now more than triple in number. Perspectives, is a well established peer reviewed Gerontological Nursing Journal, and as part of the negotiations with the Gerontological Nursing Association of Ontario, the Canadian Gerontological Nursing Association will be assuming the responsibilities for this journal. In our previous newsletter, I described to you our strategic plan developed in Halifax in June of 2010. The third goal of this plan is the Dissemination of Knowledge and Expertise and Perspectives will be a vehicle which will help us as we work toward achieving this goal. Communication with members is an important aspect of meeting this goal and as our organization is growing and becoming more complex, this goal becomes even more challenging. To help ensure that we communicate as effectively as possible, we will be forming a CGNA
Editorial Board to oversee a variety of communication strategies, and to decide what methods to use in which circumstance. Some examples that we currently utilize to communicate with our members are the CGNA Newsletter, website, newsflashes, the list serve and now we will be adding the journal to this list of communication tools. We will be asking for suggestions of members for this new Editorial Board to be appointed by the CGNA Executive and we will be looking for national representation, from a variety of nursing backgrounds, such as direct care, education, management and research. The financial implication of the large in-flux of new members was also part of the negotiation process. We are a volunteer non-profit organization and because of the change in membership numbers, all CGNA members across the country will benefit financially. In the 2012 membership year, the CGNA portion of your membership dues will decrease. You will hear more about these details at a later date. I am very happy to be able to share this exciting news. There are many people who have worked hard behind the scenes over a number of years to make this announcement possible. I would like to take this opportunity to thank Susan Ward-Moser, Mary Bawden, Gwen Harris, Diane Buchanan, Bonnie Hall, Denise Levesque and Belinda Parke. These negotiations have not always been easy, but it has always been a pleasure to work with such dedicated and accountable gerontological nurses. An additional special thanks to Denise, who has also agreed to develop and document a transition plan to ensure all necessary details are addressed and completed. With our increased membership we will have an even stronger voice for advocating for Gerontological Nursing in Canada and for the elderly in our care. The future is very bright for Gerontological nurses and nursing in Canada. This has been a very exciting time in history to be the President of the CGNA. I would like to take this opportunity to remind everyone that the deadline date for abstract submission to the 16th National Gerontological Nursing Conference to be held in Mississauga, Ontario June 8-11, 2011 has been extended to January 31, 2011 so it is not too late! I look forward to meeting you sometime during conference.

Respectfully Submitted,

Beverley Laurila, RN, BN, MSA, GNC(C)
Since the last issue of *The Canadian Gerontological Nurse*, many of the CGNA members will have participated in the Canadian Association on Gerontology Conference held in Montreal from December 2 to 4\(^{\text{th}}\). The theme of that conference was *Spotlight on Integration of Knowledge and Practice*. This event *afforded* a time for both students and gerontological practitioners from a variety of disciplines to discuss how they are addressing topics pertaining to the promotion of health and healing with this population.

In addition, site visits, such as the one arranged to the Cummings Centre (www.cummingscentre.org) demonstrated clearly the sense of community among the older adults who are members of this Centre. Based on our observations of the happy people we met there, we learned about their access to a range of “courses and activities... [that] EDUCATE, STIMULATE and CHALLENGE” (Taken from their brochure called *The Guide*, Fall 2010). Despite many of them having long-term illness conditions, there was evidence of how they went about doing what nurse researcher Carole Robinson termed “creating health” despite chronic illness.

You will all have the opportunity to learn more about the research and programs that are occurring across Canada at the **Canadian Gerontological Nurses Association (CGNA) national conference, Wednesday June 8 to Saturday June 11, 2010** in that area adjoining the southern part of Toronto, called **Mississauga, Ontario**. For info see CGNA website: www.cgna.net

I would like to remind all the members to send me their stories about programs or caring approaches in your community that you believe are helping older adults maximize their quality of life or feelings of well-being despite having a particular disease (http://www.sciencedaily.com/releases/2010/12/101213140950.htm), and despite various regional disparities (http://www.sciencedaily.com/releases/2008/11/081117082429.htm) [see Research Section of this Newsletter]

Best wishes for good health, happiness, and prosperity for the New Year. And for our francophone membres : *Que le temps des Fêtes soit joyeux et lumineux!*

Please send your submission for the April 2011 issue of *The Canadian Gerontological Nurse* to me by the **FIRST DAY OF APRIL**. Send it to me at my email address below

Carole-Lynne Le Navenec, Editor. The Canadian Gerontological Nurse. Email: cllenave@ucalgary.ca
Alberta Gerontological Nurses Association

We are excited about making plans to host our 30th annual conference in Red Deer in April 2011. The conference will focus on the past, present and future of Gerontological nurses. Check our website www.agna.ca in January 2011 for further information and registration. AGNA continues to stimulate interest, research and advocacy for Albertan seniors and to advance and support Gerontological nursing education. There are emerging trends in Alberta focusing on senior –centered care include ‘aging in place’ delivery models that adopt and integrate technology, complementary and alternative therapies for managing chronic illnesses and reviewing the seniors’ perspective and interactions within the healthcare system. We must be forward thinking yet diligently advocating for sustainability, appropriateness and accessibility of technology enabled healthcare transformation. Please continue to take the opportunity to comment or share your experiences or events with AGNA members through our newsletter or website www. agna.ca

All the best throughout the Holiday Season
Lisa LeBlanc RN MN
AGNA President

Newfoundland and Labrador Gerontological Nurses’ Association

NLGNA is actively recruiting members at a local level. A spring Education Day is being planned as part of ongoing support for gerontological nurses. Details to follow! Enjoy a healthy and Happy New Year!

NLGNA Executive Paula Walters
Clinical Nurse Specialist
(709) 570-2321 (office)
What is a Webinar?
A webinar or web conference, allows a presenter(s) to share what’s on their computer desktop with people in other locations—in real time, over the web. Participants will be able to view the slides on their computer through a web program and listen to the presentation through an audio conference line. Presenters are selected based on their expertise in the field of gerontological nursing. Participants will be able to ask questions on line or by telephone.

As a result of a call for CGNA members interested in volunteering for the CGNA Webinar Committee, I am pleased to introduce the committee members, Bonnie Hall Chairperson, Karen Horsley, Alberta; Helle Tees, Manitoba; Dr. Sharon Moore, Alberta; Joy Parson-Nicota, Ontario; Ria Spee, Ontario; Patricia Roy, British Columbia; Bonnie Laundhardt, Alberta; Michelle Copleland, British Columbia; Christine Johnson, Manitoba; Sandra Stec, Ontario. Support from Malachite Management, is CGNA Coordinator, Melanie McLeod.

In an ongoing effort to be cognizant of and responsive to the feedback and needs of the Canadian Gerontological Nursing Association (CGNA) membership, the Executive Committee and Board of Directors are happy to announce that a series of educational webinars will be launched in the fall 2010. The first series will focus on the CNA Certification Examination for Gerontological nursing. CGNA members and non-members will have the opportunity to engage in current learning opportunities at a reasonable cost and in the convenience of their own office or home.

The Webinar Committee members will assist in the development, promotion and evaluation of the CGNA webinar series. Our goal is to have the first webinar available in February. It will be the first in a series to help nurses who are preparing to write the certification exam.

Other webinar series to support gerontological nursing, like an on-going education series will be developed over time. Please feel free to communicate your ideas. Contact Bonnie Hall bhall19@cogeco.ca or Melanie McLeod, melanie.mcleod@malachite-mgmt.com

The CGNA website will be the source for information about this exciting project. We will also use the News Flash to alert you

Bonnie Hall, Chair
CGNA Webinar Committee
Dear colleagues,

Since our AGM, I have been assessing the changes in CGNA and trying to tie up loose ends. Your organization has gone through much development since our partnership with Malachite began. As treasurer, my role has changed and I have been seeking alternatives in order to find the best way to keep your executive and board best informed.

In October, at the NGNA convention (which I attended with CGNA president Bev Laurila), we discovered countless parallels between our organizations. We met with their management team as well as several executive members and began planning and acting on strategies on how to best serve both our groups. Closer connections and combining member resources was one of these ideas. For example, NGNA recognized me as a CGNA executive and registered me as a “member”. This action went further than just dollars and cents; it also served as a warm welcome to the convention. It is hard for me to describe how strongly I feel about this and I have lobbied both organizations to recognize each others memberships for the purposes of conference registration. Stay tuned for details.

In November, I attended the Gerontological Nursing Association of Ontario’s AGM in Hamilton with CGNA president Bev Laurila. Your executive felt it important that we be available to address questions or concerns regarding Ontario joining CGNA. I am pleased to report that the process is finally at its conclusion and that it was simpler than expected. Ontario will remain unique as their membership is linked with RNAO and on a November to October cycle; our Malachite team will be sorting out these final details.

Respectfully submitted,
Denise Levesque, CGNA Treasurer/Membership 2010

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**CALL FOR NOMINATIONS FOR THE EXECUTIVE OF CGNA**

The 2011 Nominating Committee of CGNA is seeking individuals who are committed to the Mission, Vision, and Role of CGNA.

**Positions to be elected at the AGM in June 2011 include:**

**SECRETARY**
Term: 2011 to 2013
Please click here for the role description

**TREASURER-ELECT**
Term: 2011 to 2014
Please click here for the role description
PRESIDENT-ELECT
Term: 2011 to 2015
Please click here for the role description

Nominations Process:

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

Nomination Form:

Please click here for the CGNA 2011 Executive Nomination Form

All nominations should be forwarded to the Nominating Committee Chair, Belinda Parke, CGNA Past President via email at belinda.parke@ualberta.ca by MONDAY, JANUARY 31, 2011.

CGNA SMALL RESEARCH GRANTS

CGNA is pleased to be offering small research grants for members of the Association. The purpose of the grant is to assist nurses to examine their Gerontological nursing practice. The funding may be used for:

(1) pilot studies which will lead to grant applications to larger funding agencies, or
(2) small studies focused on older adults and nursing for which other funding sources are limited etc.

All members of CGNA are eligible to apply (with the exception of CGNA Executive members and their families). Members without research preparation should include a nurse researcher as a member of the research team or as a consultant. Projects are expected to be conducted under the aegis of a health care agency or educational institution.
Application Procedure

1. The application form must be completed by all applicants. All details, including telephone numbers, postal codes, email addresses and so on, must be complete.
2. If the project is a pilot study the researchers should identify how the study will contribute to the development of a larger study/research program and identify the agency to which the application for the next phase will be targeted.
3. Applications must be received by April 1 of each year and the grants will be decided by May 1 of that same year.
4. The application must be typed letter quality in the appropriate spaces on the form. The project description must be typed on 8½ x 11 paper, 12 cpi or 10 point, 1.5 spacing. The project description may be ten (10) pages in length maximum, including references.
5. The project description should include all sections listed in the application form. The appendices should include consent forms, instruments, letters of support and ethical approval.
6. One letter of support is requested from the sponsoring agency or institution.
7. Ethical review process must be completed before the moneys will be distributed. The Certificate of Ethical Approval must be submitted to the CGNA Head Office prior to monies being released. If for some reason, ethics approval is not submitted in the year the award was granted, the grant will not be awarded.

Click here for more information about the application procedure, evaluation criteria, and the application form.

Submission deadline is April 1, 2011.

CALL FOR HONOURARY MEMBERS

This award is presented in recognition of a member's outstanding contribution to the field of gerontology and gerontological nursing profession or CGNA. It is conferred by the Canadian Gerontological Nursing Association. Recipient will maintain CGNA voting privileges.

Criteria

- The nominee must be a long-standing member of CGNA.
- The nominee must have made a significant contribution to gerontological nursing and/or CGNA by:

  • Creating or assisting in the organizing and implementing new or improved gerontological nursing care delivery or gerontological education programs.
  • Demonstrating clinical expertise resulting in an improvement in gerontological nursing care delivery and/or
  • Initiating or contributing to activities which have resulted in increased status and public recognition for gerontological nursing practice as a whole, through administrative ability; leadership and service
within the association; having earned the respect, admiration and support of other nurse leaders and/or
• The nominee must have made a scholarly contribution to gerontological nursing practice and growth in the areas of published material; research and teaching or public statements on questions relating to gerontological nursing.

Process

A letter documenting evidence of the above criteria must be sent to the President of CGNA by February 1, 2011.

The nominee put forth for Honorary Life Membership must be supported by ten (10) nurses who are active members of CGNA at the time of the nomination. Each of the ten (10) supporting members will write a letter documenting their view of evidence that would indicate the candidates contributions to the field of gerontology and how the contributions of the candidate has positively influenced gerontological nursing.

The recipient will be chosen by the CGNA Executive and will be notified by the President. There will be one honourary member chosen per year in the Conference year.

The recipient will have all subsequent CGNA portions of their membership fees waived. The Provincial portion of the membership fee is a Provincial decision. The recipient will maintain his/her CGNA voting privileges.

CGNA Responsibilities

CGNA will cover the following expenses for the chosen honourary member to receive their award:

Expenses covered will be: 2 nights maximum hotel stay, meals, economical travel. Expenses not covered: conference registration.

Please submit the applications via email to cgna@malachite-mgmt.com by February 1, 2011.
The Quest: Creating a Centre of Excellence in Gerontological Nursing
by Sandra P. Hirst RN, PhD, GNC(C)
Director, Brenda Strafford Centre for Excellence in Gerontological Nursing, Faculty of Nursing, University of Calgary.

Do you remember the story of Don Quixote, the Lord of LaMancha, and his quest? He was searching for an ideal. If you saw the movie or the play, there was a song in it called To Dream the Impossible Dream sung by the main character to describe his pursuit. The development of the Brenda Strafford Centre for Excellence in Gerontological Nursing (BSC) has been such a quest. When the Centre was established in the early fall of 2008 at the Faculty of Nursing, University of Calgary, through funding from the Brenda Strafford Foundation, it provided a wealth of opportunities to improve the care of older adults. For us at the Centre, the quest came in how to move forward to use these opportunities to achieve the goals of the BSC.

Quality care to older adults is at the heart of nursing practice and nursing education is fundamental to this assertion. The aging of the Canadian population poses one of the greatest challenges for professional nursing education programs and their graduates. In practice, registered nurses play a central role in providing essential care to older adults; yet, often they are under prepared to provide the specialized care that older adults may need.

One of the Centre’s goals is to support the recruitment and retention of new graduates into gerontological nursing. Today’s nursing programs need to prepare graduates with the knowledge and skills necessary to provide client-centred care that meets the unique needs of older adults. The decision was made that alternative educational models must be examined since history had taught us that past strategies to introduce students to the rewards of working with older adults have not been successful. The new integrated undergraduate curriculum instituted this year in the faculty provides such a model. Using the curriculum guidelines developed by the Hartford Foundation in the United States and the competencies generated by the National Initiative for Care of the Elderly (NICE) in Canada, students are introduced to the theory and practice of gerontological nursing. This exposure is currently integrated into content specific to population health in their first nursing semester course work and in the family courses of their following semester. Development work on the integration of gerontological content continues. Clinical practice experiences stand beside theory content so that learning is integrated. One of the most visible indicators of the Centre’s success is its Gerontological Clinician Scholar Program. While the intent is to encourage students to become involved in the care of older adults and the scholarship of gerontological nursing, its success has been far greater than initially expected. Within the current cohort of new undergraduate students, eight are enrolled in the program. Funding has been provided for a number of them to attend conferences if they have had an abstract accepted. Working with a faculty mentor in a non evaluative relationship has encouraged these students to engage in critical thinking, and to expand both their learning and that of their peers. An email list serve facilitates communication among the group of students and Centre faculty members. The Centre would like to add a train-the-trainer component to this program. Over the next year, we anticipate developing a two or
three day training program for these students. They already have the enthusiasm to care for older adults. If we can provide them with both an array of innovative resources to prepare them to work at the bedside and with some teaching skills at the same time, they can be our gerontological champions on hospital units and in community agencies where they and their colleagues are placed for clinical experiences.

Providing for the continued development of nursing staff is essential to competency, retention, and optimal client outcomes. Nurses, as the largest group of formal health care providers to older adults must be offered the opportunity to grow and develop in their professional roles to achieve quality care. Registered nurses are in a powerful position to improve and assure optimal outcomes of care at all levels. However, practicing nurses face a number of challenges. Higher acuity client levels require considerable time at the bedside to assure maximum outcomes. Nurses must receive continuing education and staff development to ensure that this challenge will be met. Providing on-site continuing education, academic education, and staff development are strategies employed by the Centre. One aspect of these strategies is to prepare nurses to write the national certification examination offered through CNA. Gerontological certification is not required for registered nurses working with older adults. Another strategy was our successful application, on behalf of the facilities of the Brenda Strafford Foundation, to be a PEACE site for CNA and RNAO. We are very pleased to be a participant in this educational program.

A well designed Centre is developed around engaging and enjoying tasks that encourage and facilitate critical thinking in gerontological education and practice. At the same time, the Centre needs to grow as an entity in itself. In other words, faculty and staff come and go, but we want the Centre to continue. This carries a huge arrange of tasks, limited only by the creativity of the Director and the staff of the Centre, and by available funds of course. Examples of such tasks include the development of publicity brochures, PowerPoint presentations, posters, oral presentations, and networking sessions. We are pleased to be one of the university sites for the Geriatric Interest Groups launched by the National Initiative for Care of the Elderly. Undergraduate and graduate students mix and mingle with professionals in the field; there are several outcomes to such interactions. However, perhaps the key one is providing students with insight into the rich and diverse field of aging, gerontology, and evidence based practice.

The involvement of diverse members of the faculty is important to building the sustainability and capacity of the Centre. We have initiated regularly scheduled Centre meetings with faculty members who have a declared commitment to gerontological nursing. The use of distributed minutes very soon after the meeting instead of prior to the next one facilitates interaction and communication about action items to be done and by whom.

For those of us involved in the Centre, we are still on our quest but it is no longer an impossible dream. We would thank the Brenda Strafford Foundation for their commitment to the health and well being of those who are sometimes most vulnerable in society, older adults who reside in long term care facilities.

Aging, Creativity, and Nursing Practice
by
Carole Lynne Le Navenec RN, PhD (cllenave@ucalgary.ca), Sandi Hirst RN, PhD, GNC(C) and Cyndie Bartlett*  *Cindy is a student in the new integrated undergraduate program of the Faculty of Nursing,
University of Calgary

At 89, Michelangelo was sculpturing the Rondanini Pieta, which he began when in his 70s. Grandma Moses started painting in her 70s.

Traditionally, the gaze of gerontology and geriatrics and has focused on the problems of older adults and aging rather than the possibilities. Problems have been largely defined in terms of declines and losses associated with concerns about rising health care costs and increasing human service needs. While the biomedical model is appropriate for addressing clinical health problems, it provides little insight into questions about the meaning of life and what is needed to improve quality of later life as one grows older. In contrast to this paradigm, we offer another one. We suggest that growing older carries the potential for engagement in the creative arts, which will maximize well-being in later life by creating opportunities for growth and meaning.

Historically, old age has not generally been regarded as a dynamic and creative period. There are some studies that have suggested creativity declines with advanced age (Abra, 1989). However, more recently, there are studies emerging in the literature which provide examples of creativity at advanced old age. The Creativity and Aging Study by Cohen (2006) was the first scientific study to use an experimental design to examine the influence of the arts on the physical and psychosocial health of older adults.

Implications for Gerontological Nursing Practice

Take a step back and examine the creative opportunities that one has in one’s own life – do you cook, do quilting, or is photography your passion? Do you anticipate these joys changing as you age, perhaps not, - might they need to be modified? Self-reflection of one’s own views of creativity is the initial step in examining how older adults might use the creative arts in their own aging experiences.

Currently, most nursing conducted assessments lean towards physical and cognitive functioning. How can quality of life for older adults be improved if clinical assessments are limited to signs and symptoms to identify problems? Cohen’s (2006) response was that assessments need to integrate person-centred focus on potential that emphasizes strengths or skills and satisfaction even in the face of any losses. Do the assessment forms that we use encourage questioning the older client about these elements of quality of life? It is a question that we need to ask ourselves.

There is much to be learned about how the meaning of aging can be enriched by creative expression and conversely how engagement in the arts enriches the experience of aging. The following poster was developed for presentation at the 39th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, held in early December in Montreal. It helps us, as gerontological nurses, to open the door to understanding how creativity may be a useful nursing intervention.

References


TAKING UP THE CHALLENGE OF CARE FOR THE ELDERLY

To see this story with its related links on the guardian.co.uk site, go to http://www.guardian.co.uk/society/2010/sep/08/heinz-wolff-care-elderly-science

The science professor tells David Brindle why he is now focusing on the care needs of the ageing population.

David Brindle, Wednesday September 8 2010 , The Guardian

Although he is now in his 80s, Heinz Wolff still displays all the boyish enthusiasm for the application of science that made him such a popular television personality on shows such as The Great Egg Race in the 1980s. Midway through this interview in his office at Brunel University's Heinz Wolff Building, he suddenly springs up and leads the way to a nearby workshop to show off his latest project: a three-wheeled BMW bubble car, converted to run on electricity as the prototype of a new mode of transport for older people.

In the professor's fertile mind, he sees the huge potential of a mass-produced electric vehicle that could park face-on to the pavement, facilitating exit through its front-opening door. For good measure, the seats would slide forward to enable driver and passenger simply to stand up and walk away. Naturally, he has himself been testing the concept by taking the car for spins around the university's west London campus? to the undoubted amusement of hundreds of Italian teenagers attending a summer course.

With his bow ties, wild hair and distinctive German accent__ He was born in Berlin but arrived in Britain in 1939, aged 11, after his family fled the Nazis. Wolff is every inch the boffin. As the undisputed father of bioengineering__ a term he believes he coined to describe an activity designed to make the huge advances that had been made in technology, during the Second World War, available to the biological sciences. He is rightly regarded as one of Britain's leading scientists. But he has now decided to renounce science-- or, at least, to declare its limitations in providing answers to what he sees as the biggest challenge facing society: the care needs of the ageing population.

In his public lectures up and down the country--he still gives an average of one a week--Wolff is these days given to brandishing a hand and declaring: "I have undergone a change of heart. I am a techie; I have spent most of my life inventing technical devices of one sort or another. But the tool required for care, the only one really required for giving care, tends to be attached to people."

In his cluttered office, surrounded by computers, gadgets and less predictable decorations such as a joke-shop selection of stylish party moustaches, Wolff explains: "I fully subscribe to the fact that in the treatment of acute diseases, in robotic surgery, all sorts of things, technology is very important."
Pairs of hands

"But when it comes to caring for people in the way I define as 'comfort care', then I think that technology is no longer important because by and large the kind of things we need already exist. And anyway we may have been addressing the wrong clientele. Therefore I have convinced myself that the actual number of pairs of hands which are available, the right kind of state of mind and so on? These are the real problems we have to solve."

By "addressing the wrong clientele", he means that the focus of assistive technology has been overly on older and disabled people themselves. Rather, he now believes, the focus should have been more on helping their carers. And, reflecting on bitter experience in trying to get take-up of devices he has developed, he now thinks he should have targeted the private sector rather than central and local government.

At one time, Wolff and his associates had no fewer than 11 prototype "intelligent homes" set up with all the latest assistive technology. One, on the Brunel campus, was lived in for 10 years. But, he concludes, "there does not appear to be a market".

One of his most recent ventures, into which he says he ploughed "something like 500,000", was the Care Companion, a computer operated [device] by [using either] a barcode scanner or touch-screen, that could carry out a wide range of functions, from home shopping to contacting the GP. It could also be used by visiting care workers. Although the scheme was trialed successfully by 100 older people in Bristol, and was demonstrated to local councils across the country, it failed to take off.

Wolff, a longstanding vice-president of the College of Occupational Therapists, remains preoccupied with the care agenda, however. This has become more so through his own circumstances: he and his wife, Joan, who is the same age, live in a five-bedroom house with three storeys, and he has a heart condition that may shortly require surgery.

He is also seized with the scale of the demographic challenge and the inability of the state to meet people's care needs, particularly given the fiscal crisis and global economic trends. Rather than add further to what he calls "the great ant-heap of unutilised technology", he is now devoting much of his time and energy to promoting a new kind of informal care scheme. "What is required," he says, "is a large increase in part-time carers who can perform domestic tasks for clients who live nearby, at the appropriate time."

His idea, which sails under the twin and topical flags of "frugality" and "mutuality", is a development of the time-bank concept. In essence, friends and neighbours would pop in to help older local residents with personal or "comfort" care tasks, perhaps washing or meal preparation, and the contribution would be formally logged as a care credit. The twist, which makes the model more like an insurance scheme, is that the care-giver would draw on their credits only when they themselves grew old and needed support.
"Comfort care is an essential component of an acceptable quality of life," says Wolff. "Everybody to some extent is afraid of what is going to happen to them when they get old. We need to put these two propositions together and get people to do things when they are younger and fitter, in order to ensure that they have an unbreakable entitlement for care when they get older."

It is, he admits, a hugely ambitious plan, nothing less than "a change in the culture of the nation", and one that raises many questions. Should all forms of care be valued equally? Should credits be tradeable? Should there be some free credits for people unable to earn them? Above all, should people who elect not to co-operate with the scheme suffer as a consequence when they need help?

Wolff accepts that the answers to such questions may be hard to swallow. And he understands that the system could not be compulsory: "There will be people who say they are too busy to do this. 'We are busy bankers earning our 3m a year. Do you really think we are going to spend four hours a day .......?' So there will be some people who will opt out and buy their care."

Ground rules

To work through all the issues, he wants to put together a group of experts and enthusiasts to draw up the ground rules. He already has "about 20 interested parties", including well-known national charities. That process might take two years, during which time he would aim to find a community of perhaps 10,000 people where the scheme could be road-tested. It would need to be a community with a relatively stable population to minimise the problem of too many people drifting in and out? "ideally an island which people were not allowed to get off or get on", he jokes.

The scheme, provisionally called Care4Care, may seem a fanciful, utopian vision. But its fundamental assumption that society will not be able to meet the care needs of the ageing population unless the community's energies are harnessed is one that many observers are coming to share. And, given his contacts, energy and general sense of mischief, it would be rash to bet against Wolff getting somewhere.

"If I am an idealist at heart, it is a fact that if we got something of this kind going, as people in villages undoubtedly did-- it wasn't just the vicar's wife who took round soup to the sick, but people would naturally pop round to the neighbour and say: 'I haven't seen you out in the garden, is there something wrong?' or would nurse them through some illness__ then we'd actually become better people," Wolff says.

"In a society that has become increasingly unconscious of the needs of others, there could actually be a degree of salvation in this."

Heinz Wolff can be contacted at heinz.wolff@brunel.ac.uk.
Despite longer life spans, fewer years are disease free:
http://www.sciencedaily.com/releases/2010/12/101213140950.htm

Research on the health status of people age 50 and over in European Union reveals vast disparities:

Decision making for the receipt of influenza vaccination in community-dwelling older adults
By Amanda Mc Intyre (and Aleksandra Zecevic, Faculty of Health Sciences, University of Western Ontario Email: azecevi3@uwo.ca

Seasonal influenza is an infection of the airways caused by various influenza viral strains. Despite being preventable, it is the sixth leading cause of death (http://www.immunize.cpha.ca). In industrialized countries, 90% of influenza-related deaths occur in the elderly. Studies have shown that the vaccine is highly effective in preventing severe illness by up to 60% and death by 80% in older adults. In 2008, only 66.5% of the Canadian elderly population (age 65 and over) had received the seasonal vaccine. The purpose of this study (qualitative study involving 37 participants who participated in focus groups) in an Ontario town) was to explore the influences on Community-dwelling elderly in deciding to accept or refuse the seasonal vaccine. The findings can be summarized as follows: Major Facilitators:
(1) Recommendation by and trust in the health care system; (2) Belief in vaccine efficacy; Major Barriers:
(1) Fear of adverse reactions; (2) Belief in resilience as an older adult. Future Recommendations: Health care professionals should aim to educate older adults in influenza symptoms, vaccine efficacy and the types of populations at risk for contracting influenza. Special focus should be given to address misconceptions surrounding vaccine adverse events.
The Interface between Creative Expression and Older Adults: A Research Update
Sandi Hirst RN, PhD, GNC(C), Carole Lynne LeNavenev RN, PhD, and Cyndie Bartlett

Abstract
This poster presents a literature review, the objective of which was to provide better understanding of the relationship between creative expression and the quality of life of older adults. Creative expression is important for older adults from all cultures, regardless of geographic location, economic status, age, or level of physical, emotional, or cognitive functioning. Knowledge of the interface between creative aging and older adults is vital in order to be proactive in providing quality nursing and health care. This is true regardless of the setting in which the older adults lives.

Method
A meta-analysis of studies was completed. Studies were retrieved via computerized literature searches, cross referencing from original and review articles, and an examination of reference lists by two advance practice gerontological nurses. ≠ specialized sources of Academic One File, Academic Search Complete, and Credo databases, ≠ used free text words, medical subject headings, search terms included: “older adults”, “creativity”, “creative”, and “elderly”, ≠ articles obtained from on-line sources, hard copies acquired when available from two university libraries, interlibrary loan, and ≠ duplicate articles removed from list.

Inclusion criteria were:
≠ research defined as containing a statement of the purpose and a description of methods and findings, regardless of whether such terms were used, ≠ reporting on “creativity” specific to the experience of aging/elder adult, ≠ some contextual/associated reference to health care/quality of life, ≠ published in the English language, and ≠ indexed between January 1999 and December 2006.

Exclusion criteria included:
≠ physiology/brain structure/focused research.

Data Analysis

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<tr>
<td>Studies included in review</td>
<td>34</td>
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An ongoing analysis was done using a matrix, and codes and categories were added, combined, or deleted. ≠ what is the author(s) definition/description of creativity? ≠ understanding the analysis process was a series of questions: What types of research questions are being asked? Are the findings of the different studies similar? What are the themes emerging from the findings? What are the implications for health care practice?

Findings
How is creativity defined/described:
≠ “stretch yourself” – Allison et al. (2004)
≠ “the creative person is open to different paths to the same goal” – Fisher (1999)
≠ “an adaptation mode” – Fisk (2008)
≠ “generally stands for spontaneity and originality” – Hummon (2006)

Four themes emerged in the review:
≠ a land without borders – there are infinite possibilities to express creativity; e.g., dance, visual arts, gardening, music, or therapy.
≠ creativity promotes personal growth – creativity is often articulated as an expression of spirituality.
≠ a bridge between growing old and quality of life – providing opportunities for creative expression promotes well-being in the later years: e.g., encourages the expression of emotions, provides a sense of purpose, and role (e.g., teacher); although creative aging is not a significant predictor of successful aging, and ≠ “crisis” finder – older adults with dementia benefit from activities which provide for creative expression; can also be an effective intervention for specific disease modalities (e.g., depression, breast cancer).

Discussion of Findings
≠ the diversity of creative activities recognizes the range of skills and abilities of older adults, regardless of the setting.
≠ choice consistent with past interests and current abilities is important in selecting appropriate creative outlets.
≠ creative activities help to provide structure to the lives of older adults.
≠ creative activities enable the older adult to identify and express emotions.
≠ participation in meaningful activities is important for older adults, including those with dementia, and ≠ there is a need for health care professionals to integrate creative activities into their repertoire of interventions.

Limitations
≠ only English language articles were reviewed; reducing the richness of information from other language sources, and ≠ some articles were not available.

Conclusion
≠ there is much that is not known about how health care professionals can enhance creative activities, e.g., music, painting, to promote quality of life for older adults.
≠ where is creative aging in the curricula of health education programs (e.g., nursing, social work)?
CALL FOR ABSTRACTS: SUBMISSION DEADLINE EXTENDED UNTIL JANUARY 31, 2011, 11:59 P.M. PT

We are now accepting submissions for oral, poster, symposium, or roundtable presentation addressing the conference theme, "To Live is to Age...Raising the Bar for Excellence". Topics for abstract submission include:

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- Gerontological Nursing Interventions
- Human Health Resources
- Mental Health (e.g., depression, delirium, dementia)
- Promotion of Healthy Aging

Abstracts will be considered for presentation in one of the following formats:

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Abstracts are welcome from both CGNA members and non-members. There is no limit to the number of abstracts that an individual may submit.

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April 14-16, 2011 (Thu-Sat): Canadian Geriatrics Society, 31st Annual Scientific Meeting
Location: The Four Seasons Hotel, 791 West Georgia Street, Vancouver, B.C.
Info (to download the brochure and register online): www.csq.2011
Link for registration: http://cagacg.us1.list-manage.com/track/click?u=bf480d65419cc37f050bc0ae2&id=7546a47fe0&e=42385f937f

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/?FestivalofInternational/442c63652d/9f9ad993b5/1630f2f2e5

July 16–21, 2011: International Conference on Alzheimer’s Disease 2011, Paris, France
INFO: www.alz.org or Email: icad@alz.org

Excerpts from Teaching Gerontology Newsletter

Centre on Aging Newsletter, University of Manitoba (Vol. 28, No 3, 2010): Recent research publications by Faculty and/or Students from this Centre.

Negative Attitudes Don’t Keep Seniors From Using Mental Health Services

*Older Adults’ Help-Seeking Attitudes and Treatment Beliefs Concerning Mental Health Problems* by Corey S. Mackenzie (Centre on Aging Research Affiliate), Tiffany Scott, Amber Mather and Jitender Sareen published in *The American Journal of Geriatric Psychiatry* 16:12, December 2008.

*(The material below was taken from Pub Med, NIH Public Access: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2735824)*

Objectives

Older adults with mental health problems are especially unlikely to seek professional mental health services. It is not clear, however, whether their help-seeking attitudes and treatment beliefs contribute to this problem. The objectives of this study were to compare older adults’ attitudes and beliefs to younger adults’ and to examine the influence of age on these variables after controlling for other demographic variables, prior help-seeking, and mental disorders.
Methods
We analyzed cross-sectional data from Part II of the National Comorbidity Survey Replication. This dataset includes 5,692 community-dwelling adults, including 1,341 who were 55 years of age and older. Participants responded to three questions assessing attitudes toward seeking professional mental health services and one question examining beliefs about the percentage of people with serious mental health concerns who benefit from professional help. We used logistic regression to predict positive versus negative attitudes and beliefs from age, gender, education, and race/ethnicity, as well as prior help-seeking and mood and/or anxiety disorder diagnosis.

Results
Overall, more than 80% of participants exhibited positive help-seeking attitudes and more than 70% reported positive treatment beliefs. In contrast to the modest effect of age on beliefs, adults 55 to 74 years of age were approximately two to three times more likely to report positive help-seeking attitudes than younger adults.

Conclusions
Older adults’ positive attitudes and treatment beliefs are unlikely barriers to their use of mental health services. This finding, which is consistent with recent positive views of aging, suggests that enabling resources and need factors are more likely explanations for older adults’ low rates of mental health service use.

Keywords: help-seeking attitudes, treatment beliefs, mental health service utilization


(THE MATERIAL BELOW WAS TAKEN FROM PUB MED:

Abstract

BACKGROUND: Quality of life in dementia has been studied in clinical settings. There is less population-based research on life satisfaction and cognition.

OBJECTIVES: (1) To compare the overall life satisfaction (LS), LS with material circumstances (LS (material)), and LS with social circumstances (LS (social)) of older adults with no cognitive impairment, with cognitive impairment no dementia (CIND), and with dementia; (2) To examine the effect of cognition on LS across a broad spectrum of cognition; and (3) To explore the effect of factors such as depressive symptoms, functional impairment, education, and social support.

POPULATION: 1620 community-dwelling older adults with a mini-mental state examination (MMSE) score > 10, sampled from a representative list were interviewed.

MEASURES: Age, gender, education, social networks, and social supports were all self-reported. The MMSE, the Centre for Epidemiologic Studies-Depression (CES-D), and the Older Americans Resource Survey (OARS) were used. Dementia was diagnosed by clinical examination using DSM-IIIR criteria. LS was measured using the Terrible-Delightful Scale. Factor analysis identified two factors: LS (material), and LS (social). A global item measuring overall LS was also used.
RESULTS: Those with dementia and CIND had lower LS than those with normal cognition, but the effect was relatively small. There was a gradient in LS which extended into the normal range of cognition. Depressive symptoms and functional status were strongly associated with LS.

CONCLUSIONS: Cognition is associated with LS, but the effect is fairly small. Most older adults are satisfied with life.

See other articles in The University of Manitoba Centre on Aging Newsletter:
http://www.umanitoba.ca/centres/aging/pubs/626.htm


HOLIDAYS ‘R’ OPPORTUNITIES by © Elderwise 2010 (Vol. 6, No. 12)

Like all the best families, we have our share of eccentricities, of impetuous and wayward youngsters and of family disagreements. Queen Elizabeth II

Some of us look forward to celebrating the holidays with our aging parents or our adult children – others not so much. We may live nearby and see each other often; but some of us only make annual or semi-annual visits - often during the holidays.

For occasional visitors, it’s an opportunity see, hear, touch and sense what’s happening with our loved ones. The result can be joy and relief, or it can be growing concern and frustration. Holidays can get weighed down with tradition and habits. Some of these are welcome, others leave us feeling that we have not “progressed” in our relationships or in dealing with matters important to the family. If you feel frustrated, consider these causes and some ways of dealing with them:

What keeps some families “stuck”?

- Denial and avoidance. These traits are part of human nature. Showing compassion towards others AND ourselves can keep emotions in check.
- Old hurts, entrenched behaviours, and fear of conflict. Recognizing our “family drama” is the first step towards re-writing our story.
- Overwhelming size or number of concerns. Breaking the problems into manageable parts and setting priorities can help.
- Feeling powerless. Lack of confidence, skills or support may make you feel like giving in or giving up.
What you can do:

- **Inform yourself** and others of the facts, issues and options. Whether it’s a health, financial, caregiving or lifestyle concern, sharing new information can be a neutral – even welcome – first step.
- **Prepare others** for talking about important matters. Give advance notice of what’s on your mind – to your aging parent or your adult child.
- Resolve to **say or do something different** this time. Using the same old approach and expecting different results just sets you up for frustration.
- **Build trust first.** Try to show that you understand another person’s values, needs and fears, before advancing your own opinions and agenda.
- **Look for shared solutions** that consider everyone’s interests. Taking too strong a position, whether you are the parent or adult child, may affect the well-being of another family member.
- **Set realistic objectives and take small steps.** Major life changes are a process, not an event. Quick and simple just doesn’t apply.
- Close any discussions by trying to **get agreement on next steps**.
- **Keep things in perspective.** Limit the time and energy you devote to your concerns. Relax and enjoy the holiday.

Once the visit is over, reflect on and celebrate your progress, no matter how small. Persist, gently and consistently, keeping everyone involved and engaged in the process.
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