This is my last newsletter message as the President of CGNA. Two years ago, I started my journey as President of the CGNA in Banff, Alberta. I will pass the torch to your new President, Diane Buchanan in June at our national conference in Mississauga, Ontario. I would like to reflect on some of the major accomplishments that have occurred over the last two years.

- We introduced a new business model with our business processes now being supported by the management support company “Malachite Management Inc.”.
- We have launched an online membership process for the provinces choosing to participate.
- We updated our CGNA website and have included a “members only” section.
- We offer on-line educational sessions, using webinar technology. We are starting with sessions to help members prepare for the CNA certification exam in the specialty area of Gerontology.
- We completed our CGNA Nursing Competencies and Standards document which members receive a copy in the members only section of the website and others may purchase.
- We have updated our by-laws to reflect our current operations.
- We opened our membership to all nurses, including Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses and Registered Practical Nurses.
- We awarded approximately $40,000.00 in scholarships, research grants and travel grants to members.
• We developed a new strategic plan with a Vision, Mission, Values, Goals and Objectives to help guide us over the next 3-5 years.
• We developed a strong relationship with the National Gerontological Nursing Association (American).
• We finalized negotiations with Gerontological Nursing Association of Ontario, who will now be conjoint members of CGNA.
• We participated on many national and international committees and projects. Some of the committees are, the Canadian Coalition for Immunization Awareness and Promotion (CCIAP), the Canadian Patient Safety Institute (CPSI), the Geriatric Education Recruitment Initiative (GERI), the Congress of National Seniors Organization (CNSO), National Initiative for Care of the Elderly (NICE) the Canadian Nurses Association Affiliate and Emerging Interests groups (CNA-AAE). Two projects are the NICE final report on “Improving Health Human Resources for Canada’s Aging Population: Recruiting Students to the Field of Aging” and work continues on the CNA, “Federal Elder Abuse Initiative-Promoting the Awareness of Elder Abuse in Long Term Care. We have also been involved on the planning committee for the last two American Gerontological Nursing conferences and have been given an opportunity to address the participants at both conferences.

Your executive team have worked hard and tried to stay true to our vision of “promoting excellence in Gerontological Nursing through Leadership, Knowledge and Scholarship.” I wish to thank them for all of their efforts, support and encouragement. I also wish to thank the dedicated board of Directors and Malachite for helping to advance our mission of “addressing 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”.

This has been a wonderful opportunity and exciting journey and I thank you, the members for electing me and allowing me to serve as your President.

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

HAVE YOU RENEWED YOUR MEMBERSHIP?

If not, please contact your provincial organization. See email address on last page.
Here we are in April already, and soon it will be time to attend the June 8 to 16 National Conference on Gerontological Nursing at the Delta Meadowvale Resort and Conference Centre in Mississauga, Ontario. I am hoping to meet many of you at the conference, to hear about your interesting stories about the roles you play in creating health and well-being for older adults and their families. If you have not yet submitted an article for publication in this newsletter, please consider submitting one for the June issue. That will be my last issue with which I will be involved as Editor; hence, please send me submissions that describe particular programs you have set up, or a set of testimonials about what older adults have informed you about the value of music, or the visual arts, or related approaches to what some of us call Serious Leisure. And please invite students or some older adults that you know to send in their news and views, particularly about what they find most contributes to their overall well-being and happiness. I would particularly welcome some beautiful Spring-Summer pictures.

I do hope you enjoy the Feature Article that was selected for this issue and also the publication by the students. The latter group spent many hours to ensure they would have it ready for this issue. Please send your submission for the next issue to me by May 20th. Happy Spring to all of you.

Carole-Lynne Le Navenec (llenave@ucalgary.ca)  
Editor, The Canadian Gerontological Nurse.
Greetings from Gerontological Nursing Association of B.C. (GNABC)

I became president of GNABC in September 2010 at our annual conference held in Prince George in Northern BC. The conference was very successful with over one hundred health care providers, all with a keen interest in caring for older adults, attending. We send a sincere thanks to the Northern Health Authority for giving many of their employees the opportunity to attend the conference. We also want to send appreciation and thanks to our sponsors, vendors and the dedicated volunteers who made the conference a success. Planning is well underway for our next conference in September.

GNABC has over two hundred and fifty members in eight chapters located in a variety of geographical areas throughout the province. We also have had several people express an interest in forming new chapters. Our goal is to support the formation of new chapters as well as retain and recruit new members to our existing chapters. We are in the process of redesigning our website. Our plan is have a site that is user friendly with access to information on the association as well as links to information that is relevant to those caring for the older adult.

GNABC has submitted a proposal to host the 2013 National Conference. We are excited about the possibility of hosting this international event and to once again highlight Vancouver!

I look forward to a successful conference in Mississauga and hope to see many of you there.

Respectfully submitted by Darlene Rogers-Neary, President GNABC

CGNA SECRETARY REPORT

The minutes have been recorded for executive and board meetings of CGNA.

The Secretary was asked to chair the Webinar Committee which was announced in the last newsletter. Two webinars have been held in March. A total of 33 CGNA members and 8 non members have participated in the two webinars representing Ontario, British Columbia, Alberta, North West Territories and Manitoba. A majority of participants have indicated through the evaluations that the webinars are meeting their expectations.

Currently, the committee is constructing a schedule of webinar presentations on current topics for gerontological nurses from September 2011 through December 2011 and the January 2012 – March 2012 presentations will focus on the needs of nurses studying for the CNA Certification Examination. If anyone is interested in presenting in the sessions please send a note to Melanie McLeod, CGNA Coordinator, Malachite Management melanie.mcleod@malachite-mgmt.com and the committee will follow up.

The By-Laws accepted at the 2009 Annual General Meeting in Halifax have been approved by Industry Canada. Thank you to all who participated in feedback and constructive suggestions.

Respectfully submitted by Bonnie Hall
CGNA NOTICE OF ANNUAL GENERAL MEETING

Thursday, June 9, 2011 5:15pm – 6:30pm
Delta Meadowvale Resort and Conference Centre

Join 200+ nurses as we celebrate nurses’ contributions to gerontological nursing and health care for aging Canadians.

Be a part of “To Live is to Age...Raising the Bar for Excellence” and join us at the Delta Meadowvale Resort and Conference Centre on Thursday, June 8, 2011 from 5:15 - 6:30 pm; held in conjunction with the Biennial Scientific Conference, for your Annual General Meeting. Registration is available on-line.

At this year’s AGM, the business agenda will include reports from Executive Committee members and provincial designates, nomination of officers, and presentation of conference travel grants.

The by-laws that were passed at the last AGM have received Ministerial approval and can be viewed at:


Events of the Conference include hearing from nurse leaders, an exhibit hall, elections, and recognition awards. Check out the conference program at www.cgna.net.

CGNA 2011 SILENT AUCTION

Canada has:

- An aging population
- A shortage of gerontological nurses

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

Please consider donating item(s) to be auctioned for this very worthy cause. For more information about the silent auction, visit http://www.cgnaconference.ca/Silent_Auction.html
REGISTRATION AND PRELIMINARY PROGRAM

To register for the conference, make your hotel reservation, and view the preliminary program, visit the website at www.cgna.net!

CALL FOR CONFERENCE GRANT APPLICATIONS

CGNA invites the membership to apply for conference grant support to attend the 16th Biennial Meeting.

This grant is made available to cover personal expenses of the applicant and not those expenses paid by other sources (i.e., an employer, a professional nursing association).

Visit http://www.cgnaconference.ca/Travel_Grants.html to download the application.

SUBMISSION DEADLINE: APRIL 15, 2011

We look forward to seeing you in Mississauga!
The 2011 Nominating Committee of CGNA has accepted nominations from individuals who are committed to the Mission, Vision, and Role of CGNA.

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


The Nominees will present their platforms to the general membership at the upcoming Annual General Meeting on June 9, 2011 at the CGNA 2011 Biennial Meeting. Nominations will also be accepted from the floor at AGM.

Slate of Nominees

Treasurer-elect

Lisa Keeping-Burke graduated with a Bachelor of Nursing (1987) and Masters in Nursing (1997) from Memorial University of Newfoundland, and a PhD in Nursing from McGill University (2010). From 1997-2007 she taught at St. Francis Xavier University in Nova Scotia, and currently holds the positions of Adjunct Assistant Professor at Queen’s University and Senior Teaching Associate at the University of New Brunswick, Saint John. Dr. Keeping-Burke has practiced nursing across a variety of health care settings, with gerontological nursing always being a focus of her practice, teaching and research. During the last four years, Dr. Keeping-Burke coordinated numerous long-term clinical placements for students, taught and supervised students in long-term care settings, mentored new clinical instructors in the long-term care setting, as well as delivered a course in Gerontological Nursing at Queen’s University. She welcomes the opportunity to become a member of the CGNA executive committee and to assume the responsibilities of treasurer.

Secretary

Carla Wells has been a member of CGNA since 1984. She was President of CGNA from 2003-2005 and Secretary from 1993-1995. Provincially, Carla has served as President of the Newfoundland and Labrador Gerontological Nursing Association. She has participated in several working groups of CGNA, including: Standards of Practice; Certification; as well as numerous other documents and initiatives of CGNA in the past 27 years.

Carla’s passion for gerontological nursing was evident through her eleven years as a Clinical Nurse Specialist in both Ottawa, Ontario and Corner Brook, Newfoundland. She chaired the Conference Planning Committee for the National CGNA conference held in Corner Brook in 2001. She was a member of the planning committee for the Ottawa Conference in 1997 and since returning to Newfoundland in 1996, she has chaired or participated in organizing several provincial conferences.

Carla currently works as Research Coordinator and Nurse Educator in the Western Regional School of Nursing’s BN program, teaching Research and Healthy Aging, two courses she remains passionate about. On an academic note, Carla recently completed her PhD in Nursing at the University of Calgary and looks forward to attending convocation a few days before the next national conference. Even though Carla has been faced with a few health challenges in recent years, she is still as committed to CGNA as she ever was and she is excited about the future direction of CGNA. Carla looks forward to serving the membership in the capacity of Secretary, if so elected.
As our population continues to age, the demand for health care professionals qualified to work with both the elderly and the terminally ill also increases.

Grant MacEwan University’s Centre for Professional Nursing Education offers an innovative post-basic program focused on preparing RNs and other health care professionals to work with our aging population.

Located in Edmonton, Alberta, MacEwan provides flexibility with this distance delivery certificate specializing in Hospice Palliative Care or Gerontological Nursing, so you can further your education in the comfort of your own community.

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Post-Basic Nursing:
Hospice Palliative Care and Gerontology
www.MacEwan.ca/postbasic
BEHIND EVERY OLDER ADULT IS A GERONTOLOGICAL NURSE
By Sandra P. Hirst RN, PhD, GNC(C) and Annette M. Lane RN, PhD
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While we admit that our title is somewhat inflated, it addresses the point that we want to make. Older adults are often supported in their aging process and related health care challenges by professional nurses. The question is asked repeatedly, what knowledge do we bring to practice?

What do we know?

Nurses’ knowledge of the health needs of older adults: Despite the aging of our population, as well as the significant proportion of older adults utilizing the health care system, the literature reveals that health care professionals, including registered nurses and nursing students, lack knowledge of how older adults differ from their younger counterparts in symptom presentation and potential complications. For instance, some registered nurses do not realize that older adults experience particular illnesses differently than their younger counterparts, such as myocardial infarctions, pneumonia, drug interactions and depression (Robinson & Mercer, 2007). Wells and associates (2004) found that nurses had less accurate knowledge about aging than older health professions. Cognitive impairment may complicate the assessment of pain, resulting in many nurses feeling uncertain about their assessments, and reluctant to administer pain medication (Kassalanen et al., 2007). Further, health related challenges and complications arising from hospitalization are often not recognized and addressed by registered nurses. For instance, delirium, a frequent and potentially life threatening condition experienced by hospitalized older adults was recognized by less than one third of registered nurses in a recent study (Dahlke & Phinney, 2008). Hospitalization often results in a functional decline in older adults, and yet, many registered nurses lack knowledge in preventing and treating de-conditioning (Gillis, MacDonald & Maclsaac, 2008).

Knowledge influences nursing care, but so do attitudes. Gallagher and colleagues (2006) reported that variations in the quality of care older adults receive may depend much on the attitude of staff towards them. Significant statistical differences in negative attitudes were found between assistant personnel and nurses and between porters and nurses; these non-professionals believed that older adults were irritable, grouchy, complaining and untidy.

Student nurses’ knowledge of gerontological nursing: Much of the research examining student nurses’ knowledge of the needs of older adults focuses upon attitudes towards caring for this population group (Cozort, 2008; Holroyd, Dahlke, Fehr, Jung & Hunter, 2009; Koren et al., 2008; Williams, Anderson & Day, 2007) and the lack of gerontological content in baccalaureate programs or proposed changes for gerontological content in nursing education (Baumbusch & Andrusyszyn, 2002; Gebhardt, Sims & Bates, 2009; Grocki & Fox, 2004; Koren et al., 2008; Plowfield, Raymond & Hayes, 2006). There is substantially less research that examines what nursing students know about the specific health needs of older adults and how they know what they know (the basis for their knowledge).

Older adults’ expectations of nursing care: Despite the body of research examining “patient satisfaction”, there is very little research that addresses what older adults expect of registered nurses. One study suggests that older adults expect nurses to be knowledgeable and recognize their needs
(Santo-Novak, 1997). Chang, Chenoweth, and Hancock’s (2003) research revealed the importance of older adults’ satisfaction with nursing care. Older adults who were satisfied with nursing care were more likely to seek prompt treatment for future health concerns. Unfortunately, there may be discrepancies between what registered nurses and older adults perceive as the health needs of older adults. For instance, in one study (Ben Natan, 2008) registered nurses and older adults did not agree on what they perceived the needs of older adults to be.

**Gap in the research:** From the above bodies of literature, it appears that registered nurses are not confident in their knowledge of health concerns (and treatment) that impact older adults. And, when identifying what they perceive to be significant needs in older adults, their patients do not necessarily agree. Clearly, there needs to be more research examining how registered nurses (and registered nursing students) identify the health needs of older adults and the basis on which these decisions are made.

**So What?**

There are two implications for us to answer the so what question. We each need to assess our own knowledge base as gerontological nurses. Critically ask yourself:

- When was the last time that I read a research study about the population that I care for?
- Have I participated in a CGNA webinar?
- Am I registered for the Mississauga CGNA conference?
- Have I had a chat with my nurse educator about changes to practice?
- Have I recently pulled up one of the RNAO best practice guidelines?
- Have I consulted GeriRN (http://consultgerrn.org/resources/hartford_geriatric_nursing_initiative_hgni/)?

The second implication is to ask, who is doing the research to answer the gap that is obvious in the literature. In brief, let’s update our knowledge. The outcome is enhanced care to older adults.

**References**


SOME HUMOR AND CLASSICAL MUSIC FOR YOUR HEALTH

An elderly patient gets hearing aids from a doctor. After a short time, he meets the doctor again.

Doctor: "Your hearing is perfect. Your family must be really pleased."
Patient: "Oh, I am in a funny situation now. I haven't told my family yet. I just sit and listen to their conversations. In a month, I've changed my will three times!"

RADIO CLASSIQUE: http://www.radioclassique.fr/fileadmin/player/player_popup.php?debit=h&rd=0
CLASSICAL 96.3 IN TORONTO: http://www.classical963fm.com/music

USING WATSON’S RELATIONAL PATIENT CENTERED CARE CONCEPTUAL MODEL TO PROVIDE NURSING CARE FOR A GERIATRIC MEDICAL PATIENT WITH DEMENTIA: A CASE STUDY
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Key Words: Linda Watson’s Relational Patient-Centered Care Conceptual Nursing Model, Older adults with dementia

ABSTRACT

In this case study, we applied Linda Watson’s Relational Patient Centered Care Conceptual Model (2008) to the care of an elderly person with dementia, and with a small bowel obstruction. We chose this model because it assisted us to provide holistic relational family centred care, which is more than completing a set of tasks. This model places an emphasis on developing therapeutic relationships, which are the foundation of quality nursing care. As first year nursing students, we used this model to address the care of our patient who was experiencing abdominal pain secondary to surgery to remove the tumor causing bowel obstruction, her anxiety and agitation, and her daughter’s caregiver strain. In accordance with previous studies, our case study demonstrates that a nursing relationship is a prerequisite to providing quality care.

Introduction

The discipline of nursing is changing. Early western models of nursing care focused on eliminating illness and disease for patients (Saylor, 2004). However, patients’ are not satisfied with having only their physical needs met, nor are they content with merely receiving treatments for their diseases (Watson, 2008). Indeed, patients are often treated with an impersonal, apathetic hand in the healthcare system (Carper, 1979). We concur with Linda Watson (2008) that patients want to develop meaningful relationships with their caregivers. The process of forming a caring relationship with patients assists nurses to adopt a more holistic approach to meeting patient needs. These needs may be within the physical, psychosocial, or spiritual domains (Watson, 2008). As nurses, or even student nurses, we bring our beliefs, spirituality, culture, history, experience, and knowledge, as well as our nursing
knowledge, with us into our nurse-patient relationships. Although we do not vocalize or involve all of our personal beliefs when caring for patients, we believe that Watson (2008) is correct in emphasizing that it is time for nursing to embrace relational patient-centered care.

In this case study, we apply Watson’s Relational Patient Centered Care Conceptual Model (2008) to the care of our patient who, for the purposes of confidentiality, we will call Mrs. Michelle (hereafter referred to as Michelle due to patient preference). More specifically, we will demonstrate how we used this model to design and implement a care plan with Michelle. Using this conceptual model allowed us to provide meaningful care for Michelle and to address her bio/psycho/social/spiritual needs.

We begin by introducing Watson’s Relational Patient Centered Care Conceptual Model (2008). Next we provide detailed information about Michelle’s medical history, and her illness experience (See Appendix B; Glossary). In the third section, we explain how we applied Watson’s (2008) conceptual model to design our nursing care plan with Michelle. In the final section, we provide our conclusion about the value of using Watson’s Model (2008) to direct our nursing care practice.

**Rational for Choosing Watson’s Model**

We chose to use Linda Watson’s Relational Patient Centered Care Conceptual Model (2008) because we believe that establishing a caring relationship with our patients is of paramount importance. We acknowledge the value of focusing on the patient’s physical needs during practice, but concurrently we also understand that our patients are people who have psychosocial spiritual needs, as well. We had previously discussed the importance of the contribution made by Peplau (1952) and Travelbee (1971). Peplau’s Interpersonal Relations Model emphasized the importance of a therapeutic relationship between nurses and patients (Peplau, 1952). Travelbee’s (1971) Human to Human Relationship Model also stressed that nursing is accomplished through therapeutic relationships between the nurse and the patient. We feel that Watson’s, Peplau’s, and Travelbee’s models acknowledge the person behind the diagnosis, which we feel is essential when providing care.

As first year students, we are limited in the number of technical skills we can execute within the clinical setting; however, we are not limited in our ability to relate to our patients. We feel that relating to our patients and understanding their illness experience is one of the areas we can excel in at this point in our careers. Therefore, we chose to use Watson’s conceptual model because it allows us to focus our nursing practice on an area we presently see as our strength. Previous studies by Frank (1991), Robinson (1996), and Moules (1999), support our contention that relating to patients is imperative in the clinical setting.

**Overview of Watson’s Relational Patient Centered Care Conceptual Model (2008)**

Linda Watson’s conceptual model was intended to focus on the care of cancer patients, but we believe her model is relevant to all areas of nursing practice. Indeed, Watson argues that all nursing is relational (Watson, personal communication, March 4, 2010). The key concept in her model is that nurses should engage in a relationship with their patients for the following reasons: to better understand the patients’ world, to decrease their feelings of isolation in the healthcare system, and to improve their satisfaction with the care they receive (Watson, 2008). The patients (and their families) are at the center of Watson’s conceptual model (Appendix A). The nurse and the patient are separated by a relational space; this space is where relational patient care occurs and where the nurse-patient relationship is enacted. It is assumed that both the nurse and the patient bring their histories, cultures,
values, beliefs, spirituality, and physical attributes to the relational space. The nurse works in the relational space to assist the patient in healing (Watson, 2008).

**Watson’s Metaparadigm of Nursing**

In this model, nursing work focuses on promoting the wellness of patients, regardless of their disease status (Watson, personal communication, March 4, 2010). Watson argues that excellent nursing care for patients must focus on disease treatment and on providing emotional support so that the patient can heal (Watson, 2008). Watson (2008) views health as being comprised of psychosocial, physical, social, cultural, and spiritual factors. Health, in this model, is the highest state of wellness a patient can achieve within the context of their disease (Watson, 2008).

The environment in this model is regarded as the healthcare system that the patient and nurse find themselves relating to each other within. The healthcare system, at this point, is overburdened and focused on technical nursing tasks. In this model, nurses are located between the healthcare system and the patient (Watson, 2008) (See Appendix A: Watson’s Relation Patient Centered Care Conceptual Model). The person in Watson’s model includes the patients and their families as the unit of concern. Watson (2008) contends that the family is always involved, even if they are not in the room or healthcare setting while the nurse is caring for the patient. Each person brings their own complex background to the nurse-patient relationship in the relational space (Watson, 2008). How patients cope with their illness is directly affected by the support around them, their previous experiences, and the quality of the relationships in which they are embedded (Watson, personal communication, April 7, 2010).

**The Case Study**

The patient we chose to focus on in this study is an 82 year old widowed Caucasian female who we will call Michelle. Michelle was admitted to a Geriatric Medical unit at the Rocky Mountain Hospital (pseudonym) from her daughter’s home on January 1, 2011. Michelle’s primary medical diagnosis was a small bowel obstruction, during which intestinal contents, fluid, and gas, are unable to pass through the bowel below the obstruction. Some possible complications include: abdominal distention, retention of fluid in the bowel, increasing pressure in the intestinal lumen, edema, congestion, necrosis of tissues, and rupture or perforation of the abdominal wall (Day et al., 2010).

In Michelle’s case, her intestinal obstruction resulted from adhesions within her abdominal cavity. The adhesions, which are inflammatory bands that connect opposing surfaces (Stedman, 2008), caused part of her small bowel to become adherent to other tissues within her abdominal cavity (Day et al., 2010), resulting in the obstruction. Michelle received emergency surgery the day she was admitted; she underwent a procedure called lysis of adhesions, which is a surgical division of adhesions (Stedman, 2008) to relieve the obstruction. We cared for Michelle on her second day post-operation.

Michelle has a secondary diagnosis of Alzheimer’s disease. This disease is a chronic, degenerative, irreversible brain disorder (Day et al., 2010). Alzheimer’s disease is a type of dementia that can affect a patient’s memory, cognitive ability, and their ability to care for themselves. Some cognitive disturbances that may be seen in a patient with Alzheimer’s disease include agnosia, aphasia, and apraxia. Alzheimer’s disease is characterized by a gradual loss of cognitive function with accompanying behavioral disturbances (Day et al., 2010).
During the week we cared for Michelle, she experienced abdominal pain related to her surgery. Michelle had difficulty forming words but she was able to tell us that she was in pain. She was also guarding her abdomen, groaning, her heart rate was elevated, and she was diaphoretic. Initially, when the nursing staff tried to give Michelle any medication through the oral route, she spit it out. Subsequently, all of Michelle’s medication was mixed in her food, including her analgesics.

Michelle is unable to complete the activities of daily living without assistance. Michelle experiences general muscle weakness and requires assistance to ambulate, and to wash herself. She experiences dysphagia and requires help to eat. Michelle was agitated and tearful the day we cared for her. We found working with Michelle to be a challenging assignment.

Michelle lives with her daughter in Calgary, AB (for the purposes of confidentiality, we have chosen to call Michelle’s daughter “Chelsea”). Chelsea, who is Michelle’s primary care giver, recently injured her wrist and is now experiencing difficulty caring for her mother. Therefore, Chelsea is applying for long term care for Michelle. Outside of the hospital, Michelle receives care from a Registered Nurse for one hour a day from Monday to Friday. This professional care helps take part of the strain off of Michelle’s family.

**Application of Watson’s Model to the Nursing Care Process**

1) **Assessment:** To begin the nursing care process, we first assessed how our backgrounds may affect our care of Michelle. We presently have family members suffering with Alzheimer’s disease and we understand that these experiences will affect our nursing care of this patient. Although we all agreed that it has been difficult to watch our grandparents suffer with this disease, it has been equally hard to watch other family members attempt to care for our grandparents by themselves.

Watson (2008) contends that nurses bring their histories to the relational space, where nursing occurs. We believe that we brought our personal experience with Alzheimer’s disease into this relational space during our nursing care of Michelle. This experience enabled us to focus our nursing assessment not only on the patient’s needs but on the caregiver’s needs.

We completed a health assessment on Michelle to create our database and to identify her most salient health concerns. We asked Michelle “yes” or “no” questions to try and understand what she was feeling. Although we understand the value of using open-ended questions, our approach simplified the health assessment process for Michelle given her aphasic condition. We consulted Michelle’s charts to gain an understanding of her biomedical condition, we took her vital signs, we asked her if her pain was tolerable, and we asked her if she was happy being in the hospital (to which she replied that she was not). We focused on assessing Michelle’s physical and emotional needs because Watson (2008) views both of these domains as being part of health.

Anxiety is a common symptom of Alzheimer’s disease (Holland & Adams, 2007). We asked Michelle’s daughter, Chelsea, if she could provide any information about what might be exacerbating Michelle’s unhappiness and agitation, and she did. Chelsea thought Michelle was agitated because of abdominal pain and because of the change of routine at the hospital compared to being at home. Chelsea also commented that Michelle had a greenhouse in their backyard where she liked to spend her afternoons. Chelsea thought that being inside the hospital and not being able to be in such an area that brings Michelle comfort was causing her to be agitated. Watson (2008) notes that patients bring their
values to the relational space where nursing occurs. We were assessing what was important to Michelle and we were assessing what she values that was missing in her hospital environment causing agitation.

Lastly, we collected subjective data from Chelsea regarding her experience as Michelle’s primary caregiver. We used this information to assess how Chelsea was coping and to determine if she had the support and services she needed. People who care for their parents with Alzheimer’s disease often experience anxiety, depression, and guilt (Wright & Leahey, 2009). Although Michelle’s family had applied for residential care for her, it was unknown when this placement would occur. We asked Chelsea questions about her emotional and physical health. We had conversations about how much time she had to herself and about how much support she had. We used the information to determine if Chelsea might benefit from forming long-term relationships with supportive organizations, such as The Alzheimer Society. Watson (2008) emphasizes the importance of forming relationships in nursing care. We also consulted Michelle’s primary Registered Nurse, and other nurses on the unit who had cared for her, to assess how they perceived Chelsea to be coping.

Chelsea explained that she had been feeling overwhelmed acting as Michelle’s primary caregiver. Chelsea found caring for Michelle time consuming and she was experiencing several previously identified negative consequences of acting as a primary caregiver, including: restrictions in her personal time, interruptions in her daily routines and social life, and negative employment consequences (McKinlay, Crawford, & Tennstedt, 1996). Pinquart and Sorensen (2003) associate the number of care giving tasks with the size of burden weighing on the caregiver. Chelsea was providing almost all of Michelle’s care, with only minimal help from a Registered Nurse; therefore, it is logical to conclude that she was under a great deal of strain. Chelsea confirmed our suspicions when she told us that she was feeling overwhelmed.

In summary, we consulted Michelle and Chelsea throughout the nursing assessment process so that we could include their concerns, in addition to ours, in the nursing care plan. Ongoing consultation with Michelle and her family also helped us to form a therapeutic relationship. Forming this relationship is central to Watson’s Relational Patient Centered Care Conceptual Model (2008).

2) Nursing Diagnoses: In collaboration with Michelle and Chelsea, we formulated three nursing diagnoses. The first diagnosis was that Michelle was experiencing abdominal pain in relation to her abdominal surgery (removal of adhesions). Then secondly, Michelle was experiencing agitation related to a disruption of her personal routine. Lastly, Chelsea was experiencing caregiver role strain related to the range of care-giving tasks she was required to perform on her own due to her limited support network.

We identified several strengths that Michelle and her family exemplified. For example, Michelle has a caring family that is committed to making sure she is well taken care of, as indicated by their frequent visits to the hospital and their willingness to engage in dialogue about Michelle’s care planning. A second strength is that Michelle is able to communicate her needs to her caregivers via a yes/no system. Furthermore, Michelle’s daughter informed the nursing staff about the many activities she enjoys (e.g., sitting in her greenhouse). Lastly, Chelsea is open to the possibility of creating long-term relationships with Alzheimer’s support networks; we see this openness as a positive first step in getting Chelsea the support she needs.

3) Planning/Goal Setting Phase: Our planning began during our first contact with Michelle and continued during the whole process of her hospital care. It began with prioritizing the diagnoses with
Michelle and Chelsea (Kozier et al., 2010). We understand that there is no cure for Alzheimer’s disease; however, we have learned that there is much fear and anxiety among this population. Hence we focused on enhancing Michelle’s quality of life, despite her illness, which is a strategy endorsed by Watson (2008).

Our first goal was to make Michelle more comfortable by monitoring and reducing her pain from her abdominal surgery. Under-treated and unrecognized pain can result in a decreased quality of life for patients (RNAO, 2004). Additionally, enhancing patient comfort is supported by Kolcaba (1994). We thought that reducing Michelle’s pain would also help to relieve her agitation in relation to the fear and anxiety associated with Alzheimer’s disease.

Our second goal was to reduce sources of anxiety and agitation for Michelle. We recognize that patients with Alzheimer’s disease can experience anxiety and agitation as a result of being startled by unfamiliar faces. Austin & Boyd (2010) agree with our contention; they argue that the change of caregivers for dementia patients can cause these individuals to have extreme anxiety reactions (Austin & Boyd, 2010). Obviously, caregivers needed to visit Michelle throughout the day while she was in the hospital. Whenever possible, we planned to keep the same, familiar caregiver for Michelle in order to limit startling and reduce her agitation. Additionally, we planned to arrange for Michelle to engage in meaningful activities, in order to facilitate her feelings of comfort.

Our third goal was to reduce the strain that Chelsea was experiencing, as Michelle’s primary caregiver. We planned to accomplish this goal by connecting Chelsea with Alzheimer Society networks that could provide her with support and information after Michelle’s discharge. We also planned to ask Chelsea about her concerns and to answer any questions she had to the best of our ability. Lastly, we planned to engage in patient teaching with Chelsea.

4) Implementation Phase: Our first nursing intervention focused on addressing Michelle’s abdominal pain. We began by evaluating her level of pain by asking her close-ended questions, such as: “Are you in pain?” “Is the pain tolerable?” “Do you need pain medication?” Secondly, we monitored Michelle for non-verbal cues that might indicate pain, such as grimacing and guarding. Michelle’s daughter notified the nursing staff when she thought her mother was in pain, and indicated when she saw her mother guarding her abdomen. This participation by Chelsea helped to enhance our therapeutic relationship with her. Thirdly, we administered analgesics as necessary to alleviate Michelle’s pain. Lastly, we monitored Michelle’s intake and output to determine if she was at risk for another abdominal obstruction.

In order to address Michelle’s agitation, we began by creating and maintaining a daily routine so that Michelle could anticipate her daily activities. We agreed that activities such as eating, bathing, and dressing should be performed in the same order and at the same time every day. We believe that Michelle would feel less agitated if she could anticipate the course of her day. Austin & Boyd (2010) agree with our contention; they argue that making routines as consistent and predictable as possible for Alzheimer’s patients help to reduce their anxiety. Whenever possible, the same care giving staff was assigned to Michelle to ensure continuity of care, in hopes of reducing Michelle’s agitation and making her feel more comfortable. All care giving staff wore nametags and introduced themselves to Michelle as they entered her room so that she could familiarize herself with them.
We arranged for Michelle to engage in meaningful activities offered through various therapists at the hospital. For example, Michelle participated in music therapy. We also asked Chelsea to bring in flowers and pictures to make Michelle’s surroundings more familiar and comfortable. One nurse was assigned to review her family scrapbook with her for fifteen minutes each day. Showing pictures of familiar people to persons with Alzheimer’s Disease also helps with memory retrieval (Austin & Boyd, 2010). We encouraged family members to take Michelle on visits to the hospital atrium to simulate the environment of her greenhouse, which she loves.

Michelle was in the advanced stage in terms of her Alzheimer’s disease and was unable to perform self care independently. Hence, we assisted her in completing the activities of daily living (ADL’s) including: hygiene, dressing, and eating. We turned on her favorite music station via her laptop to increase her comfort throughout the day. We also repositioned Michelle every two hours, as she was unable to complete this task on her own. Lastly, we took Michelle to the bathroom every two hours because she required assistance with this activity.

In order to alleviate the caregiver strain experienced by Chelsea, we focused on creating relationships between Michelle’s family and Alzheimer Society support networks. Fostering such relationships is supported by Linda Watson (2008). Additionally, we encouraged the family to show their love and support to Michelle because humans need to feel a sense of belonging and acceptance (Maslow, 1970).

Michelle’s family members had a number of concerns that we addressed with regard to her post-operative status and her progressive dependence on others to meet her needs. Chelsea was Michelle’s primary care giver and we engaged in conversation with her about her top three concerns (bathing, feeding, and safety issues such as wandering), and provided her with emotional support. Part of our dialogue included answering questions about Michelle’s disease prognosis. We explained that, due to Alzheimer’s disease, Michelle may experience impaired memory and judgment, confusion, depression, and an inability to recognize familiar people (Holland & Adams, 2007). We explained the eventual outcome of the disease. Providing education about the patient’s illness helps to build the therapeutic relationship (Austin & Boyd, 2010), which is advocated by Watson (2008). Michelle’s family actively supported her. During our shifts, we were excited to see that her bedside table was filled with flowers and postcards from her grandchildren saying “Get well, Grandma!”

Our final nursing intervention to address Chelsea’s caregiver strain included expanding our teaching to include the cause, unpredictable progression, signs, and symptoms of Alzheimer’s disease, and information about Michelle’s post-operative condition. We emphasized the importance of developing interventions that minimized her agitation and anxiety (e.g. avoiding noisy environments). Teaching helps family members to understand their roles and involvement required for the adjustment process. Additionally, teaching educates family members about what they can expect as diseases progress, and how to manage their own self-care in addition to that of their loved ones.

5) Evaluation Phase: In order to determine if our nursing interventions were successful in reducing Michelle’s abdominal pain, we asked Michelle closed-ended questions such as “Is your pain better now?” and “Are you more comfortable?”. If Michelle answered yes to our questions indicating she was in less pain, then we considered our nursing interventions to have been successful. Additionally, we also considered our interventions to have had a positive outcome when Michelle demonstrated fewer non-verbal cues that indicated discomfort, like grimacing and guarding. Chelsea assisted us in determining if
we had relieved some of Michelle’s pain by monitoring her mother’s condition throughout the day. We conclude that our nursing interventions were successful in reducing Michelle’s abdominal pain.

We considered our nursing interventions to have been successful in reducing Michelle’s agitation if she did not appear startled when caregivers entered her room, if she was cooperative when the nursing staff worked with her, if her posture appeared less tense, if her face was more relaxed, and if she was not engaging in repetitive movements. The initiation of a daily routine, providing the same caregiver whenever possible, engaging Michelle in meaningful activities, helping Michelle with her ADLs, and making her environment more familiar, all contributed to reducing Michelle’s agitation. Our care plan was successful in bringing Michelle a feeling of calm during her stay in the hospital; the majority of the time, Michelle was relaxed and she even smiled when nursing staff entered her room. Chelsea commented that now that Michelle had a structured daily routine and effective pain management, Michelle’s anxiety and agitation had greatly decreased. Chelsea believed that Michelle was now much happier.

We questioned Chelsea in order to determine if she felt she now had the support she needed to continue to act as Michelle’s primary caregiver. We found that the following were effective in reducing caregiver strain: connecting Chelsea with Alzheimer’s Society support networks, providing her with a person to confide in and council with, including the hospital chaplain, providing her with emotional support, and teaching her about Alzheimer’s disease. Chelsea reported that she now felt hopeful and prepared to continue to act as Michelle’s primary caregiver until Michelle was placed in a care facility. We also discussed the family’s plans to help Michelle adjust to a new location. Overall, we considered our nursing care plan to have been successful because we reduced Michelle’s abdominal pain and feelings of anxiety and agitation, and we provided her primary caregiver with the support she needed.

Summary and Conclusion

In this case study, we have described how we designed and implemented a nursing care plan for an 82 year old female Alzheimer’s patient who was experiencing a small bowel obstruction. We used Watson’s Relational Patient Centered Care Conceptual Model (2008) to guide our planning. Our care plan was constructed in concert with our patient, Michelle, and her daughter, and focused on alleviating Michelle’s abdominal pain, and reducing her anxiety and agitation. Our care plan also focused on reducing Michelle’s daughter’s caregiver strain. We successfully created a therapeutic relationship with Michelle and her family, and our nursing interventions succeeded in addressing all three nursing diagnoses.

In accordance with previous studies by Peplau (1952), Travelbee (1971), and Watson (2008), our study demonstrates the importance of nurturing a therapeutic relationship with patients and their families. Creating this relationship with Michelle and Chelsea allowed us to provide holistic nursing care, thereby addressing more than just our patient’s physical needs. We facilitated the creation of this relationship by including Michelle and Chelsea in the entire nursing care process from assessment to evaluation. We believe creating this relationship allowed us to improve this family’s level of well-being during Michelle’s hospitalization.

Conceptual models can often seem confusing and irrelevant to clinical practice for nursing students and healthcare professionals, alike. However, we found that Watson’s Relational Patient Centered Care Conceptual Model (2008) was clear, applicable, and accessible to our practice. Using this model as a guide, we created a relationship with Michelle and her family, and executed a care plan with them that
addressed their most salient concerns. This model helped us to identify how our experiences with Alzheimer’s disease focused our care on Michelle and on her primary caregiver, as well. Watson’s model (2008) resonated the importance to us, that caring is first and foremost a relationship instead of a list of tasks. Our care plan focused on helping Michelle and her family achieve their highest level of wellness possible within the context of the disease, as advocated by Linda Watson (2008).

Acknowledgements: We would like to thank Linda Watson for her contribution to this project. We are also grateful to Dr. Carole Le Navenec (cllenave@ucalgary.ca) for assisting with the preparation of this manuscript. Lastly, we would like to thank our patient and her family for allowing us to care for them, and to learn from them.

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APPENDIX A: DIAGRAM OF LINDA WATSON’S RELATIONAL PATIENT CENTERED CARE CONCEPTUAL MODEL (WATSON, 2008)

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APPENDIX B: GLOSSARY OF MEDICAL TERMINOLOGY

- **Activities of Daily Living (ADL’s)**: tasks that are necessary for self-care, such as eating or feeding, bathing, grooming, toileting, walking and transferring (Jarvis, 2009).

- **Adhesions**: Abnormal, fibrous tissues that bind tissues and/or organs together; also called scar tissue (Cook, 2010).

- **Agnosia**: loss of ability to recognize importance of sensory impressions (Jarvis, 2009).

- **Aphasia**: loss of power of expression by speech, writing, or signs, or of comprehension of spoken or written language (Jarvis, 2009).

- **Apraxia**: inability to perform coordinated movements (Jarvis, 2009).
- **Diaphoretic**: profuse perspiration (Jarvis, 2009).

- **Distention**: bloating or swelling of the abdomen (Borc, 2010).

- **Edema**: accumulation of fluid in intercellular spaces where it is not normally present (Jarvis, 2009).

- **Instrumental Activities of Daily Living**: functional abilities necessary for independent community living, such as grocery shopping, meal preparation, housekeeping, laundry, managing finances, taking medications, and using transportation (Jarvis, 2009).

- **Necrosis**: premature death of cells and living tissue; either from infection or the interruption of blood supply (Jarvis, 2009).

- **Neuromuscular Functioning**: characteristics and [voluntary] control of muscles by nerves (Byrne, Twist, & Eston, 2004).
UNDERSTANDING RELOCATION STRESS AMONG OLDER PEOPLE IN NURSING HOMES: APPLICATION OF ROY’S ADAPTATION MODEL

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Relocation Stress among older persons refers to any physical, mental, or emotional response to relocate them from the context where they used to live to a new context such as nursing homes. According to Brugler, Titus, and Nypaver (1993), the North American Nursing Diagnosis Association (NANDA) defined a new nursing diagnosis called “Relocation Stress Syndrome” as follows: “a state in which an individual experiences physiological disturbances and/or psychological disturbances as a result of a transfer from one environment to another (p. 45).

The negative influences of relocation stress on the elderly needs further study because they continue to be not fully understood by many health care professionals. (Nay, 1995). Some of the negative effects of relocation stress that have been reported by Komatsu, Hamahata, and Magilv (2007) include: disturbances in cortisol levels among elderly after moving to nursing homes, increased need for antipsychotic medication, feelings of grief and/or confusion, and failure to cope with new environment. Walker, Curry, and Hogstel (2007) summarized the following nine symptoms of relocation stress among older adults who had recently moved from their primary residence to a long-term care facility: “anxiety, confusion, fear, helplessness, hopelessness, indecisiveness, loneliness, suicidal thoughts, suspicion” (p. 2). In addition to these symptoms, other documented symptoms include: gastrointestinal problems, sad affect, sleep difficulties, and weight loss (Kao, Travis, & Acton, 2004).

In order to foster emotional, social and behavioral adaptation to their new nursing home environment, older adults will likely need both a thorough assessment of their initial concerns, and various types of support from staff and family (Burnette, 1986). The purpose of this paper is to give general guidelines on how nursing home staff might use Roy’s Adaptation model of nursing to help the new residents mitigate what is known as Relocation Stress. Using a case-study example to clarify these guidelines is beyond the scope of this paper.

This theory has been chosen because it helps Gerontological nurses to decide what they know and what they need to know about relocation stress, and it helps to provide better patient care (Colley, 2003) by “facilitating adaptation either by guidance and direction or active manipulation of the environment” (Giger, Bower, & Miller, 1987, p. 216). The following section includes an overview of Roy’s Adaptation Model and its application to relocation stress among older adults.

Roy’s Adaptation Model (RAM)

According to Roy’s Adaptation Model (RAM; Roy & Andrews, 1999), people are perceived as a holistic, adaptive systems that constantly change and interact with their environment. The environment has been defined as “all conditions, circumstances and influences that surround and affect the development and behaviour of the person” (Roy & Andrews, 1999, p.81). Roy defined health as a process of being and becoming integrated and whole that reflects the environment and person mutually. Roy and Andrews (1999) emphasize that the overall goal of nursing is to promote adaptation in each of the following four adaptive modes: physiological, self-concept, role function, and interdependence. Adaptation is assessed and measured in both the physiological and psychosocial (self-concept, role function, and interdependence) modes; that is, the physiological mode measures bodily
function; the self-concept mode measures composite of beliefs including spirituality and the feelings that one has of oneself at a given time; the role function measures a set of expectations about how a person functions and relates with others; and the interdependence mode measures the capacity to give and receive love through nurturing relationships.

Whereas Adaptation occurs when the person behaves positively to the environmental stimuli that allow him/her to maintain integrity and self-esteem, ineffective responses decrease integrity and self-esteem and may lead to negative health outcomes (Roy & Andrews, 1999). Roy has categorized the environmental stimuli as focal, contextual, and residual. Focal stimuli are those immediate to a person (e.g., a person needs, level of his/her adaptation, changes within the person him/herself; others; and environment). Contextual stimuli or influencing factors (e.g., social support) are other stimuli that influence focal stimuli. Finally, residual stimuli include the individual’s beliefs or attitudes that may influence the situation.

Human beings adapt with the above environmental stimuli using two processes called regulator and cognator. Regulator processes include physiological adaptive modes such as neural and chemical endocrine. The cognator process includes four cognitive emotional modes (perceptual and information processing, learning, judgment, and emotion) to solve the problem or improve personal feelings (Roy & Andrews, 1999). Adaptation occurs when the cognator and regulator subsystems are stimulated, resulting in behavior changes measured in the four modes of behavior (physiologic, self-concept, role function, and interdependence).

Roy’s model employs a six-step nursing process (Roy & Andrews, 1999, Phillips, 2006, p. 365) that can be applied to elderly people who move to nursing homes and subsequently display symptoms of relocation stress. This nursing process includes:

1. Assessment of any change of behaviour among new nursing home residents as manifested from the four modes of behaviour (physiological, role function, self-concept, and interdependence).
2. Assessment of the stimuli affecting their behavior, and subsequent categorization of the latter as focal, contextual, or residual in nature.
3. Specification of the nursing diagnosis that describes the adaptive status of the older person.
4. Planning Goals with the older person that will promote adaptation. These goals must be realistic and attainable, and the older person must be a partner in setting these goals.
5. Implementation of interventions that focus on changing the stimuli in manner that promotes adaptation.
6. Evaluation of whether the desired outcomes were achieved (e.g., reduction in the physical and psychosocial indicators of relocation stress described on the first page of this article). The step also includes making decisions about the adequacy of the goals that were set, and/or the nursing interventions that were selected to meet those goals. At this point, some specific examples of indicators that the goals and interventions were adequate should be listed to support that conclusion.

In conclusion, Roy’s Adaptation model affords a unique conceptual model that nurses can use to assess relocation stress among older adults recently admitted to a nursing home, and interventions that will mitigate their level of stress and thereby promote adaptation to their new home. It is recommended that nursing students and staff nurses share their experiences in application of a nursing model to their practice setting.
References


DVD: Promoting the concept of personhood in practice (2009). Hamilton, ON: Mc Master Centre for Gerontological Studies. DOI: 10.1017/S0714980810000619
NEW CCSMH RESOURCE!
Guideline on the Assessment and Treatment of Delirium in Older Adults at the End of Life

We're pleased to announce the launch of this new guidelines, which has been adapted from the CCSMH National Guideline for Seniors' Mental Health: The Assessment and Treatment of Delirium.

This Guideline is the culmination of several years of work of many dedicated individuals who have been working tirelessly to review the relevant literature, consult with stakeholders, and create evidence-based recommendations for delirium in older adults at the end of life.

A very special thanks to the development group for these guidelines, particularly Dr. Susan Brainard, David Wright, and Shem Heeding. Additional members of the development group include Dr. Pierre Allard, Dr. Vena Brato, Dr. Laura G shapes, Dr. Pierre Gainon, Dr. David Hogan and Cheryl Sadowski. A full listing of project contributors can be found on our website.

Funding for this project was provided by the Public Health Agency of Canada, Population Health Fund and the Canadian Institutes of Health Research.

As always this resources is available for free from our website. We encourage you to take a look and let us know what you think! And if you get a chance to use these Guidelines in your teaching, training, clinical or administrative work we're always interested in hearing your experiences.

DOWNLOAD A COPY OF THE NEW DELIRIUM AT THE END OF LIFE GUIDELINE TODAY!
CANADIAN MEDICAL ASSOCIATION JOURNAL (CMAJ) :

A new issue of Canadian Medical Association Journal has been made available:
22 March 2011; Vol. 183, No. 5
http://www.cmaj.ca/content/vol183/issue5/index.dtl?etoc

BE SURE TO READ THE EDITORIAL: A federal plan to address seniors’ health and well-being
Paul C. Hebert, Jane Coutts, Matthew Stanbrook, Noni Macdonald, and Ken Flegel
CMAJ 2011; 183 531
http://www.cmaj.ca/cgi/content/full/183/5/531?etoc

Available by contacting Greg Shaw: gshaw@ifa-fiv.org Some illustrative segments from this issue are:

▪ Senior Government Officials (SOM) Reports: Social Inclusion for an Ageing Population
▪ Elder Abuse Awareness Teen Kit
▪ Building the WHO Global Networks of Age Friendly Cities: 1st International Conference, 28 to 30 September 2011, Dublin, Ireland. For more information on the conference please follow this link www.afc-internationalconference.ie or contact the conference office at info@afc-internationalconference.ie

▪ New Law Planned in China to Support Older People (make visits to elderly parents by their children compulsory)
▪ International Perspectives on Ageing and Disability (publication launched in December 2010; info re purchasing a copy: http://www.magcloud.com/browse/issue/141078/follow

▪ New Study Sees Growing Home Health Care as Key to Saving U.S. Billions in Hospital Care

TEACHING GERONTOLOGY, FEBRUARY 15, 2011 Issue
Editor: Harry (Rick) Moody (hrmoody@yahoo.com).
Published by: Association for Gerontology in Higher Education (AGHE) 1220 L Street, NW, Suite 901, Washington, DC 20005 Tel: 202.289.9806
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In this issue:
.....Don't Know Much Gerontology?
.....Teaching Civility
.....Gerontology Class in Residential Facility
.....Population Aging in Japan
.....Web Sites to See
.....Lighting a Fire
DON'T KNOW MUCH ABOUT GERONTOLOGY?

"Don't know much about history
Don't know much biology
Don't know much about a science book
Don't know much about the French I took
But I do know that I love you
And I know that if you love me too
What a wonderful world this would be"

A new book casts doubt on just how much students are learning in college these days. The book, ACADEMICALLY ADRIFT: Limited Learning on College Campuses, has been released by the University of Chicago Press. The authors ask "How much are students actually learning in contemporary higher education? The answer for many undergraduates, we have concluded, is not much."

So write the authors, Richard Arum, Professor of sociology and education at New York University, and Josipa Roksa, assistant professor of sociology at the University of Virginia. For many undergraduates, they write, "drifting through college without a clear sense of purpose is readily apparent." The book cites data from student surveys and transcript analysis showing that many students have minimal expectations about class work and respond accordingly.

It made me wonder: Are we doing any better in teaching about aging? Some major findings reported in the book include the following:

▪ No critical thinking: "gains in critical thinking, complex reasoning, and writing skills (i.e., general collegiate skills) are either exceedingly small or empirically non-existent for a large proportion of students"

▪ Students aren't doing much writing: e.g., fewer than half of college seniors produced more than 20 pages of writing in a course the prior semester
▪ More than a third of all students demonstrated NO significant gain in learning (as measured by standard assessment methods) during four years of college
▪ Comparison with research from earlier decades suggests that there has been a substantial decline in students' work habits
▪ On the positive side, liberal arts students did much better in critical thinking, especially in comparison to those in business, education or social work (what about gerontology? I wondered)

Overall, lots of bad news. What will we be doing about it?

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TEACHING CIVILITY

As a teacher of gerontology, I've taught the subject through "great debates" in which I encourage students to argue for views that may be opposed to others in the class. This approach is very different from an easy-going relativism that shrugs off contradictory views (e.g., assisted suicide, privatizing Social Security) by saying, in effect, "Whatever..." or "Everyone's entitled to their point of view."

Yet debate isn't easy, whether in the classroom or in public life. We've heard much talk in recent weeks about the need for "civility" in our political discourse, especially on topics of intense debate (think: healthcare reform).
But how do we teach "civility?" How do we teaching listening? Philosophy professor Jacob Needleman offers a clue: "In my philosophy classes I make use of what counselors and mediators sometimes call the practice of "mirroring." In that exercise two people holding passionately opposed opinions about an important issue debate each other under the following strict condition: they can express their views only after they have faithfully summarized what the other has just said. I treat this exercise not so much as an instrument of reconciliation, but mainly as a means of studying and understanding what it really means to listen to another human being. The result is often nothing short of miraculous, even to the point of bringing tears to my eyes."

For more on Needleman’s distinctive approach, visit: http://jacobneedleman.com/blog/

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……GERONTOLOGY CLASS IN RESIDENTIAL FACILITY

David Steitz, who heads the Gerontology Program at Nazareth College in upstate New York, teaches an upper-division class on "Issues in Aging." At many institutions his class would be held on campus, but Prof. Steitz teaches his 22 undergraduate students at St. John’s Meadows, a local independent living campus. 13 resident elders from the facility attend his class each week, offering a unique intergenerational approach to gerontology education. For more on the Nazareth class, visit: http://blogs.naz.edu/braveman/2010/03/index.html

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…… POPULATION AGING IN JAPAN

Standard and Poor's has downgraded Japan's credit rating because of its rapidly population aging. S&P issued this statement: "Few countries share the acute aging problems of Japan... (with) the world's highest median age, 9Japan) lacks clear policy measures to tackle its long-term demographic problems. Barring structural changes in old-age related government spending, Standard & Poor's Ratings Services believes that a rapidly graying society will lift expenditures. This, in turn, threatens to weaken the sovereign ratings on Japan in the long term... It is important that Japan start structural adjustments of major age-related expenditures, such as public pension funds and old-age medical insurance programs, to reduce costs.
For details, visit:

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……WEB SITES TO SEE

WELFARE STATE. The International Journal of Aging and LaterLife (free on-line periodical) has a special issue on "Ageing societies and the Welfare State," with articles exploring work, retirement, and caregiving in welfare states. Available at:
http://www.ep.liu.se/ej/ijal/

UNEMPLOYED OLDER WORKERS. Read "Can Unemployed Older Workers Find Work?" by Richard W. Johnson and Janice Park at:
http://www.urban.org/publications/412283.html

SOCIAL SECURITY. For a report on public opinion trends on the
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…..LIGHTING A FIRE

"Education is not the filling of a bucket but the lighting of a fire." William Butler Yeats

END OF EXCERPTS FROM TEACHING GERONTOLOGY

RESEARCH: BELIEFS ABOUT ALZHEIMER’S DISEASE

While much is known about people’s beliefs about aging, beliefs about one age-specific disease, Alzheimer’s disease (AD), have been largely overlooked. In a study conducted at the University of Alberta, students completed a newly developed beliefs questionnaire designed to assess beliefs about aging and AD in the cognitive, social and physical domains. Students characterized AD by losses in the cognitive and social domains and gains in the physical domain. Students’ ratings indicated that AD is a disease of the mind and that, in comparison to normal aging, physical prowess is enhanced in AD. These findings – perceived gains in the physical domain and losses in the social and cognitive domains – advance our understanding of beliefs about AD.

Read more in:
**UPCOMING EVENTS**

**28-29 April 2011 AGNA Conference: Gero Nursing - A community of services**, Radisson Hotel, Calgary, AB. Info and registration (only $90 for members and $50 for students): www.agna.ca (click on Conferences and AGM)

**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: 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:**  
16TH NATIONAL CONFERENCE ON GERONTOLOGICAL NURSING  
Delta Meadowvale Resort and Conference Centre, Mississauga Ontario.  
INFO: www.cgna.net

http://www.alz.org/icad/icad_abstracts.asp or Email: icad@alz.org

**October 21-23, 2011**  
Canadian Association of Gerontology 40th Annual Scientific and Educational Meeting, "New Directions for Aging". Ottawa, Ontario. Info: contact@cagacg.ca

**November 7, 8, & 9, 2011: Health Achieve,** Metro Toronto Convention Centre, Toronto, ON  
With an expected 50 educational sessions and 250 speakers of the highest quality, this year’s Health Achieve will again be the largest event of its kind in North America. For delegates, the singular opportunity is to Engage, Recharge, Focus, Network and Expand with the best and brightest health care leaders. For exhibitors, the decision to attend is strictly business – and we are working harder than ever to get them the results they demand. Info: www.healthachieve.com

**October 4-5, 2011 RESEARCH DATA CENTRE Conference - Call for Abstracts**  
2011 RDC CONFERENCE "Coming of Age: The Policy Impact of an Aging Population"  
Sutton Place Hotel, Edmonton, Alberta Pre-conference workshops : October 3, 2011  
The Research Data Centre at the University of Alberta invites researchers from any discipline to present their research findings at the Canadian Research Data Centre Network's ninth annual conference on the theme *Coming of Age: The Policy Impact of an Aging Population*. Proposals for oral presentations,
symposia or posters on any issues related to aging, older adults or intergenerational relationships are welcome. Topics include, but are not limited to: social, economic, mental or physical health and well-being; employment; older workers; retirement planning and retirement transitions; family and social networks; grandparenting; special populations such as aboriginal and immigrant seniors; healthy aging; aging well/well-being in later life; aging with mental illness; public health implications of population aging; caregiving; built environments for an aging population; driving and other transportation needs; age-friendly communities. All presentations should address the policy and/or practice implications of the findings.

Preference will be given to papers based on RDC data and research focusing on issues of concern to Canadian decision makers and practitioners, but other empirical or synthesis papers are welcome. While papers need to meet high disciplinary standards, the presentations must be understandable to those outside the presenters' discipline(s) and to decision makers outside of academia. Graduate students are encouraged to submit abstracts, and to take advantage of pre-conference training activities.

Abstracts should specify the type of presentation being proposed (oral presentation, symposium or poster) and include the title, author(s) name(s) and affiliation(s), contact information (mailing address, telephone number and e-mail address) for the presenting author, and 300 to 500 words describing the presentation's objectives, rationale, methodology, preliminary findings and policy and/or practice implications.

Proposals for symposia should submitted as a package that includes name(s) and contact information for the proposer(s), a brief description (approximately 200 words) of the overall objectives of the symposium and abstracts (see above) for each of 3 to 4 papers to be presented. Symposium organizers are encouraged to identify a moderator and/or discussant for their symposium.

Abstracts should be submitted electronically to Dr. Janet Fast at rdcconf@library.ualberta.ca by April 30, 2011. Authors will be notified about the selection of papers by May 30, 2011. Questions should be directed to Dianne Kieren, Conference Co-ordinator, at rdcconf@library.ualberta.ca.
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<th>Advertisement Type</th>
<th>Rates</th>
<th>Submission Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newsletter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/4 page : 1.875&quot; x 2.5 &quot; (5 cm x 6.5 cm)</td>
<td>$100 + GST</td>
<td>All ads must be camera ready in digital format, i.e. Postscript, TIFF, High Resolution PDF</td>
</tr>
<tr>
<td>1/2 page: 7.5&quot; x 5&quot; (18.75 cm x12.5 cm) OR 3.75&quot; x 10&quot; (9.37cm x 25cm)</td>
<td>$200 + GST</td>
<td>Send advertisements and invoicing information to CGNA Project Manager, Sharon Leung, at <a href="mailto:sharon.leung@malachite-mgmt.com">sharon.leung@malachite-mgmt.com</a></td>
</tr>
<tr>
<td>3 /4 page: 7.5&quot; x 7.5&quot; (18.75 cm x 18.75 cm)</td>
<td>$300 + GST</td>
<td>Following the Editor’s approval, you will be sent an invoice, which is payable upon receipt, with a cheque made out to CGNA</td>
</tr>
<tr>
<td>Full Page: 7&quot; x 10&quot; (18.75 cm x 25cm)</td>
<td>$400 + GST</td>
<td>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.</td>
</tr>
<tr>
<td>Email List Serv: for each mailing</td>
<td>$100 + GST</td>
<td>All postings to the listserv, emails, and web postings must include the following disclaimer: “Senders(s) or poster(s) opinions are their own and do not necessarily reflect the views of the CGNA”</td>
</tr>
<tr>
<td>Website Advertisement</td>
<td>3 months $200 + GST</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 months $700 + GST</td>
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</tr>
</tbody>
</table>

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