

THE CANADIAN GERONTOLOGICAL NURSE



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PRESIDENT'S MESSAGE



I would like to begin with a passage:

We are in the midst of a paradigm shift. Everything we have known and come to value and expect in our world is undergoing significant modification. There is nothing in our surroundings and in each individual person that is exempt from dramatic transformation. Driven by technology and the proliferation of information, every aspect of human life is being altered and new kinds of understanding and implications are emerging from the center of the change vortex at a rate that prevents deliberate response. Trying to adapt quickly leaves little time to explore what the changes mean and to discern where they are taking us. Unfortunately, understanding the forces unleashed is a work in progress. The best any of us can do is identify the signposts of the journey and agree to travel together.

(Tim Porter-O'Grady, 1995)

Well, it is over a decade since Porter-O'Grady wrote those words, and I'd say we're still shifting, even the sign posts seem at times to be written in a language not easily understood BUT working together remains a key factor in succeeding ... I do not agree however, that we are prevented from making a deliberate response! We must lead **NOW** with a deliberate response.

Negotiate Opportunities with Wisdom

We can no longer be invisible; gerontological nurses must step forward and grasp their leadership potential; be a solution for health care aging issues that are facing our country today and prepare to be a solution in the future. It is our time to shine: locally, nationally and internationally.

Negotiating opportunities with wisdom is not a simple matter but many great leaders have found a way. In the words of **Colin Powell**, "**Great leaders are almost always great simplifiers, who can cut through argument, debate, and doubt to offer a solution everybody can understand.**" We can deliberately cut through the current day arguments with our knowledge and skill to offer our version of healthy aging. There are many facets to aging – new insights are needed, a doom and gloom attitude toward an aging population can stop with us. As individual gerontological nurses and as nursing organizations we have the ability to make choices, to be intentional, and on fire for what we want.

Persistent negotiating to turn challenges into opportunities requires leadership. Vivacious, strong, well-prepared and informed gerontological leadership is within our membership but we need more of you to take up the cause. **John Buchan said, "The task of leadership is not to put greatness into people, but to elicit it, for the greatness is there already."**

We all have our individual philosophical beliefs about leadership, what are yours? And do your beliefs about leadership help or hinder your ability to take charge, become empowered?

I want to emphasize authentic leadership (Shirey et al. 2006). An authentic leader is an individual in a position of responsibility. Please note—**position of responsibility**—not a role or job description. Not me and none of you, no one is exempt from professional responsibility. Think about the Registered Nurse assisting an individual to sit-up to take their medication; a Licensed Practical Nurse explaining a blood pressure reading to a family member; a Registered Nurse talking to a student nurse about a dressing change technique; a Registered Nurse visiting a group of older adults at a recreation center to talk about falls prevention. There are small and grand responsibilities but responsibilities nonetheless that require thinking and action on the part of a nurse. We hold professional responsibility for the practice situations we are involved in; this responsibility is not dependent on a role or job title we hold at any given time.

An authentic leader is a person that has the attributes of genuineness, trustworthiness, reliability, compassion, and believability – the public believes nurses have these attributes—I believe these attributes are the hallmark of gerontological nursing. Authentic leaders are described by Avolio (2004) and George, (2003) as individuals who are deeply aware of their own and others' values/moral perspectives; they have knowledge and strengths, and they are aware of the context in which they operate. These are individuals who are confident, hopeful, optimistic and resilient; they are capable of establishing enduring relationships. According to George (2003) authentic leaders get to know the life stories of those with whom they work and care for by cultivating mentoring relationships.

Gerontological nurses across this country share a connectedness as we work toward common goals. Authentic leaders have purpose and passion; our purpose in gerontological nursing is to address the health concerns of older Canadians. We take account of political, economic and social conditions that surround us. We must view ourselves positively in order to move from passivity to active participation, to challenge the *status quo* and reject oppressive ageist attitudes. **Nelson Mandela reminds us: “It is what we make of what we have, not what we are given, that separates one person from another.”** So you see, as gerontological professionals with a specialized body of knowledge, standards of practice, and caring relationships, the attributes of authentic leadership are ours and if you feel they are not yours, you have the choice to make them yours.

Wisdom involves seriously considering what types of social change are feasible at this time, and what preparation is necessary to build the argument for change. Gerontological leaders must also determine what social change is desirable for older people and the nurses who work with them. This requires discernment to know when and how to act so that our efforts achieve change. This is a socially and professionally responsible way of being, one in which we can all take a pro-active approach. If we don't, the alternative is to take the path of least resistance and accept the *status quo*. In taking the path of least resistance we fail to question what is happening to the health care system, to older people, and to ourselves as people and gerontological nurses collectively. Another words, we knowingly or unknowingly become complicit. In being deliberate **Muriel Strode reminds us, “Do not follow where the path may lead. Go instead where there is not a path and leave a trail.”**

If we are not deliberate in our approach, we will most likely be reactive, complacent perhaps, frustrated no doubt, and tired for sure—the danger is we will lose hope and faith in our ability to make a difference even in small incremental ways in the health care system and in ourselves as professional practitioners. We have to learn the skill of asking questions, or to say, ‘enough’!

Leadership is timeless but people who lead must change with the times—we must change not only the way we think but also the way we act—to act requires competencies but competencies must be combined with knowledge of our times. As gerontological nursing leaders we need to develop participation and interpersonal competencies. We must have competencies in negotiation and mediation—we are often advocates for the frail, disempowered older person and their aging family members. Facilitation skills aid in directing processes that help show what is necessary for improving care and service for older people. Coaching is a must in order to help older people and their family members take charge. Gerontological leaders must also take care of our discipline with these competencies. I challenge each of you to find one other nurse who you can coach in the fine art of gerontological nursing principles of care; find someone to light on fire, a person (man or woman) who you can mentor in the profession.

What will it take? We can wait to be pressed into options? Or we can lead our own way through the chaos and obstacles by stepping forward. If we negotiate opportunities with wisdom we have a better chance of becoming part of local discussion and decision-making processes; we can make our own contributions to change society in small ways that will grow into big ways. We have to write a new script for ourselves – we are the leadership stewards of our future.

“Opportunities do not wait for readiness; they have their own timetable. The good strategist sees opportunities approaching and anticipates them. There is rarely time to adapt and prepare all the variables to accommodate an opportunity. What usually happens is that the opportunity creates demands where they did not formerly exist. It requires people to stretch their readiness and skills to the limit, challenging them to adapt old process to new realities.” (Porter-O’Grady, 1995, p20)

Think to the future; discern what is most important at this time—what will build leverage and sustainability—to do this requires that you reflect on your practice—what will give you wins quickly. Look for quick wins as gerontological nurses and participate in quick wins for our collective voice.

“You’ve got to think about big things while you’re doing small things, so that all the small things go in the right direction.” Toffler

Working together is a possibility open to all of us. The Canadian Gerontological Nursing Association realizes that partnerships are an imperative in our aging world—collaboration is needed but more importantly, it is cooperation that extends our abilities to influence and change the status quo—this is leadership-in-action. We have reason to be together, work together and stay together.

What does the future hold? The answer, no one is certain but opportunities and great joys are real possibilities as are challenges and risks. Innovation and leadership are essential because we already have an incredibly knowledgeable and informed group of gerontological nursing experts to maximize care for older people across health care settings. So, leap, reach, grasp, take and create opportunities because you can decide to do so with wisdom and grace NOW. You are today’s and also tomorrow’s gerontological nursing leaders. Open up to surprises—they are opportunities for new ideas – by all means consider options but don’t get stuck in over analyzing the benefits and burdens, these are always present. Refresh yourselves and your commitment to gerontological nursing NOW. Believe in yourselves as leaders, see yourselves as leaders, and act on your vision for gerontological nursing NOW.

(This message has been adapted from the closing plenary address given by Dr. Parke titled, **Gerontological Nursing: Our Time to Shine is NOW**, at the *Older Adults: Maximizing Care Across Health Care Settings Conference*, Newfoundland June 4th and 5th 2008)

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PRESIDENT-ELECT

This has been a very busy year for me as the President-Elect for the CGNA. The Executive have regular meetings by teleconference, with very frequent email and phone conversations occurring in between the meetings. The CGNA also has regularly scheduled board meetings by teleconference. One priority for me this past year was to find a new Webmaster due to the retirement of our previous Webmaster. This also presented the opportunity to review and update our website. This is still a work in progress and I would very much appreciate feedback and suggestions. Provincial associations are also encouraged to post contact information and their provincial application form under the Province links. If the province has a website this can also be linked under the provincial title and some provinces have already implemented this linkage with the CGNA website. We were very fortunate to be able to award 3 additional Ann C. Beckingham bursaries this year and I thank the members that assisted in the award process. My most recent project has involved ensuring our list serve is up to date. This is a very efficient way of communicating with our members. Within a few minutes of sending out some information I can have feedback from four different provinces and I can respond to their emails quickly. Another important communication tool is the questions that people send to our website. I am looking for assistance with responding to the email questions and I am presently in the early stages of putting together a list of "experts" to help me respond to the questions. An example of a question was related to incontinence from someone working in the country and I was able to hook her up with an expert in that area. A second question that has come up several times relates to CNA certification supports. If you would be willing to participate and feel that you have some expertise to share, I would be happy to hear from you at blaurila@sogh.mb.ca. The Executive is very excited about our retreat which is planned for Sunday June 15th, 2008. This will be an opportunity for us to meet and work together in person. This is a special year for nurses because we are celebrating our 100th Anniversary. I will be taking advantage of the opportunity to attend the conference while in Ottawa. I am a big country fan and I especially excited about Paul Brandt performing at the banquet. We will work hard, learn lots, network and play a bit. It doesn't get much better than this.

Respectfully submitted by Bev Laurila President-Elect

TREASURER'S REPORT



Membership numbers are stable overall, even increasing. Saskatchewan has seen a boom. I hope they can share their strategies. One province is having difficulties with recruitment and retention. The membership structure of CGNA will be under scrutiny in the coming year as members have voiced their wish that CGNA be inclusive to all nurses. This will be a major undertaking. Stay tuned.

The 2007/2008 Year-End Audit has been completed. The CGNA is a fiscally viable non-profit organization. There are changes to the categories of this year's report. Expenses paid to the board and executive are now transparent. Support for certification will be discussed at the AGM. Network and partnerships is a new expense line but not a new activity. As one of many national and international groups with similar goals, costs arise from establishing and maintaining relationships. Costs include travel to meetings, registration fees, activities, and events. In past years, expenses were included under a general category such as travel. As opportunities arise for our participation and influence, we make difficult decisions on which projects and groups to support. Political advocacy and research represent other important aspects of CGNA. Telecommunications costs continue to rise with the number of ongoing projects and an increase has been accounted for in the budget.

The Biennial Conference hosted by Winnipeg in 2007 was a success. Without conferences, CGNA will always show an annual deficit. Conference profits are intended to be split over two years to cover the deficits. We currently have a healthy surplus. Seed money has been loaned to the 2009 Banff Conference which will be returned in 2009 and then forwarded to the 2011 conference. The 2007 Conference also raised and donated another \$2,000 to the Memorial Scholarship fund.

Last year, \$25,000 was awarded in Ann C. Beckingham Memorial Scholarships and \$4,546 was spent for a breakfast promoting the fund at the 2007 Winnipeg Conference. This fund continues to grow and there is a final dispersal yet to be received. The Fund is now invested in GIC's and is easy to manage with no investment fees.

If members would like more explanation or details of my report or if you would like an electronic copy of the auditor's report, please e-mail me and I will reply to you directly. I intentionally omitted the details since this newsletter is posted on the internet.

Respectfully submitted by Denise Levesque, June 7, 2008

NOTE FROM THE EDITOR

Happy summer everyone! As your editor I hope you will take time to relax, to travel and to reflect and also send me your news about research, about conferences you have attended, about new programs that you have heard about for our next issue. Let's try and focus on one major theme for each issue. What would you think about September's theme being on "How do we attract students and new graduates into the area of gerontological nursing? You will note that in this issue there is a feature article by a new graduate, Sonya Kreamer (skraemer58@hotmail.com) entitled "From Novice to practicing nurse: How a new grad became a gerontological nurse." Would you please distribute this article to all new grads and students and invite them to submit a similar article.

Please take note also of the other feature articles in this issue. I would appreciate hearing from you about your interest in these and related topics.

I would need your submission for September 1st. Please send it to cllenave@ucalgary.ca

ANNUAL GENERAL MEETING: TUESDAY, JUNE 17TH 2008

It has been an exciting year for CGNA. Much has been accomplished and I am grateful to the CGNA members who have devoted their time assisting with advancing our mission and mandate. The executive team has devoted much attention to addressing current day issues that affect us as an organization. These issues revolve around four major themes:

- Infrastructure and organizational systems and processes
- Sustainability of the organization
- The image of gerontological nursing/nurses
- Preparation of future nurses in gerontological knowledge and skills

I will try to highlight some of the important initiatives from this past year (June 2007 to June 2008) as they pertain to these themes.

The by-laws that were passed at the last AGM were initially denied Ministerial approval but have now been amended and approved. These by-laws will be undergoing further revision in the months to come to support the 2007 membership motion to open CGNA membership. Activities are underway to address membership expansion.

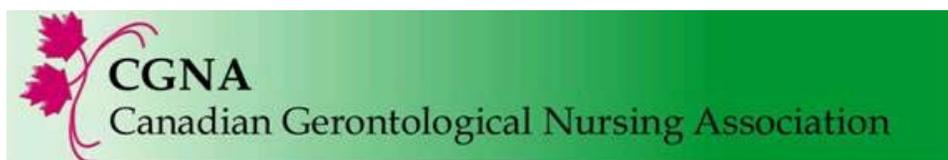
CGNA and the National Gerontological Nursing Association (NGNA) have completed the joint position statement, *Prescriptions for Excellence in Gerontological Nursing Education*. This document is available on the CGNA website; a dissemination plan is in progress. We hope to have other conversations with NGNA regarding review and possible revision of our standards of practice document. This would be in keeping with our vision of an International Gerontological Nursing Federation.

This year also saw CGNA website development; updating of the listserve; our collaborative networking and partnering relationships are growing (i.e., Canadian Geriatric Society, NICE, NGNA and the Gerontological Nurses Association in Ontario). We've realized a growth in scholarship funding, and the renewal of our research focus beginning with the Institute of Ageing to promote our research, practice and education agenda.

Work and attention to addressing Revenue Canada; Industry Canada/Corporations Canada; Registered Charities rules, regulations and documentation requirements has strengthened our infrastructure in order to meet government requirements. More work is needed as this must tie into a larger vision of our business practices, membership needs, and vision for service.

The future will see more attention to the four themes. The future is bright for gerontological nurses. Attention needs to focus on the sustainability of our organization. This will be a focus in the months to come. I am grateful to the executive team for their due diligence in addressing the issues that face the organization—everyone played an important role.

Dr. Belinda Parke RN MScN GNC(C)



PRESCRIPTIONS FOR EXCELLENCE IN GERONTOLOGICAL NURSING EDUCATION

CGNA is pleased to announce the position paper that it developed in partnership with our colleagues in the United States is available on our web site (<http://www.cgna.net/>).

We encourage you to review it, talk about it with your nursing colleagues, and help us to move forward to ensure that every nursing student is informed about the health and wellness needs of older adults.

Submitted by Dr. Sandi Hirst, RN, PhD, GNC(C), Past President

NARRATIVE ANALYSIS ON HEALTH PROMOTING THEORY-BASED RESEARCH VERSUS EVIDENCE-BASED PRACTICE.

By Liz Ilczaszyn RN, GNC (C), BSN student(liz@gederbycentre.ca)

Editor's Note: We really appreciate that you would send us an article on the one of your major papers you did. Congratulations on receiving a CGNA Scholarship in 2007 and for soon to be receiving your BSN. Please consider send us more articles in the future.

Evidence is information acquired through scientific evaluation of practice. Decision making in nursing is influenced by evidence and also by individual values, client choice, theories, clinical judgment, and legislation and practice environments. (Canadian Nurses Association (CNA) 2002). This narrative looks at the way that Evidence Based Practice (EBP) enables or constrains theory based nursing practice.

Walker, (2003) tells us “the assumption is that EBP will result in best practice”. One must ask: Best practice for whom? Our current healthcare system is dominated by economic resources and fiscal viability. Is the quality of EBP dependent on the finances available? Some years ago I attended a workshop where the clinical nurse specialist informed the class that instead of bathing elders every week it should be every two weeks as bathing causes dry skin. This was supposedly based on the evidence at the time. My colleagues at work laughed at my naivety and informed me that it costs less in manpower to bathe residents every two weeks. I continue to question the evidence which practice is based on and what constitutes reliable knowledge. It is my professional responsibility to do so.

The Theory of Nursing as Caring (Boykin & Schoenhofer, 1993) is a grand theory of nursing. It focuses on living caring rather than on achieving an end product. I will examine if this theory and EBP work relationally using the philosophical perspective of phenomenology. Forbes (2003)reminds us that “EBP is about two things: answering specific clinical questions with and for individual or groups of patients, and the way that health professionals access and use the knowledge available to answer those questions.”

EBP provides guidelines for nurses to follow when doing assessments, deciding on interventions and care planning for the resident. It does not appear to be individual focused. The nurse must use her critical thinking skills and knowledge to adjust the practice to meet the needs of the individual and must state her own evidence for deviating from EBP. Pre-conceptions of situations constantly need adjustment if we are to uncover an understanding of the lived experiences of people and provide care through a phenomenology lens. This may put the nurse in ethical dilemma if the employer demands care based on EBP.

The philosophical underpinnings of the theory of Nursing as Caring are based on Meyeroff's (1971) caring ingredients: knowing, alternating rhythm, patience, honesty, trust, humility, hope and courage. The theory is based on the assumption that all persons are caring and that nursing exists when the nurse actualizes personal and professional commitment to the belief that all persons are caring. If this aspect is in place, then the foci of health and environment will be part of the caring process. The reason for the theory is to guide and improve nursing practice. This theory does not support the nursing process because the nursing process is problem orientated and relies on practice to guide the solutions. Nursing as Caring relies on the caring nurse to bring her knowledge and expertise to the nursed in a caring situation, which will enhance personhood, which will lead to the appropriate outcome.

EBP definitely constrains the theory of Nursing as Caring if they each stand alone. If we look at the theory as a grand theory attempting to answer the question of what nursing is, and we know that the profession is constantly evolving then it may be appropriate to merge EBP with the theory.

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FROM NOVICE TO PRACTISING NURSE: HOW A NEW GRAD BECAME A GERONTOLOGY NURSE.

By Sonya Kraemer, RN, BSN, ACRN (US)

Two years ago I graduated from nursing school with a BSN and began to work in the field of geriatric nursing. My transition from a novice to practicing nurse was supported by entry into the pilot project for the Gerontology Nursing Initiative for New Graduates coordinated by Dr. Jennifer Baumbusch for Vancouver Coastal Health Authority. This innovative program focused on new graduates interested in working with the older adult population. A series of educational workshops provided ongoing learning to support the integration of standard nursing skills and assessment specifically for older adults. Working as part of a nursing team allowed me to develop a relationship with my clients and my colleagues. Having a regular line was a key factor in my transition from novice to practising nurse: I needed the structure and routine of work to apply my knowledge and assessment skills. I gained confidence with experience on the floor, at the bedside, and as part of a nursing team. Two years later, I am a gerontology nurse.

Academic Preparation

On reflection, my entry to gerontology nursing practice began when I entered the School of Nursing (SON) at the University of British Columbia. All undergraduate nursing students are required to take a course on gerontology nursing with both an academic and clinical practice component; this course provided an introduction to older adult population from a nursing perspective. In addition, I found a role model in one of the clinical field instructors who had extensive experience in medicine and a passion for geriatric nursing. Discussions with this nurse provided insight to the diversity of nursing opportunities in this field. The SON supported my growing interest in geriatric nursing: for example, by a clinical rotation in home nursing and another in community public health where I developed a nutritional education program for seniors. I also had the opportunity to shadow a geriatric nurse specialist on a Geriatric Outreach Team. My last clinical placement was on a geriatric acute medicine unit also known as the Geriatric Assessment and Treatment Unit (GATU). Though my nursing program provided the introduction to geriatric nursing, my experience working with the nurses on GATU also made a difference: they were welcoming of new grads, had excellent professional practice standards and a passion for their work. Thus, my academic and clinical rotations created a desire to work in gerontology nursing.

Gerontology Nursing Initiative For New Grads

I was able to obtain casual work and then temporary part-time work on that same geriatric acute medicine unit; however, I was advised most permanent positions are given to nurses with their Gerontology Nursing Certification and two years experience. Therefore, the Gerontology Nursing Initiative for New Grads was just what I needed: an opportunity for permanent employment with older adults and support to develop specific knowledge and skills for this population as I gained experience by working on the floor.

In the Gerontology Nursing Initiative, new grads were to work in different areas to gain exposures and experience; for example, Transitional Care Unit, Residential Care and Community. It was during my second placement that I found my “home”: it was a residential floor on a complex care facility within the health authority. Again, it was the attitude of the nursing team and the professional care given to residents which drew me to the unit. I have not worked in other complex care facilities; therefore, I cannot describe what it is like elsewhere. I can say, however, that I believe the range of supports and services available to staff and residents reflect my ideal nursing home.

Teaching Nursing Home

Residential care facilities, often called nursing homes, can never be a real home but we can strive to provide elements which we identify with “home”. I believe my workplace reflects the values consists with my own definition of a teaching nursing home: a complex care facility which supports resident autonomy and quality of life within a home-like environment and consistently provides a high quality of professional nursing care utilizing evidence-based nursing knowledge and caring as displayed in a compassionate and respectful relationship with clients from admission to end-of-life. We are able to provide this care with RNs and Care Aides who work as a team. Care Aides are also supported with educational workshops to develop their knowledge of older adults and how to deal with challenging behaviours. Both RNs and Care Aides work together on the floor and laughter is often heard.

Our residential facility is directly behind an acute care facility and shares resources commonly found in acute such as a clinical wound and ostomy nurse specialist, a nurse educator with a clinical teaching lab in the building, a geriatrician physician, social workers, a dietician, physiotherapy, occupational therapist, speech-language pathology therapist, an activity worker, an IV team, and a pharmacy in the building staffed by pharmacists who have experience working with older adults. Thus, nurses are supported in their ability to maintain quality of life and provide end-of-life care as they deal with the increasingly complex and challenging clients in residential care.

Working in this facility provided insight to what is possible. Supporting nurses within a residential facility should reduce the cost to an acute facility and stress to residents. By having residential RNs do IVs and blood transfusions, residents stay in familiar surroundings. Sharing clinical resources such as wound and ostomy nurse quality of care supports nursing interventions to prevent deterioration and transfers to acute. In my view, this results in both cost-effective and client-centred nursing care.

Attitudinal Barriers

On reflecting on gerontology nursing, I wonder if ageism and sexism are two major barriers to recognition of the professional scope of practice by nurses working with the older population and the limited financial resources available. Is it time to have

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geriatric nursing as a mandatory educational component for undergraduate nursing programs in Canada? If the nursing profession requires maternity and paediatrics in an undergraduate program, why omit the older population?

In Canadian society, it was the older population who advocated and brought into being our universal medical system; their taxes have paid for our health care system. However, now that they are old, I perceive their needs are not acknowledged by our society. I am left with the impression that retirement seems to signal a moving out of the mainstream of society; our culture tends to identify us with our work: we are the plumber or the secretary. I have observed that older adults no longer have this identity with strangers; they are simply an old person. The older adult appears to become invisible as government cut-backs remove home care services that allow them to live independently in the community and the number of publicly funded long-term care beds remains inadequate. We need to ask ourselves if this is a reflection of ageism in our society.

Though nursing remains open to both genders, I note that women still dominate this profession. Both as nurses and women, we should support education and resources for older adults. It is common knowledge that women tend to live longer than men, thus we are more likely to be working with older women. Therefore, I consider geriatric nursing care as a form of feminist practice; it is about empowering clients by working collaboratively and validating their intrinsic worth. When we advocate for our older population, we are also advocating for women and, ultimately, for ourselves.

There's Something Different About Gerontology Nurses

I believe there is something different about those who choose gerontology nursing. The nurse-client relationship is significant: we are nursing not just our client but often their family too, especially with end-of-life care. Clinical assessment skills are used daily as we monitor for subtle signs and symptoms indicating changes in medical conditions. There is a great deal of autonomy and trust in our nursing judgement as physicians are not always present and they rely on us to call them when needed. We advocate for our clients, ensure they are treated with respect and dignity, and strive for the quality of life we would wish for ourselves.

In the Future

When I look back, I can see my transition from novice to practising nurse. When I look forward, I see the possibility of becoming an expert nurse. To reach that goal, I will continue working on the floor and develop competencies with self-directed learning such as online courses. I will be studying for the Gerontology Nursing Certificate exam in spring 2009. The Gerontology Nursing Initiative opened the door for me to join the community of nursing and to develop professional standards of practice within the older adult population. I hope other new grads will have the same opportunity: I look forward to seeing them on the floor!

NB: for more information about the Vancouver Coastal Health Authority Pilot Project entitled the Gerontology Nursing

INFLUENCES OF CONTEXTUAL FACTORS ON CHINESE CANADIAN SENIORS' DIETARY PRACTICES

Xianmei Meng, BScN, MN, and Tam Donnelly, BscN, MScN, PhD
Associate Professor, Faculty of Nursing, University of Calgary, Alberta.

The purpose of this qualitative study was to explore from the perspective of Chinese Canadian seniors the influence of contextual factors (such as cultural, social, historical, and economic factors) on their dietary practices. The ultimate goal is to increase the health care professionals' awareness and understanding on how to provide culturally appropriate and effective health care that meet the elderly Chinese immigrants' dietary needs, including planning nutritional health promotion programs.

Method

Theoretical frameworks used to guide this study were the PRECEDE-PROCEED model (Green & Kreuter, 1991; Green, Kreuter, Deeds, & Partridge, 1980) and Kleinman's explanatory models (Kleinman, 1978; Kleinman, 1980). Moreover, the essential concepts of ethnography (e.g., focus on culture, cultural immersion, and reflexivity) were also considered when design this qualitative study because it provided a contextual understanding of cultural behaviours and the relationships (Roper & Shapira, 2000). The selection criteria included Chinese Canada seniors who: are 65 years of age or older; can communicate in English, Mandarin, or Cantonese; live in their own home; and are involved in decision-making regarding their diet, even when there are other persons who help purchase and prepare foods.

By using the convenience, purposive, and snowball sampling, 5 female and 5 male Chinese who ranged in age from 65 to 88 participated in the study. These participants were varying with different backgrounds, such as birthplace, marital status, the length of living in Canada, yearly family income, physical status, etc.

Data Collection and Data Analysis

In-depth interviews using a semi-structured questionnaire were used as a main method of data collection. The understandings of literature review and the theoretical frameworks constituted the basis of the open-ended questions asked during the interview of approximately 1½ hours. The first author collected data at the homes of the participants or at the location where participants felt convenient. An interpreter was used when it was necessary. All interviews were audio taped with the permission from participants and subsequently translated and transcribed verbatim to facilitate data analysis. The data collected also included socio-demographic information, an eco-map (Hartman, 1978), as well as field notes from interaction with participants and informal observation (Morse & Field, 1995).

The data collection and data analysis occurred concurrently. As suggested by Carspecken (1996) and other researchers, three main steps were considered in data analysis: coding, analysis, and interpretation. Recoding was done in each transcript in order to find

more relevant code and revise code categories. Furthermore, comparing the code categories from different transcripts and examining the relevance of data coded in one category to that in other categories resulted in a systematic and rigorous development of code categories and subcategories. Finally, the analytic interpretations and questions were discussed with participants in the second interview to ensure the study's rigour and credibility. Ten participants attended the first interview, but two participants refused the second interview because of busy schedules.

Findings

Three main themes were identified in this study: (1) cultural influences; (2) influences of family members, peers, and health care professionals and services; and (3) biological changes, psychological health, accessibility and availability of traditional Chinese foods, and financial issues (see Table 1).

Cultural beliefs and values were strong determinants in shaping how the elderly Chinese participants define an appropriate diet for seniors, improve their diet, and obtain health information. Furthermore, the cultural beliefs and values exerted both positive and negative influences that contributed to the elderly participants' dietary practices. For example, unhealthy childhood dietary habits and dietary beliefs may prevent the elderly participants from consuming a healthy diet.

Consideration of family members' dietary needs was addressed by most participants. Many considered their children's dietary needs as priorities. The elderly participants had varied sources from which to obtain health information, and self-learning and peer-learning were the most common way. However, most participants identified the necessity to evaluate the health information gained. Finally, language barriers (e.g., English and different Chinese dialects) and inappropriate content were mostly mentioned when discussing current health care programs.

Biological changes were the most salient factor influencing participants' dietary changes and related dietary practices (e.g., cooking and buying groceries). Maintaining psychological health was also deemed necessary when having a healthy diet and lifestyle. Traditional Chinese foods were available and accessible in Canada, and most participants had no difficulties in having traditional Chinese foods. Also, most of them can afford their favorite foods, regardless of socioeconomic status, and it may be because they were always able to achieve an economical food budget. However, financial issues may become serious with aging, which may prevent participants from having a healthy diet.

Conclusions

This study represents a preliminary understanding of contextual factors influencing Chinese Canadian seniors' dietary practices. The findings of this study reinforced those of past studies; but also extended beyond previous work by expanding the current understanding of their specific personal, social, and cultural context.

All these outcomes have implications for increasing Chinese Canadian seniors' quality of life and nutritional status by Registered Nurses (RNs). The findings of this study identified that viewing the dietary practices of Chinese seniors in a holistic manner would contribute to RNs in Canada understanding the contextual factors, and then providing culturally appropriate and effective nutritional consultations as well as advocating for the availability of traditional ethnic foods and menus to improve these seniors' diets in both communities and health institutions. Furthermore, the findings may help the Canadian Nurses Association with updating the guidelines for RNs who work with elderly Chinese immigrants. This includes the importance of gaining an understanding of how Chinese Canadian seniors' cultural beliefs and values shape their expectations of a healthy diet and determining factors in the context of their daily lives. Finally, the findings in this study may facilitate the development of longitudinal designs and qualitative research methodologies, and comparative studies may be conducted in order to explore the dietary issues among elderly immigrants from other ethnic backgrounds.

Table 1. Contextual Factors Influencing Chinese Seniors' Dietary Practices
Major Themes and Subthemes

1. Cultural Influences	<ul style="list-style-type: none"> ■ Cultural conceptualization of an appropriate diet for seniors <ul style="list-style-type: none"> ◆ Keeping a balanced diet ◆ Having a plain diet ◆ Eating less refined foods ◆ Fitting physical needs ■ Cultural values of dietary practices <ul style="list-style-type: none"> ◆ "Cu Cha Dan Fan" (Having a simple diet) ◆ Childhood dietary habits and long-term dietary beliefs ◆ Concerns of dietary acculturation 	<ul style="list-style-type: none"> ■ Influences of health care professionals and services <ul style="list-style-type: none"> ◆ Needs to gain health information ◆ Varied sources of gaining health information ◆ Evaluating health information gained
2. Influences of Family Members, Peers, and Health Care Professionals and Services	<ul style="list-style-type: none"> ■ Consideration of family members' dietary needs ■ Significance of social activity to have a meal with others 	<ul style="list-style-type: none"> 3. Biological Changes, Psychological Health, Accessibility and Availability of Traditional Chinese Foods, and Financial Issues <ul style="list-style-type: none"> ■ Biological changes influencing Chinese seniors' dietary practices ■ The influences of psychological health ■ Accessibility and availability of traditional Chinese foods ■ Financial issues <ul style="list-style-type: none"> ◆ Achieving an economical food budget ◆ Financial issues with aging

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TWO SIDES TO A COIN

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Take a coin out of your wallet or pocket. Flip it up and down a few times and you will quickly realize that there are indeed two sides to it. What makes it land on the *tail* side on one flip and then perhaps *tails* again on the second toss, or does it land with the *head* side up? I would like to reflect upon two sides of a coin.

Natural disasters such as the recent spring floods in the Maritimes, the 1998 ice storms in Quebec and Ontario, and the 2003 fires in British Columbia, caused tragedy and loss for individuals of all ages—from the very young to the very old. However, there are additional challenges faced by older adults such as medication management, reduced income, limited transportation, sensory decline, and mobility impairment. There are also situational concerns; for example, power outages which prevent the uses of electronic wheelchairs and elevators. We might call this the *tail* side of the coin.

Now let's have a look at the *head* side. There is evidence in the literature that aging may insulate some older adults from some of the tragedy associated with natural disasters. For example, Seplaki, and Goldman, Weinstein, and Lin (2006) analyzed data on 1160 older individuals from a national, longitudinal survey with interviews before and after the Taiwan earthquake in 1999. Findings suggest that people who experience damage to their home during a disaster were at risk of experiencing depressive symptoms, however the elderly were more resilient than the near-elderly. Yeung and Fung (2007) reported that older adults consistently experienced less anger than did younger ones at the peak of the SARS outbreak in Hong Kong. Their findings suggested that older adults may be better at emotional regulation than are their younger counterparts; they react to a crisis with less anger and are better able to adapt their coping strategies to the changing environment. The conclusions of Yeung and Fung have been supported by other researchers. Acierno et al (2006) used a random digital dialling method to survey 113 older adults (60+) and 413 younger adults residing in Florida counties directly affected by the 2004 hurricane. Older adults reported fewer symptoms of post traumatic stress disorder, major depressive disorders, and generalized anxiety disorders.

Back to my coin analogy, is it luck or the sudden gust of wind that causes the coin on the third flip to land with the *head* side up? Perhaps it is prior experience, a sense that I have lived through previous disasters and I can live through this one, which provides older adults with the resources required to adapt. Their wealth of knowledge and historical experiences may be an inspiration to others.

As gerontological nurses, we seek to promote the health and well being of older adults during natural disasters but it is also noteworthy that older adults may bring resources to help us in our role. Framing support within a partnership perspective, older adults and gerontological nurses, is important to capture the complexity of the challenges faced in natural disasters and to ensure an integrated and comprehensive approach response.

Both sides of the coin contribute to gerontological nursing knowledge and to the implementation of care in disasters. Both sides bring gifts and challenges. Together, they deserve to be acknowledged, embraced, and examined in the fullness of their contribution.

UPCOMING EVENTS

SPOTLIGHT ON RESEARCH Breakfast

November 5, 2008, Shaw Conference Centre

Join us for breakfast and hear how the Glenrose Rehabilitation Hospital is changing the lives of patients who are living with spasticity.

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Fourth Annual Mental Health Research Showcase

November 19–21, 2008

The Rimrock Resort Hotel, Banff, Alberta Info: www.ambh.ab.ca/showcase

16th Annual Alzheimer's Association Dementia Care Conference

August 24–27, 2008

Hyatt Regency Orange County, Garden Grove California

Questions: careconference@alz.org, Website: <http://www.alz.org/careconference/08/registration.asp>

15th National Conference on Gerontological Nursing (“Making Moments Matter”),

Banff Conference Centre, Banff, Alberta, May 27–30, 2009. For **Call for Abstracts** and List of Key Note Speakers, see website for the **Canadian Gerontological Nurses Association:** www.cgna.net

Canadian Association on Gerontology – 37th Annual Scientific & Educational Meeting

October 23–26, 2008, The Hilton London, London, Ontario. Info at: www.cagacg.ca



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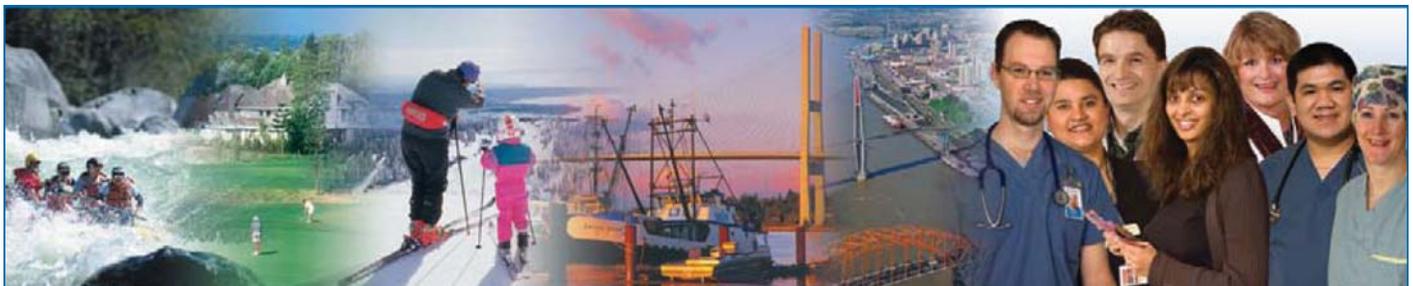
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YES VIRGINIA, THERE IS HOPE FOR ALZHEIMER'S PATIENTS!

Ashby Memory Method / Cognitive Retention Therapy Overview — Part 1

One out of three people in Canada is directly or indirectly affected by Alzheimer's Disease or dementia, yet, until now, the medical community has been able to offer them very little hope.

Now a Calgary-based health research company has unveiled a cognitive retention therapy that could change the way we think about—and treat—Alzheimer's: not as a curable disease, but as one in which we can actually reverse some of the decline and roll back symptoms experienced by patients through brain therapy.

The Ashby Memory Method is a scientifically-designed brain fitness program designed to rebuild memory pathways in people with memory loss, dementia or first and second stage Alzheimer's.

This program is a **breakthrough discovery** that can provide very immediate benefits to the 450,000 Canadians whose lives are being short-changed by Alzheimer's, dementia, or memory loss, as well as their families.

As Gayle Burrows, a former RN working as a caregiver in Vancouver says: "*I can finally say 'Yes! There is something we can do to help. The Ashby Memory Method works!' It is exciting!!*" Field trials with 50 patients have shown a 12–14% improvement in the memory after using the brain exercise program for one year. And these are folks who were already showing memory loss—with an average memory score (using the standardized Mini Mental State Exam) of 20 out of 30.

The research of Dr. Mira Ashby, who won the Order of Canada for her work with the brain injured, has been developed by her son, John Ashby into the Ashby Memory Method. *It is a natural progression of the scientifically-designed therapies—now standard treatment—for brain-injured victims of car collisions, workplace accidents and stroke patients. What is new is that it works against Alzheimer's and dementia. It is the only treatment or therapy that has shown real, measurable improvement in quantitative mental tests and more importantly, in the quality of life people enjoy—outstripping the primarily symptom-easing benefits of medications. Some family members describe it as "bringing them back."*

This non-drug intervention does not interfere with medication, and it can be done in a hospital (to ameliorate post-operative dementia), seniors' residence or at home. The caregiver works with the participant twice a week on a scientifically-designed series of exercises that come in a book format (easily accepted by seniors).

The implications for the program are extremely significant to the estimated 3.5 million patients in North America personally affected by Alzheimer's and the millions more who are directly involved in providing care to their spouse or parent. Findings suggest that in addition to improving memory, this targeted intervention program has the potential to maintain people's functional abilities much longer, building on the known connection between higher MMSE scores and people's increased ability to perform activities of daily living such as grooming, dressing, household chores, and keeping appointments. This discovery promises to extend their independence, delay a move to institutional care by several years, or reduce caregiver burden. It also promises to improve the all-important quality of life and save the public health care system millions of dollars in facility costs.

In conclusion, the Ashby Memory Method may be one of the important therapeutic breakthroughs to emerge in the field of Alzheimer's treatment in recent years.

Learn more by visiting www.alzinnovation.com or calling 1-877-300-8988

Next month Part II – Real life stories and how to do the Ashby Memory Method with your patients

Joan Crockett, Chief Executive
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ARTICLES/WEBSITES

Elder Wise INFO Newsletter Articles: www.elderwise.ca

Computer Training for Seniors: **Volume 4, Number 7 [2008]**

For more information about individual training, visit http://www.brightideasweb.ca/serv_indiv.html

Articles to Peruse from the Canadian Journal on Aging Vol. 27(1) Spring 2008

Garret, D.D. et al. (2008). Planning for end-of-life care :Findings from the Canadian Study on Health and Aging. Pp.11–22

Blakeborough, D. (2008). "Old people are useless": Representations of aging on *The Simpsons*. Pp. 57–68

Wiersma, E.C. & Pedlar, A. (2008). The nature of relationships in alternative dementia care environments. Pp. 101–108.

Canadian Medical Association Journal*, new issue: 6 May 2008; Vol. 178, No. 10

URL: <http://www.cmaj.ca/content/vol178/issue10/?etoc>

CMAJ Table of Contents for 22 April 2008; Vol. 178, No. 9

GREEN THUMBS AND HEALTHY LIVING – HORTICULTURAL PRACTICES FOR OLDER ADULTS

*Sade Abiola - Horticultural Consultant
Treasured Plants Consulting*

Sade Abiola is a horticultural consultant in Calgary, Alberta, her two great passions - people and plants are being combined in HT.

It gives me great joy to share with you the health benefits we gain through horticulture and horticultural activities. I feel very privileged to be in the company of older adults in this day and age, when everybody is too busy to do things in the way that help us pass down the family and cultural traditions we all have come to hold so dear and precious. It is my hope that this article will inspire you to consider gardening as not just an activity, but rather as a tool, when considering healthy living for older adults. Through my own personal experience, it has been more evident to me in the last three years that truly, gardening is a therapeutic and healing tool. I am very convinced about it and would like to share the idea with you, so you too can benefit from it in your own ways.

The practice involving the intentional use of plants, horticultural activities and the natural world to promote awareness and improve the body, mind and spirit is a process that enhances the quality of life of its participants. This has also been described as a process that encourages healing cognitively, physically, and emotionally as well as and socially and spiritually, it is known as Horticultural Therapy (HT). You can enjoy the benefits of gardening whether you participate actively or passively in the process. Passive involvement includes sitting on a park bench and being relaxed in the serenity of the atmosphere or taking a walk through nature and enjoying the beauty of the environment. Active participation in gardening involves digging, planting, hoeing, weeding and carrying out other maintenance gardening activities. This is definitely more beneficial to the participant than being just passively involved. It is also an established fact that people derive maximum benefits by attending a program that is facilitated by a Horticultural Therapy professional. With the older adults, adaptive tools (e.g. long-handled tools with comfortable grip, kneeling stools and pads) and techniques (raised beds, containers at easy-reach levels and protection from the elements) make gardening a still-enjoyable activity, having in mind the challenges each individual might be facing in an attempt to carry out a once-enjoyable activity.

In my search of previous work conducted in HT, I have established that its principles and practice are used in rehabilitation programs for patients recovering from stroke, spinal cord injuries, traumatic brain injuries, drug and alcohol addiction and mental illness. HT is also used in Services for the Elderly and in Offender Rehabilitation Services. Persons with physical and developmental disabilities also benefit from HT programming. Other programs where the principles of HT are being applied today are: botanical gardens, community gardens, homeless shelters, hospices and war veteran centres. You too can benefit from the principles and practice of HT in your day-to-day life. For instance, bridging the generational gap between you and your grandchild can be one way of using HT programming to benefit your family and this can become a tradition that will be passed down from one generation to another in your family. I sincerely hope that this article will encourage you to make a decision to put in the necessary efforts to gain the said benefits of HT from here on. When individuals feel well within themselves, our community will be a better place for all in many respects and we can have you, our older adults with us for a longer time to share with us what money cannot buy—your wisdom. I wish you the very best of the growing season, enjoy it all!

For further information about HT, visit: www.chta.ca and www.ahta.org For contact in Calgary, Alberta, visit: <http://ca.groups.yahoo.com/group/chtasa/>.

PROVINCIAL NEWS



It is with great delight that I can announce that the Gerontological Nurses Group of British Columbia will now be known at the Gerontological Nurses Association of British Columbia. Our “Transition Team” received final confirmation in May that our constitution and by-laws were accepted by the Provincial Government and we have now become an independent non-profit society. We implemented this change as the College of Registered Nurses of British Columbia had placed restrictions on our group that our members found unacceptable. We were the first Nursing speciality group to leave the college and other groups have subsequently initiated the disaffiliation process. Congratulations to the Transition Team!

As an association we are now able to offer full membership with both Licensed Practical Nurses and Registered Psychiatric Nurses. We are also pleased that we now have the ability to support CGNA with regards to political advocacy and look forward to doing so. The transition team is currently in the process of changing our documents and website to reflect our new name. Work will be ongoing regarding planning for the future of our association.

We continue to have eight chapters throughout the province and our membership is increasing! The individual chapters have continued to offer exciting educational sessions and networking opportunities for our members. There have also been changes in the chapter executives and I would like to thank all the executives stepping down for their contribution and also to extend a warm welcome the new executive members. You have joined a great team!

Our Annual Conference and AGM is scheduled this September 18th – 20th in Coquitlam, B.C. The theme of the conference is, “New Frontiers in Gerontology” and information is available on our web site. Application forms will be ready soon and will also be

Continued on page 13

available on our website. There is an excellent range of topics and guest speakers, something of interest for everyone. I know that I am personally looking forward to hearing what the future holds in the field of Gerontology. We look forward to seeing you there!

We will have two provincial executive positions available – that of Education Chair and President-Elect. Our newsletter editor is also looking for someone to join her team. This is a wonderful opportunity to work with people that share the same interests - that of ensuring that gerontological nursing practice continues to move forward and that positive changes continue in gerontological nursing practice. If you are interested in any of these positions, or know of someone that is, or just have some questions, please contact Judy Delaney, head of the nominations committee. She can be reached at: judithsdel@shaw.ca. We look forward to hearing from you!

*Respectfully Submitted,
Catherine Marsden,*



As the new president of MGNA I would like to take this opportunity to thank all the members of the MGNA 2007–8 Executive. The MGNA had a very successful year thanks to all of the hard work and dedication of: Pat Cossette, Helen Zelinski, Jason Hillier, Denise Levesque, Christine Johnson, Judy Robertson and

Bev Laurila. I would like to give a special thanks to the past President, Pat Cossette.

On May 2, 2008, the MGNA held the annual general meeting which was a fitting way to end the 2007–2008 season. The theme of the Education Day was Caring, Connecting and Communicating and was very well received by 34 members and 14 non-members. The MGNA Distinction Award was also presented at the event to Sheila Kehler and our congratulations go out to her.

As previously mentioned, the success of the MGNA is directly linked to those members who volunteer their time and energy. A warm welcome is extended to the new 2008–2009 Executive, Pat Davidson, Carole Prince and Barb Tallman. At the same time, a thank-you is extended to the outgoing Executive members, Helen Zelinski, Denise Levesque and Bev Laurila.

On behalf of the MGNA executive and members I hope that everyone gets to experience a warm and relaxing summer and I look forward to connecting and conversing with CGNA over the course of 2008-2009.

Respectfully submitted: Anne Williams, President MGNA



Our education day and annual meeting was held on April 18, 2008 with 96 nurses, 10 students and 20 sponsors in attendance. The topic “Caring: for Clients, Family and Ourselves” was explored through round table discussions on such topics as Caring for the Older Adult in Acute Care; Caring for Ourselves: Work/Life Balance; Strategies for Positive Involvement of Families; and many others. The round table discussions also gave members an opportunity to network and share their expertise. Our keynote speaker Florence Myrick spoke on Preceptorship: Educating for the Care of the Older Person.” She challenged us to value our role as Gerontological nurses and share our knowledge with others. Our final speaker, Pat Casey-Jurgens, spoke with

passion and humour. She expressed her respect for Gerontological nurses and challenged us to care for ourselves as well as the clients and families we serve.

We are very busy preparing for the 15th National Conference on Gerontological Nursing “Making Moments Matter.” It will be held in Banff, so as well as a chance to learn more about gerontological nursing and network with your peers, you will have the opportunity to enjoy the mountains. I would encourage you to submit an abstract for a poster or presentation and plan to attend.

At the annual meeting two motions were passed. The first motion encourages AGNA executive and members to advocate for more geriatric mental health continuing care facilities, long-term care and designated assisted living, throughout the province of Alberta. The second motion authorized the executive in conjunction with CGNA to explore the issue of expanding the membership to include all regulated nurses. This is an important issue and reflects the current practice in which all nurses function as members of the nursing team. The executive will be considering these motions and developing plans to address them.

*Respectfully submitted
Ruth Graham, President AGNA*

Hi! Dawn Fenton from New Brunswick filling in for Lois Carson.

Membership sign up is going slowly as we did not have an Education Day in April 2008. I spoke with the person that had the Education Day in October 2007 and she informed me that although she had no new people sign up, she did have a good turnout. In any case with my persistence and presentations on NBGNA, I have managed to sign up a few new faces, and remind those interested to renew their memberships. I hope our Education Committee can put together something for Fall 2008.

*Respectfully submitted,
Dawn Fenton, for Lois Carson, president NBGNA*





**15th National Conference on
Gerontological Nursing
Alberta Bound!**

"Making Moments Matter"¹

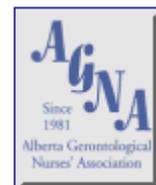
May 27-30, 2009
The Banff Conference Centre

CALL FOR ABSTRACTS

Deadline for Submission Oct 1, 2008

The Canadian Gerontological Nursing Association invites you to share your knowledge and experience with others at our biennial conference. We encourage you to submit an abstract for a paper or poster presentation which would offer insight into how your work in practice, education, research or administration has "made a moment matter" for older adults. The abstract submission form and guidelines for submitting your abstract are found on the CGNA website:

www.cgna.net



¹ Pringle, D. (2003). Making moments matter. *Canadian Journal of Nursing Research*, 35(4), 7-13.



Mitzi G. Mitchell
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Lecturer
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A NURSE'S VIEW OF THE END OF SUMMER

My calendar says it's still mid-August,
But I feel deep down the end of summer.
It's in the cool rain falling on my face;
It's in the plaintiff sound of a wild duck's cry.
My skin feels it with the frosty morning;
I see it in one golden leaf falling and
Gently drifting through the slowly greying sky.
I taste it in the fresh cream of yellow corn,
In the sweet juice of a blushing peach.
Now nights come creeping in on silent silky paws,
Dawns open their hazy eyes just a moment later;
They whisper softly in my ear the end of summer.

My calendar says it's still mid-August,
But I feel deep down the end of summer.
It's in my bones which ache just a little
It's in the breath of frost which touches my hair.
I see it in my soft golden skin,
A tiny line falling gently down my face,
A touch ever so lightly under my rainy eyes;
The texture of my peach-like cheek not quite
so buttery and soft.
My dusks and dawns come just a heart beat later.
They whisper softly in my ear the end of my summer.

Stanza one of this poem describes the little signs in nature that autumn is coming and summer's end is near. The four seasons can be a metaphor for the seasons of life: spring – youth; summer – full maturity; autumn – middle-age; winter – the elder years. This transition between the fullness of maturity with all its promises, hopes and dreams and the early middle years of fulfillments, regrets, and reality is depicted in the second stanza. The poet stands at a pivotal point when past, present, and future converge and become clear to her as she looks at her face and life.



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